Findings and Conclusions

Findings

7.1.0 Socio - Demographic Profile

- Though in the study 490 people from same number of house holds were interviewed and gathered information regarding their and family members health issues.

- Totally this study would reveal health information of 2463 people.

- High human development Index (HDI), Bangalore (n = 434, 17.6 %), Udupi (n= 340, 13.8 %) and Mangalore (n= 362, 14.7 %) were represented by 1136 people.

- Low developed districts, which are identified through low human development Index (HDI) Raichur (n= 457, 18.6%), Chamarajanagara (n= 317, 12.9%) and Gulbarga (n= 553, 22.5 %) were represented by 1327 of total 2463.

- Among people who are from HDI high districts 570 (50.4%) were male and 562 (49.6 %) were female out of 1132 subjects.

- In HDI low districts 692 (52.3 %) were male and 631 (47.7%) were female out of 1323 subjects.

- Totally 1262 male and 1193 female related information was collected from both types of districts.

- Percentage of females was more found in high HDI urban districts 49.6% compared to 47.7% rural low HDI districts.
• Education level was significantly low in low HDI districts (38.9 % illiterate of total low HDI people) compared to high HDI people (15.5 % illiterate of total urban people).

• Married members of high HDI districts were 56.7 % (n=641) out of 1131. Other 40.1% (n=453) were never married in this category.

• Among low HDI districts 55% (n=727) were married, 43.8% (n= 579) were never married and 1 of them separated from marital relationship out of 1322. Totally out of 2453 people 55.8% were married and 42.1 % were never married.

• Religious background of participants 490 households were Hinduism (n= 448, 91.4 %), Islamism (n=19, 3.9%), and Christianity (n=23, 4.7%)

• Religious background of high HDI districts were majority from Hinduism (n= 213, 86.9%) and others were from Islamism (n=13, 5.3%) and Christianity (n=19, 7.8%).

• Religious background of low HDI districts were majority from Hinduism (n= 235, 95.9%) and others were from Islamism (n=6, 2.4%) and Christianity (n=4, 1.6%).
7.2.0 Employment and Borrowing Patterns

- Among high HDI people, they employed in all sectors some what equal, but in low HDI group 45.6% people were employed in agriculture sector.

- In high HDI variety of job opportunities were present and ‘others’ type of industry led maximum in category of industry (29.2%).

- Only 23.6% of high HDI people were employed in agriculture sector compared to 45.6% of low HDI people.

- Security Guard job (60.5 %) was more among high HDI people and tailoring job (76.4%) and Painting job (68.5%) were more in low HDI people.

- People from high HDI area were more regular in employment than people from low HDI area (81.6% and 59.9%).

- Low HDI people (72.8 %) mainly reached their work place on foot than high HDI people (62.5%).

- Percentagewise comparison between high and low HDI indicated former group people traveled more distance to job place.

- Mainly from both high and low HDI group people employed more than 15 years, 32.9% and 35.9% respectively.

- Majority of both groups were employed more than 5 years. Among less than 5 years length of employment, high HDI group percentage was higher than low HDI group (38.5 & 29.3% respectively).

- High HDI people had taken relatively higher amount of loans (22.9 %: Rs 50000-100000, 18.8%: more than Rs 100000) compared to low HDI borrowers (12.8 %: 50000-100000 Rs, 14.2%: more than Rs 100000). Totally 244
participants shared details of loans 148 of them from low HDI districts and 96 of them from high HDI districts.

- Majority of borrowers from low HDI borrowed money from private lenders and majority of people from high HDI borrowed from government or semi-government institutes.

- Significantly high percentage of borrowers from low HDI (38.8%) borrowed from money lenders, whereas 19.8% of borrowers from high HDI depended on money lenders.

- Illness caused more burden of borrowing 9.7% in low HDI group compared to 5.4% in high HDI.

- High HDI borrowed 18.3% of total borrowing for education purpose, but low HDI borrowed only 1.4% of their total borrowing for education.

7.3.0 Major Illness

- Common illnesses are found as main illness among both high HDI group (73.2%) and low HDI Group (82.7%). Common illness is found more among low HDI people than high HDI group. Another significant finding is hypertension and diabetes is another major illness prevalent among high HDI and low HDI people.

- People from low HDI areas (84.1%) had been admitted to hospital than high HDI people (73.7%) associated with major illness.
• Both high HDI and low HDI group depended on allopathy to treat major illness 82.7% and 96.2% respectively.

• High HDI group also have shown interest towards Ayurveda (2%) and indigenous medicine (12.8%), though low HDI group depended only allopathy to treat major illnesses.

• Low HDI group people depended on money lenders to meet treatment expenditure of major illness than high HDI group.

• Both groups equally depended on friends and relatives financially treat major illnesses.

7.4.0 Chronic Illness

• Majority of high HDI group people spent less than Rs 1000 and majority of low HDI people spent more than Rs 1000 for health related expenditure.

• Among low HDI group 34.8% of people spent more than Rs 5000 and 18.6% of high HDI group spent more than Rs 5000 as treatment expenditure.

• Another key finding is 18.5% of people who reported health expenditure from low HDI spent Rs 10001-50000 and only 8.8% people from high HDI spent same amount.

• Low HDI group people depended on money lenders to meet treatment expenditure of major illness than high HDI group.
• Results indicated more high HDI people (69.4%) could limit chronic illness difficulties to 9 days than low HDI people who could limit (54.2%).

7.5.0 Health expenditure and Nature of Health Services Accessed

• Majority of high HDI group people spent less than Rs 1000 and majority of low HDI people spent more than 1000 Rs for health related expenditure.

• Among low HDI group 34.8% of people spent more than Rs 5000 and 18.6% of high HDI group spent more than 5000 Rs as treatment expenditure.

• Another key finding is 18.5% of people who reported health expenditure from low HDI spent Rs 10001-50000 and only 8.8% people from high HDI spent same amount.
7.6.0 Conclusion

India witnessed steady progress in all spheres of life in post independent era, through planned social welfare policies. Despite of huge population growth, sincere attempts were organized to promote health among population by governmental and non governmental organizations. However large unmet needs could not be met for all sections of society due to lack of resources and low literacy level of people. Administrative hurdles such as corruption, influence of caste or region based discriminations slowed the social changes in India. But it would be appropriate to move forward from present status to higher quality of health services delivery. This study was planned to give momentum through describing health inequality prevailed between developed and under developed districts of Karnataka. Critical appraisal of health services generated insights to plan intensive steps to tackle health inequality.

Sex ratio, number of females was more in high HDI (Human Development Index) districts compared to low HDI districts. Education level was significantly low in low HDI districts compared to high HDI people. Higher birth rate is found among low HDI group. Another major finding is around 39 % of population are in below age of 20 years in low HDI, only 30% of people from high HDI are in below HDI group. Longer life expectancy is found among high HDI group.

Common illness is found more among low HDI people than high HDI group. Hypertension and diabetes are major illnesses prevalent among high HDI and low HDI people.
Among high HDI people, they employed in all sectors some what equal, but in low HDI group 45.6% of employed people were employed in agriculture sector. Only 23.6% of high HDI people were employed in agriculture sector compared to 45.6% of low HDI people among employed people of each group. Security Guard job was more among high HDI people and tailoring job and Painting job were more in low HDI people. People from high HDI area were more regular in employment than people from low HDI area. Low HDI people mainly reached their work place on foot than high HDI people. Among less than 5 years length of employment, high HDI group percentage was higher than low HDI group.

Number of working days was less among low HDI people (only 53.8% of them worked more than 21 days in a month) compared to high HDI people (79.9% of them worked more than 21 days in a month). Results indicated more high HDI people could limit chronic illness difficulties to 9 days than low HDI people who could limit. Percentage of dependents was slightly higher among low HDI than high HDI.

High HDI people had taken relatively higher amount of loans compared to low HDI borrowers. Majority of borrowers from low HDI borrowed money from private lenders and majority of people from high HDI borrowed from government or semi government institutes. Illness caused more burden of borrowing in low HDI group compared to in high HDI. High HDI borrowed 18.3% of total borrowing for education purpose, but low HDI borrowed only 1.4% of their total borrowing for education.

Among low HDI group 34.8% of people spent more than 5000 Rs and 18.6% of high HDI group spent more than 5000 Rs as treatment expenditure. Another key finding is
18.5% of people who reported health expenditure from low HDI spent 10001-50000 Rs and only 8.8% people from high HDI spent same amount. Low HDI group people depended on money lenders to meet treatment expenditure of major illness than high HDI group. Both groups equally depended on friends and relatives financially treat major illnesses.

People from low HDI areas (84.1%) had been admitted to hospital than high HDI people (73.7%) associated with major illness among those who had major illness from each group. Both high HDI and low HDI group depended on allopathy to treat major illness 82.7% and 96.2% respectively. High HDI group also have shown interest towards Ayurveda (2%) and indigenous medicine (12.8%), though low HDI group depended only allopathy to treat major illnesses.

Employment status, literacy level, health infrastructure, financial availability of health professionals and health awareness have been identified as target indicators to change for leading population from poor health care services to high quality health care services. Neglect towards nutrition and immunization needs of under developed or rural population would increase health care cost of nation, which is primarily responsible for health care. As popularly believed only healthy citizens would be able to contribute to development needs of country. Significant portion of budgetary allocation is essential to build health infrastructure in the society.

Karnataka has been noted among international community through its rapid growth in the area of technological revolution and urbanization rate. This potential state steadily contributes to national economic growth and industrialization. Cultural and
geographical diversity have been observed in the state as a boon to learn how to tackle various social needs in a harmonious environment. But huge health inequality would lead to greater resentment among population, as noted in multiple nations in this decade. Presence of trained professional social workers in the state is a good indicator to bridge gap in the area of health services. Mere buildings or few policies on paper might not change grass root realities of health. Active participatory model of health policies and implementations are essential to change neglected attitudes towards health needs of marginalized sections of societies. Investment in the area of health should not be considered as a financial burden. It should be considered as an investment for future.

The study findings offer an empirical background to plan tailor made programs for people from low human develop index. Only such programs would decrease infant mortality rate, malnutrition, maternity mortality rate, birth rate, disability adjusted life years and prevalence of both communicable and non communicable illnesses. Involvement of various stake holders in planning level is important to formulate need based interventions to settle health inequality. In those committees must be formulated under the professional leadership of trained social workers who work to promote health among vulnerable populations. Both quantitative and qualitative studies should be continued to monitor the progress and to evaluate cost effectiveness of each health care programs. Sensitization and continuous training programs for health care professionals and policy makers are required to ensure the acceleration of change. Application of modern technology and high quality man power managements can be used to enhance
health care services. Up gradation of current infrastructure and transportation facilities would complement the changes in the health scenario.

Satisfactory health services must be available to all people irrespective of region, sections and economic status. Human develop index can be used to identify the regions, where all social indicators are low. Holistic development is the solution to ensure equity in health services, than just constructing physical infrastructure. Social work interventions will play key role in future to eradicate health inequality.

Social work profession has been evolved to current form of profession through helping patients with illnesses in hospital settings. Social study had been used in those years to understand background of persons who sought financial help. This study in the same context could identify health in equality respective to backgrounds of people from different human development index level. Health inequality prevails between urban and rural community is distressing the hope social workers to help less privileged rural community. It is sure that study findings would guide professionals to lobby more organized financial support from state and central governments. Collective actions from NGOs are need of the curb health in equality suffered rural community. Professional social workers from development and health field must coordinate their services to provide need based social work interventions.