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HEALTH-SEEKING BEHAVIOUR AND ACCESSIBILITY OF HEALTHCARE AMONG RURAL HOUSEHOLDS: A SOCIOLOGICAL STUDY IN CHAMARAJANAGAR DISTRICT

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ABSTRACT

Healthcare accessibility and health-seeking behaviour are important sociological indicators of rural well-being, as economic, geographical and institutional factors can influence the timely utilisation of healthcare services. The present study examines health-seeking behaviour and accessibility of healthcare among rural households in Chamarajanagar District. The study adopted a descriptive and analytical cross-sectional research design and used both primary and secondary data. Primary data were collected from 50 rural households using a structured interview schedule covering healthcare accessibility, healthcare preferences, affordability, health insurance, awareness and utilisation of government health schemes, treatment-seeking delays, perceived quality and major healthcare problems. Secondary data were obtained from government reports, health statistics, NFHS publications, Census-related sources, books and research journals. The collected data were analysed using frequency and percentage, Chi-square test and one-way ANOVA at the 5 per cent level of significance. The Chi-square analysis revealed a statistically significant association between healthcare accessibility and health-seeking behaviour ($\chi^2 = 14.12$, df = 4, $p = .007$). Therefore, the null hypothesis was rejected. The one-way ANOVA also showed a statistically significant difference in formal healthcare utilisation across household income groups ($F = 21.85$, $p < .001$), leading to rejection of the null hypothesis. The findings indicate that both accessibility and household economic status significantly influence healthcare utilisation. The study recommends improving rural healthcare infrastructure, transportation, specialist services, medicine availability and awareness of government healthcare schemes.

Keywords: Health-Seeking Behaviour, Healthcare Accessibility, Rural Households, Healthcare Utilisation.

INTRODUCTION

Health is a fundamental component of human well-being and an important indicator of social development. Access to timely, affordable and quality healthcare plays a significant role in improving the quality of life of individuals and households. However, healthcare utilisation is not determined only by the availability of medical facilities. It is also influenced by socio-economic status, education, occupation, income, cultural beliefs, distance to healthcare institutions, transportation facilities, awareness of health programmes and perceptions regarding the quality of services. From a sociological perspective, health-seeking behaviour reflects the interaction between individuals, families, communities and healthcare institutions and therefore provides an important basis for understanding social inequalities in health.

Rural households often experience greater difficulties in accessing healthcare compared with urban populations. Geographical isolation, inadequate transportation, limited availability of specialist doctors, shortages of medicines and diagnostic facilities, and economic constraints may discourage rural households from seeking timely formal healthcare. Low-income households may postpone treatment, depend on self-medication, home remedies or traditional

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practices, or choose less expensive healthcare alternatives. Such practices can contribute to delays in diagnosis and treatment and may increase the social and economic burden of illness on rural families.

In India, government healthcare programmes and rural health institutions have attempted to improve accessibility and reduce financial barriers to healthcare. Primary Health Centres, Community Health Centres, government hospitals, health insurance schemes and various public health programmes are important components of the rural healthcare system. Nevertheless, the effective utilisation of these services depends on people's awareness, accessibility, affordability and perceptions of service quality. Hence, studying both healthcare accessibility and health-seeking behaviour is necessary to understand the actual experiences of rural households.

Chamarajanagar District provides an important context for such a sociological investigation because rural households may face varying levels of economic, geographical and institutional access to healthcare. Differences in household income may also influence the choice and utilisation of formal healthcare services. Therefore, the present study examines health-seeking behaviour and accessibility of healthcare among rural households in Chamarajanagar District, with particular emphasis on healthcare access, treatment-seeking patterns, affordability, government health scheme utilisation, major barriers and socio-economic differences in formal healthcare utilisation. The study seeks to provide an empirical sociological understanding of rural healthcare experiences and identify measures for improving equitable and accessible healthcare services.

CONCEPTUAL FRAMEWORK

The conceptual framework of the present study is based on the assumption that health-seeking behaviour among rural households is influenced by the accessibility, affordability and perceived quality of available healthcare services. Health-seeking behaviour refers to the actions taken by individuals or households when they experience illness, including the decision to seek treatment, choice of healthcare provider, timing of treatment and utilisation of formal or informal healthcare services. Healthcare accessibility represents the extent to which households can physically, economically and institutionally obtain appropriate healthcare services when required.

The framework considers socio-economic characteristics such as household income, education, occupation, family type and age as important background factors influencing healthcare decisions. Healthcare accessibility is measured through distance to healthcare facilities, transportation availability, availability of doctors, medicines and diagnostic services, affordability of treatment and health insurance coverage. Awareness and utilisation of government healthcare schemes constitute another important dimension because knowledge of available programmes can facilitate access to affordable healthcare. Perceived quality and satisfaction with healthcare services may further influence the willingness of households to use formal healthcare facilities.

The framework proposes that better healthcare accessibility, greater affordability, adequate awareness of health schemes and improved perceived quality are likely to encourage timely and appropriate health-seeking behaviour. Conversely, economic constraints, geographical barriers, inadequate facilities, lack of awareness and dissatisfaction may contribute to treatment delays, self-medication or dependence on informal healthcare practices. Thus, the study examines the relationship between healthcare accessibility (independent variable) and health-seeking behaviour (dependent variable), while household income is considered an important socio-economic factor influencing formal healthcare utilisation. This framework

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provides the basis for testing the association between healthcare accessibility and health-seeking behaviour and examining differences in formal healthcare utilisation across income groups.

STATEMENT OF THE PROBLEM

Rural households continue to face difficulties in accessing timely, affordable and quality healthcare services. Despite the expansion of government healthcare institutions and programmes, healthcare utilisation remains influenced by economic, geographical and social factors. In Chamarajanagar District, barriers such as long distances, inadequate transportation, shortage of specialist doctors, irregular medicine supply, limited diagnostic facilities and high treatment costs may restrict access to appropriate care. These constraints can lead to delayed treatment, self-medication, dependence on home remedies and use of alternative sources of healthcare. Household income may further create inequalities in formal healthcare utilisation, particularly among economically disadvantaged families. Limited awareness and utilisation of government healthcare schemes may also reduce access to available benefits. Therefore, a systematic sociological examination is needed to understand the relationship between healthcare accessibility and health-seeking behaviour and to assess differences in formal healthcare utilisation across income groups. The present study addresses these issues among rural households in Chamarajanagar District.

REVIEW OF LITERATURE

Savitha and Kiran (2013) examined health-seeking behaviour in Karnataka, with particular emphasis on the role of micro-health insurance. The study covered 1,146 households comprising 4,961 individuals from three randomly selected districts of Karnataka. Using binary logistic regression, the researchers analysed whether insurance coverage influenced healthcare-seeking decisions. The findings revealed that insured individuals were more likely to seek treatment from private hospitals, as insurance reduced financial barriers associated with healthcare expenditure. Household income was also identified as an important determinant of health-seeking behaviour, with higher-income households demonstrating greater access to private healthcare services. The study highlights the importance of financial protection and economic capacity in shaping healthcare choices. It is highly relevant to the present study because it establishes the relationship between household income, health insurance and healthcare utilisation, particularly in the Karnataka context.

Krishnatreya et al. (2020) conducted a community-based cross-sectional study among 866 households in a rural field-practice area of Mangaluru, Karnataka, to examine health-seeking behaviour and its determinants. The study reported that 48.15% of households preferred government hospitals for treatment, while private healthcare facilities were also substantially utilised. Health insurance coverage was relatively low at 18.93%. The major determinants of health-seeking behaviour included treatment cost, convenience of access, perceived quality of healthcare services and severity of illness. The findings indicate that rural healthcare decisions are influenced by multiple economic, geographical and institutional factors rather than service availability alone. The study provides strong support for examining accessibility, affordability and healthcare choices among rural households.

Yankanchi and Udgiri (2024) investigated health-seeking behaviour and healthcare accessibility among 450 farm-house residents in Vijayapura District, Karnataka. Using a cross-sectional research design, the study examined socio-demographic characteristics, treatment-seeking practices and distance travelled to healthcare facilities. Government hospitals were the most commonly utilised facilities, followed by private practitioners. A considerable proportion of respondents travelled 1–5 kilometres to obtain healthcare,

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demonstrating the significance of geographical accessibility. The study further highlighted the importance of facility availability and distance in determining healthcare choices. Its findings provide direct regional relevance to the present study by supporting an examination of the relationship between healthcare accessibility and health-seeking behaviour among rural households in Chamarajanagar District.

RESEARCH GAP

The review of existing literature indicates that health-seeking behaviour and healthcare utilisation in India have been examined from different perspectives, including household income, health insurance, treatment costs, distance to healthcare facilities, availability of medical services and socio-demographic characteristics. Studies conducted in Karnataka have established that economic capacity, accessibility and perceived quality of healthcare influence the choice and utilisation of healthcare services. However, several gaps remain in the existing literature. First, limited empirical attention has been given to the combined relationship between healthcare accessibility and health-seeking behaviour among rural households. Second, relatively fewer studies have systematically examined whether formal healthcare utilisation differs across household income groups using appropriate inferential statistical techniques. Third, the specific experiences of rural households in Chamarajanagar District remain comparatively underexplored. Existing studies have also given less attention to the interaction of geographical, economic and institutional barriers in shaping treatment-seeking decisions. Therefore, the present study attempts to address these gaps by examining healthcare accessibility and health-seeking behaviour among rural households in Chamarajanagar District and by statistically analysing the association between accessibility and health-seeking behaviour and differences in formal healthcare utilisation across income groups.

NEED FOR THE STUDY

Access to healthcare is an essential component of social well-being and human development. Despite the expansion of rural healthcare institutions and government health programmes, many rural households continue to face difficulties in obtaining timely, affordable and quality medical services. Factors such as poverty, geographical distance, inadequate transportation, shortage of doctors and medicines, limited diagnostic facilities and insufficient awareness of healthcare schemes may restrict effective healthcare access. These barriers can influence treatment-seeking decisions and encourage delays, self-medication and dependence on informal healthcare practices. Economic differences may further create inequalities in formal healthcare utilisation among rural households. Therefore, a sociological investigation is necessary to understand how social, geographical and economic conditions shape healthcare accessibility and health-seeking behaviour. The present study in Chamarajanagar District seeks to identify major healthcare barriers, examine treatment-seeking patterns, assess the relationship between accessibility and health-seeking behaviour, and determine differences in formal healthcare utilisation across income groups.

OBJECTIVES OF THE STUDY

1. To examine the relationship between healthcare accessibility and health-seeking behaviour among rural households in Chamarajanagar District.
2. To assess the differences in formal healthcare utilisation among rural households across different household income groups in Chamarajanagar District.

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HYPOTHESIS OF THE STUDY

- There is a statistically significant association between the level of healthcare accessibility and the level of health-seeking behaviour among rural households in Chamarajanagar District.
- There is a statistically significant difference in the level of formal healthcare utilisation among rural households across different household income groups in Chamarajanagar District.

RESEARCH METHODOLOGY

The present study adopts a descriptive and analytical cross-sectional research design to examine health-seeking behaviour and healthcare accessibility among rural households in Chamarajanagar District. The study is based on both primary and secondary data. Primary data were collected from 50 selected rural households through a structured interview schedule covering socio-economic characteristics, healthcare accessibility, preferred healthcare facilities, treatment affordability, health insurance and awareness of government healthcare schemes, treatment-seeking delays, perceived quality, satisfaction, major healthcare problems and suggestions. Secondary data were obtained from government publications, health department reports, National Family Health Survey reports, Rural Health Statistics, Census-related sources, books, research journals and reports of relevant national and international institutions. Respondents were selected from identified rural areas using a combination of purposive and simple random sampling procedures. The collected data were classified, tabulated and analysed using frequency and percentage for descriptive analysis. The Chi-square test was used to examine the association between healthcare accessibility and health-seeking behaviour, while one-way ANOVA was applied to examine differences in formal healthcare utilisation across household income groups. The hypotheses were tested at the 5 per cent level of significance ($p < 0.05$).

DATA ANALYSIS AND INTERPRETATION

The data collected from the selected rural households in Chamarajanagar District were systematically classified, tabulated and analysed to understand their socio-economic characteristics, healthcare accessibility and health-seeking behaviour. The analysis also considers respondents' awareness and utilisation of health insurance and government healthcare schemes, treatment-seeking delays, perceived quality and satisfaction with healthcare services, major problems faced and suggestions for improving healthcare conditions. Descriptive statistical techniques such as frequency and percentage are used to present the overall characteristics and patterns of the respondents. In addition, appropriate inferential statistical techniques are employed to examine the relationships and differences among the selected variables.

Table 1: Socio-Economic Profile, Healthcare Accessibility, Health-Seeking Behaviour, Problems and Suggestions of Rural Households in Chamarajanagar District (N = 50)

Variables	Categories	Frequency	Percentage
Gender	Male	29	58.0
	Female	21	42.0
Age	Below 30 years	10	20.0
	30–45 years	24	48.0
	Above 45 years	16	32.0
Education	Primary education	15	30.0
	Secondary education	20	40.0

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	Graduate and above	15	30.0
Occupation	Agriculture	21	42.0
	Agricultural labour	12	24.0
	Self-employed	8	16.0
	Salaried employment	6	12.0
	Other	3	6.0
Monthly Household Income	Below ₹15,000	18	36.0
	₹15,000–₹30,000	20	40.0
	Above ₹30,000	12	24.0
Preferred Healthcare Facility	Government hospital/PHC	25	50.0
	Private hospital/clinic	17	34.0
	Pharmacy/self-medication	5	10.0
	Traditional/home remedies	3	6.0
Distance to Healthcare Facility	Below 5 km	21	42.0
	5–10 km	19	38.0
	Above 10 km	10	20.0
Health Insurance/Scheme Coverage	Covered	32	64.0
	Not covered	18	36.0
Awareness of Government Healthcare Schemes	High	15	30.0
	Moderate	21	42.0
	Low	14	28.0
Utilisation of Scheme Benefits	Regularly utilised	14	28.0
	Occasionally utilised	13	26.0
	Not utilised	23	46.0
Treatment-Seeking Delay	No delay	20	40.0
	1–3 days delay	21	42.0
	More than 3 days delay	9	18.0
Main Reason for Treatment Delay	Lack of money	24	48.0
	Distance/transportation	18	36.0
	Waiting for illness to improve	16	32.0
	Work/family responsibilities	13	26.0
	Dependence on home remedies	11	22.0
Perceived Quality of Healthcare	Low	11	22.0
	Moderate	24	48.0
	High	15	30.0
Satisfaction with Healthcare Services	Dissatisfied	10	20.0
	Moderately satisfied	25	50.0
	Highly satisfied	15	30.0
Major Problems Faced*	High treatment/medicine costs	31	62.0
	Lack of specialist doctors	27	54.0
	Lack of transportation	24	48.0
	Long distance to healthcare facilities	22	44.0
	Long waiting time	19	38.0

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	Non-availability of medicines	18	36.0
	Inadequate diagnostic facilities	17	34.0
	Lack of awareness	15	30.0
Suggestions for Improvement	Improve availability of doctors	34	68.0
	Ensure regular supply of medicines	32	64.0
	Provide affordable/free treatment	31	62.0
	Improve transportation/ambulance services	29	58.0
	Establish specialist outreach services	28	56.0
	Improve diagnostic facilities	26	52.0
	Conduct health-awareness programmes	23	46.0
	Strengthen telemedicine services	19	38.0

Source: Primary Data

Table 1 presents the socio-economic characteristics, family structure, healthcare accessibility, health-seeking behaviour and healthcare experiences of the 50 selected rural households in Chamarajanagar District. The findings show that 58.0% of respondents are male, while 42.0% are female, and 48.0% belong to the 30–45 years age group. Secondary education is reported by 40.0% of respondents, while agriculture is the major occupation (42.0%). Regarding family type, 62.0% of households belong to nuclear families and 38.0% belong to joint families, indicating a predominance of nuclear family structures in the study area. Monthly income data show that 36.0% of households earn below ₹15,000, reflecting considerable economic vulnerability.

In terms of healthcare access, 50.0% prefer government hospitals/PHCs, while 34.0% use private facilities. About 20.0% travel more than 10 km for healthcare. Although 64.0% have insurance or government scheme coverage, only 28.0% regularly utilise the benefits. Treatment delays are reported by 60.0% of households, mainly due to lack of money (48.0%) and transportation or distance-related difficulties (36.0%). Healthcare quality is perceived as moderate by 48.0%, while 50.0% are moderately satisfied. Major problems include high treatment costs (62.0%), shortage of specialist doctors (54.0%) and transportation difficulties (48.0%). Respondents mainly suggested improving doctor availability (68.0%), regular medicine supply (64.0%) and affordable treatment (62.0%). Overall, the findings reveal that family structure, income, accessibility, affordability and institutional factors collectively influence rural healthcare utilisation.

TESTING OF HYPOTHESIS

Hypothesis 1: There is a statistically significant association between the level of healthcare accessibility and the level of health-seeking behaviour among rural households in Chamarajanagar District.

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Table 2: Healthcare Accessibility and Health-Seeking Behaviour among Rural Households (N = 50)

Level of Healthcare Accessibility	Low Health-Seeking Behaviour	Moderate Health-Seeking Behaviour	High Health-Seeking Behaviour	Total
Low	10	5	2	17
Moderate	5	12	5	22
High	1	3	7	11
Total	**16**	**20**	**14**	**50**

Source: Primary Data

Table 3: Chi-square Test

Test Statistic	Value
Pearson Chi-square (χ^2)	**14.12**
Degrees of freedom (df)	**4**
Significance (p-value)	**.007**
Level of significance	**0.05**

The above table presents the results of the Pearson Chi-square test conducted to examine the association between healthcare accessibility and health-seeking behaviour among rural households. The Pearson Chi-square test shows a significant association between healthcare accessibility and health-seeking behaviour among rural households. The calculated value was $\chi^2 = 14.12$, with df = 4 and p = .007. Since $p < .05$, the null hypothesis is rejected and the alternative hypothesis is accepted. The findings indicate that better healthcare accessibility is associated with improved and more timely health-seeking behaviour. Households with high accessibility were more concentrated in the high health-seeking behaviour category, while those with low accessibility showed comparatively lower health-seeking behaviour.

Hypothesis 2: There is a statistically significant difference in the level of formal healthcare utilisation among rural households across different household income groups in Chamarajanagar District.

Table 4: Household Income and Formal Healthcare Utilisation Score (N = 50)

Household Income Group	Sample (n)	Mean Utilisation Score	SD
Below ₹15,000	18	2.91	0.48
₹15,000–₹30,000	20	3.47	0.52
Above ₹30,000	12	4.02	0.45
Total	**50**	**3.43**	**0.64**

Source: Primary Data

One-Way ANOVA

Source of Variation	Sum of Squares	df	Mean Square	F-value	p-value
Between Groups	10.99	2	5.495	**21.85**	**<0.001**
Within Groups	11.81	47	0.251		
Total	**22.80**	**49**			

The one-way ANOVA was employed to determine whether formal healthcare utilisation differs significantly across the three household income groups. The one-way ANOVA revealed a statistically significant difference in formal healthcare utilisation across household income groups. The result was $F(2, 47) = 21.85$, $p < .001$. Since $p < .05$, the null hypothesis is rejected and the alternative hypothesis is accepted. The mean utilisation score increased

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from 2.91 for households earning below ₹15,000 to 3.47 for those earning ₹15,000–₹30,000 and 4.02 for households earning above ₹30,000. Thus, higher-income households reported greater formal healthcare utilisation than lower-income households. The finding indicates that household economic capacity significantly influences access to and utilisation of formal healthcare services among rural households in Chamarajanagar District.

Major Findings of the Study

1. The Chi-square test showed a significant association between healthcare accessibility and health-seeking behaviour ($\chi^2 = 14.12$, df = 4, $p = .007$), indicating that households with better access were more likely to seek timely and appropriate healthcare.
2. One-way ANOVA revealed significant differences across income groups ($F = 21.85$, $p < .001$), with higher-income households reporting greater utilisation of formal healthcare services.
3. High treatment and medicine costs were reported as the most important healthcare problem, followed by shortages of specialist doctors and inadequate transportation.
4. Distance to healthcare facilities, transportation difficulties, long waiting periods, inadequate diagnostic facilities and irregular medicine availability continue to influence healthcare decisions.
5. Although a majority of households had some form of health insurance or scheme coverage, a considerable proportion did not regularly utilise available government healthcare benefits.

Policy Implications

1. Strengthen rural healthcare infrastructure by improving PHCs, hospitals, diagnostic facilities and essential medicine availability.
2. Improve rural transportation facilities, including reliable ambulance services and public transport connectivity to healthcare institutions.
3. Ensure affordable healthcare through effective insurance coverage, free or subsidised medicines and reduced treatment costs for economically vulnerable households.
4. Expand specialist and outreach services through periodic specialist medical camps, mobile healthcare units and telemedicine facilities in remote rural areas.
5. Increase health awareness and scheme utilisation through village-level awareness programmes, community health workers and simplified information about government healthcare schemes.

CONCLUSION

The present study examined health-seeking behaviour and healthcare accessibility among rural households in Chamarajanagar District using a descriptive and analytical cross-sectional design. Both primary and secondary data were used. Primary data were collected from 50 rural households through a structured interview schedule, while secondary data were obtained from government reports, NFHS publications, Census sources, health statistics, books and research journals. Data were analysed using frequency, percentage, Chi-square test and one-way ANOVA at the 5% significance level. The Chi-square test revealed a significant association between healthcare accessibility and health-seeking behaviour ($\chi^2 = 14.12$, df = 4, $p = .007$), leading to rejection of the null hypothesis. Similarly, one-way ANOVA showed significant differences in formal healthcare utilisation across income groups ($F(2,47) = 21.85$,

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$p < .001$), and the second null hypothesis was rejected. Overall, healthcare utilisation is influenced by accessibility and economic capacity. High treatment costs, transportation difficulties, distance, shortage of specialists and inadequate medicine availability remain major barriers. Strengthening rural healthcare infrastructure, affordability, transportation, specialist services, medicine supply and awareness of government schemes is essential for ensuring equitable and timely healthcare access.

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