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An Analysis of Women Doctors Opinion About the Relationship Between Class and Health: in Tumkur District

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ABSTRACT

The unequal distribution of power, money and resources also creates health inequities. While the relationship between poverty and health outcomes are clear, the overall level of class inequality (i.e. the relative gap between the rich and poor) also shapes health outcomes and this relationship tends to be less intuitive. For example, we know that people with low incomes often lack health insurance, cannot afford to pay for medical treatments, lack education associated with better health, and so on. However, regardless of the level of a person's income, the gap between a person's income and the upper tier of society also affects health outcomes in unique ways. A strong correlation between high income inequalities in a society and many negative social factors, including health, more violence, drug problems, child well-being, and mental illness. In India who are socially disadvantaged by income, employment status, education and place of residence also have a higher risk of Chronic diseases, such as diabetes, heart disease and cancers, HIV Communicable diseases Skin Problems and depression etc. We have taken 100 Sample for study Thus , the present study is based on the primary data collected form women doctors practicing both at government and private hospital in Tumkur district through structured interview schedule. The main objective of the paper is to find doctors opinion about the relationship between class and health.

KEYWORDS : Doctors, Health, Socio-Economic, Status and Class.

Introduction

The unequal distribution of power, money and resources also creates health inequities. There has always been an association between health and social class and, despite the welfare state and the improvement in health in all sections of societies over the years, this discrepancy remains. It applies to all aspects of health, including expectation of life, infant and maternal mortality and general level of health. Whilst the failure to close the social gap is a disgrace to some, others would claim that so long as these parameters are improving in all levels of society there is no cause for concern.

While the relationship between poverty and health outcomes are clear, the overall level of class inequality (i.e. the relative gap between the rich and poor) also shapes health outcomes and this relationship tends to be less intuitive. For example, we know that people with low incomes often lack health insurance, cannot afford to pay for medical treatments, lack education associated with better health, and so on. However, regardless of the level of a person's income, the *gap* between a person's income and the upper tier of society also affects health outcomes in unique ways.

A strong correlation between high income inequalities in a society and many negative social factors, including health, more violence, drug problems, child well-being, and mental illness. In India who are socially disadvantaged by income, employment status, education and place of residence also have a higher risk of Chronic diseases, such as diabetes, heart disease and cancers, HIV Communicable diseases Skin Problems and depression ext. In our study we ask to Doctors about patient health and family conduction they said middle class and poor are less concentrate because less/low income they safer from chronic diseases.

Objectives of the Study:

The objectives of the present study is to find out the socio-economic status of the women doctors and to Know the women doctors opinion about the relationship between class and health.

Research Methodology

A close study has been carried out by selecting the a sociological study of women doctors in Tumkur City and the methodology in social research comprises selection of study area, selection of sample and collection of both primary and secondary data for the study. The samples are restricted to only women doctors in government and private hospitals and the universe for data collection is restricted to the Tumkur district only.

Sources of Data:

The present study has been conducted with the help of both primary and secondary sources of data.

Primary Data:

The study is mainly based on the primary data. The primary data were collected through a structured interview schedule consisting both open and close ended questions. Before the actual collection of data, the questionnaires were pre-tested through a pilot study. Necessary modifications were made in the questionnaires on the basis of testing. The questionnaires were personal interview method. Some of the respondents were also contacted personally. An in-depth discussions / interviews were also held with women doctors at Government and private Hospitals.

Sample:

The samples of 100 women doctors were selected on purposive sampling method.

Tools for Analysis:

In the present study statistical tools like averages, percentages, and growth rates are used wherever necessary. Further data are classified and presented in simple and lucid styles by using tables, graphs and simple charts.

Field work:

The field investigation was undertaken during the period of December 2014 to march 2015. The personal interview method was adopted. The researcher has received the required co-operation in the govt. and private hospitals from women doctors, However, certain problems were encountered by the researcher in collecting the data from the medical records and eliciting the information from women doctors.

Secondary Data:

The secondary data are drawn, classified, and studied from the Govt. Publications, monthly journals of the hospitals, including the annual reports of women doctors Wherever, necessary reference was also made to different issues of bulletins viz., sociological background of women doctors, Hospital Administration, Indian Journal of Public Health, Hospital and Health Service Administration,

Limitations of the Study:

The present research work was mainly based on the primary data collected from the sample respondents. The study includes all allopathic women doctors and excludes dentist and AYUSH doctors.

Data Analysis

Socio-demographical characteristics

In age wise distribution of respondents in women doctors in Tumkur city of the present study area it is astonishing to note that majority of the respondents fall in the adult category of 24-34 years this may that many young generation people would like to start practice im-

mediately after studies with 52 percent whereas respondent's age category 45-54 years accounted to 18 percent. And it is clear that lowest number of respondents aged 55 and above years is only 5 percent. With regard to religion the 84 percent of respondents belong to Hindu religion, Muslim accounted to 10 percent, followed by 06 percent are from other religion in the study area and it was found during the study that the maximum number of respondents in the study belongs Lingayats, Gowdas, Minorities etc. it is found that 59 percent of respondents belong to General merit, 28 percent belongs to OBC whereas 8 percent belongs to SC and 5 percent belongs to ST caste in the study area. It is revealed from the above table that the 40 percent respondents are from joint family and 60 percent women doctors are from nuclear family. This evinces the disintegration of joint family. Majority of the doctors were from urban area accounting to 69 percent while 31 percent hailed from rural area. Though India is a land of villages we find that majority of them were from urban area and their presence in urban made them easy access to medical course. It is also found that 27 percent respondents were born in a village whereas 30 percent respondents were from town area, 31 percent women doctors were from city and only 12 percent respondents was born in Metropolitan. With regard to marital status 70 percent of women doctors were married and 30 percent women doctors are unmarried in the study area.

Category of people investing on better health

Health care system, our regulatory system, and our social environment actively discourage this common sense approach to better health and lower costs. The following table expressed about which category of people are interested in better health.

TABLE.NO.1.1
Category of People Investing on Better Health

Particulars	Frequency	Percent
Educated rich class	50	50
Middle class	48	48
Economically backward	2	2
Total	100	**100**

Sources: Field Survey

The Table-1.1 shows which category class of people is mostly interested in better health. 50 per cent said that educated rich class people invested on better health, 48 percent said that the middle class people wants better health and 2 percent respondents said economically backward approached the doctors. Generally medicine is bit expensive which stops the economically backward people to go to hospital and often relay on self medication.

Conclusion

People need the basic material requisites for a decent life, they need to have control over their lives, and they need a voice in decision-making processes and implementation of policy and programs that affect them. Economic and social policies generate and distribute political power, income, goods and services. And who you are will affect your access to quality and affordable education and health care, sufficient nutritious food, good work and leisure conditions, among other things. Together these factors constitute what determines your health and social health inequalities. A first glance, the "social determinants of health" approach suggests that health inequities are produced (and prevented) by policies and actions within the health sector.

But much of the responsibility of the social inequity that leads to different health outcomes lies elsewhere. Health is affected by policies in other sectors, such as education, taxation, transport, and agriculture too. Education, for example, equips people with the resources needed throughout life to achieve a secure income, provide for family, and cope with disease. Children from economically disadvantaged backgrounds are more likely to do poorly in school and drop out early.

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