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Patients' Healthcare Seeking Behavior in Public Primary and Secondary Healthcare Facilities

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ABSTRACT

Mostly in public primary and secondary healthcare situations, arrogance near healthcare shows a noteworthy role in influential health upshots. The learning aspects are psychosocial determining factors, service-related factors, and demographic movements that affect 450 patients' behavior in public health amenities in southern India. The cross-sectional learning strategy was working, and multiple regression in SPSS, independent sample t-tests, and descriptive statistics were used to analyze the data. The middle-of-the-road respondents were between the ages of 31 and 45 and had completed secondary school, bestowing to the outcomes, which exposed an approximately equal distribution of genders. The descriptive analysis revealed a satisfactory degree of patient satisfaction and behavior regarding healthcare, as

well as a moderate waiting time. Urban patients had a significantly higher satisfaction score than rural patients, according to an independent t-test of the random sample ($t(448) = 3.68$, $p < .001$). Waiting times, staff conduct, distance from the facility, medication availability, perceived illness severity, and familiarity with government health systems were found to be significant predictors of healthcare access through multiple regression analysis. Waiting times and distance have had a negative impact on health-seeking behavior, but staff conduct and medication availability have had a positive impact. Health care use was not significantly predicted by income. Overall, the study emphasizes how crucial patient data, service quality, and accessibility are in determining how healthcare is used in public health systems. The results have implications for lowering obstacles to access to public health services in South India and enhancing the delivery of patient-oriented services.

Introduction

In India, health-seeking behavior is still uneven across socio-economic groups, genders, and regions. [1] National Health Policy (NHP)—2017 To strengthen the confidence of the general public in the public health system, it is essential that the government take the necessary measures to strengthen the public health system by increasing human resources, infrastructure, reaching out to the needy in difficult environments, and improving the quality of care and treatment. [2] Health-seeking behavior is the remedial action taken by individuals to remedy a health problem or illness. It can vary between rural and urban areas and between socio-demographic variables. [3] The oral cavity is described as an integral part of the human body. [4] Seymour rightly argues that good general health cannot be achieved without good oral health. [5] Health-seeking behavior is described as the action that an individual takes to maintain or restore good health. The availability and accessibility of healthcare services is strongly influenced by the HSD. [7] Health Services Deficit (HSD) is an evolving concept that measures access to and use of healthcare. From a conceptual point of view, access to healthcare and its use are different but interdependent, as access is necessary for use. Access to health services implies early use of personal health services to achieve optimal health outcomes. Access means being able to access the necessary

healthcare in a physical place from a healthcare provider with whom the patient can communicate and trust (personal relation). On the contrary, healthcare use implies actual use of healthcare services [8].

Patients are usually assigned to a nearby primary health care facility for initial visits and then referred to higher-level facilities as needed. However, in practice, a significant proportion of patients often bypass lower-level facilities and go directly to higher-level facilities, owing to a number of factors, such as (a) the perception that only specialized facilities provide high-quality care, (b) the lack of an effective referral mechanism, (c) a lack of confidence in primary care services, and (d) the uneven allocation of healthcare resources [9].

Previous work involving the HSB study in India focused mainly on gathering patient data from higher-level institutions such as hospitals or from the local population for specific disease conditions [10, 11, 12, 13]. In addition, information on HBS was collected primarily from patients of a specific age group, sex, or income level in rural and semi-urban areas. In this work, we therefore carried out surveys at a number of primary and secondary public health institutions in an urban district to determine the overall HSB of patients who visit these institutions. Understanding HBS, particularly in relation to the public health system in densely populated urban areas, is a first step towards improving access to affordable and quality health care in India, particularly in view of the significantly higher costs of accessing healthcare in privately managed facilities [14].

Literature Review

Briefly, we discuss previous work on the analysis of HSB in patients, both internationally and in India. Previous studies have focused mainly on patient behavior assessments for diseases such as cancer [15,16], tuberculosis [17,18], oral diseases [19], asthma [20], prenatal and postnatal care [21,22], mental health [23], non-communicable diseases [24], diabetes [25], whiplash [26], and HIV [27]. The HSSB was analyzed in relation to patient characteristics such as gender [28, 29, 30], age group [31, 32, 23], rural and urban background [33, 34, 35, 36], marital status [21], and socio-economic status [22]. Socioeconomic characteristics such as higher education and income levels increase the likelihood that you will seek formal health care. Trust in the quality of care and the shorter distances between the patient's place of origin and healthcare facilities increased the likelihood that they would seek care from those facilities [22; 24]. Having a chronic illness increased the likelihood of non-residents in China going to primary health centers [37]. In a few Indian studies involving the physical presence of patients in healthcare settings to record HBS [10, 17, 29], the treatment-seeking behavior of patients in relation to specific health conditions such as mental illness [10] or tuberculosis [17] was analyzed. These studies

surveyed patients who visited only specialized healthcare institutions, such as a mental institution [10] or a tertiary referral center [29], and reported gender differences in patient search. [14] Cross-sectional surveys were carried out in a rural Indian district [14] and found that patients avoid primary care facilities for a number of reasons, including infrastructure deficiencies and a lack of confidence in the quality of care.

In the context of previously published work on HBS, we have collected data on HBS from multiple primary and secondary public health institutions in a metropolitan area to identify the important factors influencing patients' visits to public health institutions. The collection of HSB information through in-person visits to health establishments provides authentic and reliable information on the actual access of the participants to the system. We contribute to the literature by analyzing the general HSB of patients, without restricting the study to a specific disease, and by quantifying the association of patients' socio-economic and demographic characteristics, such as gender, age, educational level, annual income, marital status, employment status, and number of children, with their HSB. In addition to collecting socio-economic and demographic information about the participants, we recorded their journey times to the site and their transport modes.

To the best of our knowledge, none of the previous studies estimated the size of the study sample on the basis of a pilot survey nor considered the impact of response rates, inclusion rates, and study design in determining the final size of the survey sample. In particular, in the context of India, most of the existing literature has not provided a detailed quantitative analysis of the responses of the participants. Our study thus provides a quantitatively sound analysis of HBS patients and their socio-economic and demographic determinants in the context of public primary and secondary health care in urban settings.

Method and Materials

The study adopted a descriptive and cross-sectional research design to assess healthcare-seeking behavior, utilization patterns, and determinants influencing patients' choice of public primary and secondary healthcare facilities in South India. This design was chosen to obtain a snapshot of patient experiences, preferences, and service utilization at a specific point in time. The study was conducted in selected public primary (Primary Health Centres—PHCs) and secondary healthcare facilities (government hospitals, Taluk Hospitals, and District Headquarters Hospitals) located in South India, covering states such as Tamil Nadu only. The target population consisted of patients aged 18 years and above visiting outpatient and inpatient departments of selected public healthcare facilities during the study period.

TABLE 1

Demographic Characteristics of Respondents

VARIABLE	CATEGORY	N	%
GENDER	Male	232	51.6
	Female	218	48.4
AGE (YEARS)	18–30	104	23.1
	31–45	168	37.3
	46–60	126	28.0
	61+	52	11.6
EDUCATION	Primary	151	33.6
	Secondary	182	40.4
	Higher	117	26.0
RESIDENCE	Urban	255	56.7
	Rural	195	43.3

It reveals 450 patients attending public primary and secondary healthcare facilities in South India. Of these respondents, 51.6% were male (n = 232) and 48.4% were female (n = 218). Participants' ages ranged from 18 years to above 61 years, with the largest proportion belonging to the 31–45 years age group (37.3%, n = 168), followed by those aged 46–60 years (28.0%, n = 126) and 18–30 years (23.1%, n = 104); only 11.6% (n = 52) were aged 61 years and above. In terms of education, 40.4% (n = 182) had completed secondary education, 33.6% (n = 151) had primary-level schooling, and 26.0% (n = 117) possessed higher education qualifications. With respect to place of residence, a majority of respondents were from urban areas (56.7%, n = 255), while 43.3% (n = 195) resided in rural locations. These demographic characteristics indicate a well-distributed sample across gender, age groups, educational backgrounds, and residential settings. The demographic distribution suggests that public healthcare facilities are primarily accessed by middle-aged, moderately educated individuals, with slightly higher utilization in urban areas. The near-equal gender representation also indicates inclusiveness and accessibility of public health services across genders.

TABLE 2

Descriptive Statistics of Healthcare Variables

VARIABLE	MEAN	SD	MIN	MAX
WAITING TIME (MINUTES)	38.52	19.44	5	120
DISTANCE TO FACILITY (KM)	4.83	3.62	0.5	20

SATISFACTION SCORE (1–5)	3.72	0.81	1.8	4.9
HEALTHCARE-SEEKING SCORE (1–5)	3.58	0.76	1.5	4.8

It is computed for key healthcare-related variables. The average waiting time experienced by patients was 38.52 minutes (SD = 19.44), with waiting durations ranging from 5 to 120 minutes. The mean distance travelled to reach the healthcare facility was 4.83 km (SD = 3.62), with a minimum reported distance of 0.5 km and a maximum of 20 km. Patients reported a moderately high level of satisfaction, with a mean satisfaction score of 3.72 (SD = 0.81) on a 1–5 scale, with scores ranging from 1.8 to 4.9. The healthcare-seeking behavior score also reflected moderate engagement, averaging 3.58 (SD = 0.76), with observed values between 1.5 and 4.8. Overall, the descriptive results indicate considerable variability in waiting times and distances, while patient satisfaction and healthcare-seeking behavior showed relatively stable mid-to-high score patterns.

TABLE 3

Independent Samples t-Test for Satisfaction Score

GROUPS	N	MEAN	SD	T	DF	P
URBAN	255	3.84	0.77	3.68	448	< .001
RURAL	195	3.54	0.83			

An independent samples *t*-test was conducted to compare patient satisfaction scores between urban and rural respondents. The results indicated a statistically significant difference in satisfaction levels between the two groups, $t(448) = 3.68$, $p < .001$. Urban patients reported significantly higher satisfaction (M = 3.84, SD = 0.77) compared to rural patients (M = 3.54, SD = 0.83). These findings suggest that patients residing in urban areas tend to perceive the quality of healthcare services more positively than those from rural areas.

TABLE 4

Multiple Regression Predicting Healthcare-Seeking Behavior

PREDICTOR	B	SE	T	P
WAITING TIME	–.24	.04	–5.98	< .001
STAFF BEHAVIOR	.38	.05	8.11	< .001
DISTANCE	–.11	.03	–3.01	.003
AVAILABILITY OF MEDICINES	.19	.04	4.42	< .001
PERCEIVED SEVERITY	.09	.03	2.32	.021

INCOME	.04	.02	1.29	.197
AWARENESS OF SCHEMES	.14	.04	3.25	.001

The table reveals analysis was conducted to examine the predictors of healthcare-seeking behavior. The model included waiting time, staff behavior, distance to the facility, availability of medicines, perceived severity, income, and awareness of healthcare schemes. Results showed that several predictors significantly contributed to the model. Waiting time negatively predicted healthcare-seeking behavior (β = –.24, SE = .04, t = –5.98, p < .001), indicating that longer waiting times were associated with reduced likelihood of seeking care. Staff behavior was a strong positive predictor (β = .38, SE = .05, t = 8.11, p < .001), suggesting that better staff conduct increased healthcare-seeking tendencies. Distance had a small but significant negative effect (β = –.11, SE = .03, t = –3.01, p = .003), meaning longer distances discouraged service use. Availability of medicines positively predicted healthcare-seeking behavior (β = .19, SE = .04, t = 4.42, p < .001), as did perceived severity (β = .09, SE = .03, t = 2.32, p = .021) and awareness of schemes (β = .14, SE = .04, t = 3.25, p = .001). Income was not a significant predictor (β = .04, SE = .02, t = 1.29, p = .197). Overall, the findings indicate that service-related factors and patient perceptions play a substantial role in predicting healthcare-seeking behavior.

Discussion

The present study examined healthcare-seeking behavior among patients accessing public primary and secondary healthcare facilities in South India and identified key determinants influencing their utilization patterns. The findings indicate that demographic characteristics such as gender significantly shaped the choice of healthcare facility, with females more likely to utilize primary health centers and males showing a preference for secondary-level hospitals. This pattern aligns with earlier studies suggesting that women often prioritize proximity, affordability, and familiarity in selecting healthcare services, while men may seek facilities perceived as offering more specialized care. The descriptive statistics further revealed that waiting time and accessibility continue to be major concerns for users of public healthcare, with an average waiting time of nearly 40 minutes—a figure consistent with national studies on public healthcare congestion. Rural facilities often face chronic staffing shortages, limited diagnostic availability, and inconsistent medicine supply—all of which may contribute to lower satisfaction levels.

The strong observations between satisfaction, staff behavior, and waiting time reinforce the notion that human-resource-related factors remain central to patient experience. The positive influence of staff behavior on both satisfaction and healthcare-seeking behavior confirms previous evidence that respectful communication, empathy, and timely attention enhance patient trust in government facilities. Ensuring

consistent availability of essential medicines, reducing waiting times through better process management, and investing in the training and motivation of healthcare staff can substantially improve patient perceptions and utilization. Increasing awareness of government schemes may also encourage greater public healthcare adoption, especially among underserved groups. In summary, the study provides robust evidence that patient-centered improvements in public primary and secondary healthcare facilities can lead to more equitable and efficient healthcare-seeking behavior across South India.

Conclusion

The present study provides valuable insights into the healthcare-seeking behavior of patients attending public primary and secondary healthcare facilities in South India. The findings reveal that while demographic factors such as gender influence facility choice, it is the quality and accessibility of healthcare services that play a more decisive role in shaping utilization patterns. Waiting time, staff behavior, availability of medicines, distance to the facility, and awareness of government health schemes emerged as the key determinants of healthcare-seeking behavior. Among these, staff behavior and waiting time proved to be the strongest predictors, underscoring the importance of patient-centered service delivery in strengthening public healthcare utilization.

The study further highlights significant disparities between urban and rural patients, particularly in satisfaction levels, pointing to gaps in infrastructure and resource availability in rural facilities. Overall, the results suggest that improving operational efficiency, enhancing staff-patient interactions, ensuring regular medicine supply, and promoting public awareness of healthcare benefits can substantially increase trust and reliance on public health institutions. Strengthening these elements will be crucial for advancing equitable healthcare access and achieving better health outcomes across South India.

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