CHAPTER-VI

FINDINGS, SUGGESTIONS AND CONCLUSION

After analyzing the data, the major findings of the study are presented in this chapter. Suggestions have been made wherever appropriate for consideration and for further action by the policy makers. For effective management of rural healthcare in Andhra Pradesh. The finding have been presented on the current status of management of rural healthcare in AP

Findings and Suggestions

1. Distribution of respondent of different age groups. Out of total 900 respondents, 37 percent are in the age group of 20 to 30 years, 36 percent, in the age group of 30 to 40 years, 17 percent in the 40-50 years age bracket and only 2.5 percent in the above 50 years age group. This makes significant reading and poses the question ‘Despite the higher probability of old age-related ailments, how is it that the proportion of elderly persons availing of the benefits of PHCs is so low in all the districts? Is it that they accept their medical condition as ‘incurable’ and hence feel visiting PHCs as a waste of time or they are unable to find escorts to take them to the PHCs? The concerned medical authorities need to address this issue.

2. The table 5.2 highlights that out of the total 900 respondents, female beneficiaries constitute 61.3 percent. It is also found that, male beneficiaries did not respond in the same manner as their female counterparts. This issue is found to be applicable for all the three districts under study.

3. Occupation of the respondents is an important demographic factor that influences the analysis of PHCs. The sample beneficiaries were divided in five different occupations. They included: farmer, labour, student, housewife and others. The majority of the beneficiaries are farmers (68.6 per cent), followed by labour group and students.

4. Literacy Rate of the Respondents. They have been divided into the following groups: illiterate, up to 10 classes, inter and degree. It can be seen that 77 percent
are illiterate, and 10 percent have studied up to tenth class. A realistic assumption can be made here that the respondents who visit these primary health-care centres belong to the relatively low literacy level groups.

5. **Income Groups of the Respondents.** They have been divided into four income groups: (i) less than Rs. 20000, (ii) Rs 20000 to 40000, (iii) Rs 40000 to 60000, and (iv) greater than Rs 60000 per annum. Financial strength of an individual is an important driving force for the persons accessing the health-care centres. It can be seen that majority (57.6) percent of the beneficiaries belong to the ‘between Rs 20000 to Rs 40000’ annual income range. This is true for all the districts. Another significant fact that emerges is that for the income level above Rs 60,000, except for Guntur district, none of the beneficiaries availed of this benefit. Even in Guntur, the number of respondents belonging to this income level who are visiting PHCs is very less.

6. **Awareness about availability of doctors in PHCs.** Majority of the respondents in the three districts replied in the affirmative. However, the apparent high rate of awareness cannot be interpreted as a high rate of people accessing primary health-care. On analysing the data, it can be seen that there is a strong association (statistically significant) with the number of times the respondents actually access PHCs and it appears to correspond with the awareness about availability of doctors.

7. **Awareness about the availability of doctors in rural PHCs.** The responses are measured on the nominal scale. In all the three districts, the majority of the respondents are aware of the availability of doctors in primary health-care centres. The question arises how many of them make optimum use of the PHCs?

8. **Respondents who visited the primary health-care centres in a year.** The responses are measured on the scale of: (i) 0 to 5, (ii) 5 to 10, (iii) 10 to 15, and (iv) above 15. Out of the total 900 respondents, 50.4 percent visited the primary health-care centre 5 to 10 times in a year, and 42 percent, 10 to 15 times. The number of those making more than 15 visits in a year is insignificant in all the districts.

9. **Does the health-care centre meet all the health of the beneficiaries?** The responses have been divided into four groups: (i) Not at all, (ii) Reasonably, (iii) Very Much, and (iv) Fully. It can be seen from Table 4.8 that the responses ‘Reasonably’ and
‘Very Much’ in all the districts taken together are far more than the other two ones. However, a very large number of respondents in Mahaboob Nagar (43.5%) expressed the opinion ‘Not at all’. This should be a cause of some concern since the success of a PHC can be gauged by the degree of satisfaction of the beneficiaries.

10. Does the health-care team visit the villages? It can be seen that there is a wide degree of variance in responses to this question. In Mahaboob Nagar (67.3 percent) and Guntur (53.9%), the affirmative responses were more. However, 81.3 percent of the respondents in Anantapur replied in the negative. This suggests large scale absenteeism by the medical staff in Anantapur District. Urgent Steps need to be taken to remedy the situation. There may be instances where emergency cases are left untreated due to the ‘irresponsibility’ of the medical staff. Such a situation is totally unacceptable.

11. Health-care promotion awareness through the programmes. Awareness about health-care promotion through the programmes plays a very significant role in the success of a primary health-care centre. The study has selected the five point Likart scale range from ‘Very Good’ to ‘Very Poor’. Table 5.10 brings out the large proportion of negative responses (especially in Mahaboob Nagar, where it is to the tune of 56%). It shows that government needs to take proper initiatives to promote the health-care awareness programmes among the beneficiaries.

12. The efforts taken by health servants for providing health-care services to the beneficiaries. This is a major resource to the primary health-care centres in Andhra Pradesh. It can be seen that the respondents in all the three districts have tended to avoid the extreme responses ‘Very Good’ and ‘Very Poor’. There appears to be a positive perception (total of ‘Good’ and ‘Fair’) on this issue in Mahaboob Nagar (59%) and Guntur 63%). However, in Anantapur, the negative perception (‘Poor’ plus ‘Very Poor’ - total 48%) is very significant. This brings out that a lot still needs to be done to promote greater awareness about the health-care programmes.

13. The role of doctors and nurses in improving the health of the patients. Doctors and nurses play a very significance role in primary health-care centres. The study has selected five point Likart scale range from ‘Very Good’ to ‘Very Poor’. Table 5.12 analyses the responses regarding the role of doctors and nurses in improving the
health of the patients. It can be seen that in all the three districts, the proportion of those conveying a positive response (‘good’ plus ‘Fair’) is generally high. However, in Anantapur District, the totals of positive responses (‘Good’ plus ‘Fair’) are almost equal to the negative ones (‘Poor’ plus ‘Very Poor’). Sincere efforts are needed to change the negative perceptions about the medical staff.

14. **Cleanliness in health-care centres.** A clean environment can help check the spread of diseases like malaria, plague, cholera and jaundice. Health workers are expected to impress on the target audience the need to keep the surrounding neat and tidy. However, if their own environs are shabby, their messages will not carry much conviction. Just as in the case of most other replies, this aspect too brings out that the proportion of extreme ratings – ‘Very Good’ and ‘Very Poor’ is much less compared to the other ones. Table 5.13 brings out that the overall positive ratings – ‘Good’ plus ‘Fair’ are generally more than the negative ones – ‘Poor’ plus ‘Very Poor’. However, in the case of Anantapur District, these two ratings are almost equal. The concerned authorities need to impress on the medical staff to pay greater attention to the cleanliness aspect.

15. **Efficiency of the medical staff.** The Confidence in the efficiency of the medical staff is very essential for the success of a medical centre. If the patients feel that those taking care of their health needs are not very competent, they (the patients) may not feel very motivated to follow the advice given. Alternatively, they may opt for availing of medical services from other sources. Table 5.14 brings out the perceptions of the respondents regarding the efficiency of the health-care staff. It can be seen that the overall positive ratings (‘Good’ plus ‘Fair’) outweigh the negative ones (‘Poor’ plus ‘Very Poor’). However, it is pertinent to bring out here that the figures are almost equal in the case of Anantapur District. The message that emerges is that there should be greater focus on improving the level of confidence of the intended beneficiaries so that health-care centres can perform their functions more effectively.

16. **Follow-up monitoring of patients.** The follow-up and monitoring the process of patients is an important component of the treatment process. If these are not adequate, there is every possibility of a relapse. It can be seen that the sum of the positive responses (‘Very Good’, ‘Good’ and ‘Fair’) is more than the sum of the
negative ones (‘poor’ and ‘Very Poor’) in Mahaboob Nagar and Guntur districts. However, in Anantapur district, the negative ratings are more in number. It is also pertinent to mention here that the number of ratings ‘Very Poor’ is much more than the ‘Very Good’ ratings in all the three districts. This lacuna need to be addressed on priority.

17. **Adequacy of staff services.** A PHC can perform its functions adequately only when it has sufficient staff services available. Many of the health issues may need to be tackled on the spot itself and referring serious cases to higher and more specialised medical centres may result in loss of time which may at times turn out to be fatal. Table 5.16 brings out that only in Guntur district did a large number of respondents find these services to be ‘Perfectly Adequate’. Majority of the respondents in Mahaboob Nagar (41.6%) and Anantapur (39.6%) gave the rating ‘Moderately Adequate’. Vigorous efforts need to be undertaken by the medical authorities to ensure that the staff services are reasonably adequate. Otherwise, the very purpose of establishing a PHC may be defeated. There is a improving need for human resources management function at the PHC level.

18. **Availability of Medicines.** It needs to be emphasised here that proper intake of the necessary medicines is very much an integral part of the treatment process. In a rural setting, the patient may not be able to afford the cost of medicines. Also, unlike urban areas, there may not be any medical shop nearby to procure medicines not available in the PHC. Hence, for a PHC to be able to perform its responsibilities effectively, it should be adequately stocked with medicines to deal with both routine and emergency cases. Table 5.17 clearly brings out that in all the three districts, very few respondents gave the rating ‘Perfectly Adequate’ or ‘Very Inadequate’. Most of the responses in all the three districts ranged between ‘Fairly Adequate’ and ‘Fairly Inadequate’. Steps need to be taken to improve the stock positive of medicines in the PHCs so that the beneficiaries are assured of better medical care. There is need for improving supply and store management function at PHC level.

19. **Availability of rooms.** In any medical setting, there are generally two types of patients – in-patients (who are required to stay in the hospital itself since the treatment process is such) and out-patients (who can be attended to on the spot itself
and need not stay back for further monitoring of their health condition). Also, inpatients may need 24 hrs monitoring. Adequacy of rooms would enable handling of late night emergencies. In Mahaboob Nagar and Anantapur, the total of negative ratings (‘Fairly Inadequate’ plus ‘Fairly Inadequate’ - 62% and 72% respectively ) is more than that of positive ones (‘Fairly Adequate’ plus ‘Moderate Adequate’). However, in Guntur District, the sum of the two positive ratings is about 62%). It is suggested the number of rooms in PHCs (especially in districts like Mahaboob Nagar and Anantapur) be increased

20. Availability of beds. It is not always enough to have a number of rooms in any hospital. Even more important is whether sufficient numbers of beds are available for the patients. Off and on one comes across instances of even terminally ill patients being forced to sleep on the floor on shabby mattresses in over-crowded corridors. One can well imagine the quality of treatment they would be receiving. Beds need to be neat and arranged in reasonably well-ventilated rooms. It is seen that the majority of respondents in all the districts have generally avoided the extreme ratings – ‘Perfectly Adequate’ and ‘Very Inadequate’. A significant fact that emerges is that the totals of the positive ratings (‘Perfectly Adequate’ and ‘Fairly Adequate’) are more than those of the negative ones (‘Fairly Inadequate’ and ‘Very Inadequate’) in all the three districts. It only remains to be seen how many of the respondents have actually ‘utilised’ this facility and have merely filled in the responses just as a matter of routine!

21. Availability of laboratory services. Proper treatment for many ailments can commence only after the reports (blood, ECG, urine, X ray, etc) are scanned. No wonder, laboratory services are integral parts of good hospitals. In the absence of these, the reports have to be procured from outside sources – often at exorbitant costs. In a rural setting, clinical laboratories may not be available in the vicinity. It is, therefore, imperative that rural PHCs are equipped with at least the basic laboratory services. Table 5.20 depicts the ratings on this issue. It can be seen that, in all the three districts, the positive responses (‘Fairly Adequate’ plus ‘Moderately Adequate’) are more than the negative ones (‘Fairly Inadequate plus ‘Very
Inadequate’). Efforts should, nevertheless, be made to significantly enhance the satisfaction levels of the beneficiaries on this score.

22. **Availability of mobile medical vans when required.** Mobile medical vans are very essential for the success of any hospital. These greatly enhance the mobility of the medical personnel – especially for their visits to remote areas and for bringing seriously ill patients to the hospital. Table 5.21 below presents the ratings on this aspect. It can be seen that the satisfaction levels are more on the positive side in all the three districts. However, a lot more can be done to further improve the situation.

23. **Adequate availability of doctors for women.** There are a number of ailments which are specific only to women. Hospitals, therefore, strive to have sufficient number of lady doctors with whom the female patients can feel more comfortable. Given the fabric of our rural society with its great insistence on privacy, female patients may feel hesitant to discuss their unique ailments with male doctors. Table 5.22 brings out the ratings on this score. It can be seen that in all the districts, the generally negative ratings are more than the generally positive ones. The lesson that emerges is that there is a pressing need to make available more doctors (preferably female) to attend to the specific needs of female patients of the PHCs.

24. **Availability of doctors and nurses with medical vans.** A medical van is much more than drivers and attendants to ferry the patients to and from the hospital. It is equally important that doctors and nurses are also available with these vans to attend to the patients during the process of transit. What are the perceptions of the respondents on this issue. Table 5.23 shows that in Mahaboob Nagar and Guntur districts, there is a trend towards positive ratings (‘Fairly Adequate’ plus ‘Moderately Adequate’) as against the negative ones (‘Fairly Inadequate’ plus ‘Very Inadequate’). On the other hand, in the case of Anantapur district, there is a reverse trend. The message that emerges is that a lot more needs to be done to significantly increase the levels of satisfaction of the users.

25. **Adequacy of Medical facilities in the villages.** It is a well known fact that majority of our citizens reside in rural areas. However, when we analyses the provision of medical services to these areas, we find that these are in no way commensurate with the number of potential beneficiaries residing here. It is also
a fact that our villagers are most vulnerable to ailments like waterborne diseases. A rural PHC is intended to provide at least the basic medical care to the intended beneficiaries. How do the respondents in the three districts feel about this issue? Table 5.24 brings out that, in all these districts, the respondents are rather favourably inclined about the facilities available. However, the numbers of those dissatisfied are also quite significant. The concerned authorities need to address this issue on priority. There is a need for improving facilities planning at the level of primary healthcare.

26. Availability of amenities like electricity, running water and toilets. A medical centre can perform its functions effectively if it is equipped with facilities like assured electricity supply, running water and toilets. Electricity would help to provide lighting, allow fans to run and facilitate the running of sophisticated equipment. Running water would improve the cleanliness of the centre besides adequately meeting the various water needs of the medical staff and the patients. Toilets would help in maintaining sanitation in the centre. We can see from Table 5.25 that in the case of Mahaboob Nagar and Guntur districts, the generally positive ratings (‘Fairly Adequate’ plus ‘Moderately Adequately’) outweigh the negative ones (‘Fairly Inadequate’ plus ‘Very Inadequate’). However, in Anantapur district, the story is quite different. A noticeable feature is that respondents have tended to give the least weightage to the extreme ratings – ‘Perfectly Adequate’ and ‘Very Inadequate’. This is true for all the three districts.

27. Quality of health-care services delivery. The effectiveness of any medical centre depends largely on the quality of its service delivery. This is particularly true of rural PHCs since a large number of patients are likely to utilise their services. Table 5.26 makes interesting reading. In Mahaboob Nagar district, the number of negative ratings (‘Fairly Inadequate’ plus ‘Very Inadequate’) exceeds that of the positive ones (‘Fairly Adequate’ plus ‘Moderately Adequate’). However, in the other two districts, the respondents are more favourably inclined.

28. Satisfaction regarding prescriptions. The Medicines prescribed form an integral part of any medical setting. The patients need to feel convinced that these medicines would help in the recovery process. Otherwise, they may not feel inclined
to consume the medicines. How do the respondents in the three districts rate the satisfaction level on this issue. Table 5.28 brings out that in all these districts the generally positive ratings (‘Satisfied’ plus ‘Somewhat Satisfied’) are more than the negative ones (‘Dissatisfied’ plus ‘Very Much Dissatisfied’). An interesting feature emerges when we compare the figures for the extreme ratings – ‘Very Much satisfied’ and ‘Very Much Dissatisfied’. These are respectively in the ratio of 1:2 (Mahaboob Nagar) and 1:2.7 (Anantapur). However in the case of Guntur district, the ratio is about 3.6:1. Vigorous efforts are needed to increase the satisfaction levels of the beneficiaries on this account.

29. Is sufficient time devoted to the patients? Given the generally shy nature of many rural patients and their relatively inadequate communication skills (also due to illiteracy), they may not always be able to adequately describe their exact medical problem, which could lead to adoption of an incorrect course of treatment. It is, therefore, imperative that the medical staff devote adequate time to the patients and make them feel comfortable before arriving at any diagnosis. Table 5.28 depicts the ratings on this issue. It is seen that in Mahaboob Nagar and Guntur districts, the generally positive ratings outnumber the negatives ones. However, the situation is quite the opposite in Anantapur district. A disturbing feature in Guntur is that those giving the rating ‘Perfectly Adequate’ is very miniscule (only 0.8 percent of the respondents. The concerned authorities need to impress on the medical staff to take their duties more seriously and not examine patients in a perfunctory manner. There is need for training the medical staff to prepare them to serve the patient with love and devotion.

30. Adequacy of medical equipment. An effective medical centre is one which has all the essential medical equipment in good working condition. Shortage of equipment can greatly hamper the diagnosis and treatment process. Table 5.29 presents a rather dismal picture with respondents in both Mahaboob Nagar and Anantapur districts expressing generally negative views on the issue of adequacy of medical equipment in the PHCs. Only in the case of Guntur district are the generally negative and positive ratings almost equal. The message that emerges is that a lot more needs to be done to equip the PHCs with at least the bare essential medical equipment.
31. Satisfaction regarding health-care received and the outcome of the treatment. A major determinant in the treatment process is the level of satisfaction of the patients. It is only when he/she feels assured of being in safe hands that the patient will feel inclined to cooperate with the medical staff. An encouraging that emerges from a perusal of Table 5.30 is that in all the three districts, the generally positive ratings are more than the negative ones. However, a startling fact is that none of the respondents in Anantapur district expressed total satisfaction on this parameter. There is, thus, an urgent need to put in vigorous efforts to significantly increase the satisfaction levels of the beneficiaries. There is need to improve patient care management through proper training of para medical for upgrading skills.

32. Are Medical centres being effectively run by the health-care staff? A medical centre can be viewed as effective if it is (and perceived to be) run efficiently by those responsible for its administration. Only when the potential beneficiaries are positively inclined towards it, will they be motivated to utilise its services. When this is not the case, the patients may (i) go in for treatment by quacks, (ii) approach practitioners, or (iii) leave the ailment untreated and expect God to ‘cure’ them. Each of these courses can be harmful for the health/pockets of the patients. Let us see the perceptions of the respondents on the effectiveness of the PHCs and the personnel managing these. Table 5.31 brings out conflicting perceptions on this issue. In Mahaboob Nagar district, the generally positive ratings outnumber the generally negative ones. However, in Anantapur district, the trend is reversed. In the case of Guntur district both these ratings are almost equal in number. The message that emerges is that a lot needs to be done to phenomenally increase the satisfaction levels of the beneficiaries of the PHCs. It show up absence of leadership and participative management in primary healthcare centres.

33. Adequate Respect to patients. The clientele of a hospital (especially a rural one) may be largely composed of aged, infirm, female, destitute or illiterate persons. That should not mean that they be treated discourteously or in a patronising manner. Major components of the treatment process include: care, understanding, empathy and adequate respect. How do the PHCs in the three districts measure up on this score? Table 5.32 presents a rather heartening picture. In all the three districts, the
positive perceptions outnumber the negative ones. However, a disquieting feature is that the number of respondents expressing total satisfaction is quite low. The concerned authorities need to impress on the medical staff to treat the patients with more consideration and dignity. The policy makers should arrange to run courses on “medical humanities” to the medical staff in PHCs.

34. Perceptions on Rajiv Arogyasri Benefits. Rajiv Aarogyasri is the flagship scheme of the Government of Andhra Pradesh. It aims at providing quality health-care to the poor. In order to facilitate the effective implementation of the scheme, the State Government has set up the Aarogyasri Health-care Trust. The network of Aarogyasri providers includes both public and private hospitals. As of January 2010, there were a total of 342 hospitals in the network of which 98 were public hospitals and 244, private hospitals. The main reason for Aarogyasri Trust deciding to work with private providers was the lack of resources in the public system. The government has been unable to attract the needed specialists to public facilities, while the private sector has rapidly expanded high quality health-care services. Table 5.33 brings out the overall positive perceptions about the working of the Scheme. Another heartening feature is the very low number of totally negative ratings. Since this Scheme is a very prestigious initiative of the State Government, greater efforts are required to make it even more effective so that other States get motivated to replicate it.

35. Providing Medicines on time. There are many ailments for which medicines need to be dispensed on time; lest the condition of the patients deteriorates. In a rural setting, the patients may perforce have to depend on the PHCs for the medicines – either because they cannot afford the cost or there are no chemists’ shops within easy reach. Quite often, we hear about medicines not being provided on time, either due to these not being in stock or the callous or sadistic nature of the concerned staff. Table 5.34 makes a very disturbing reading in that an overwhelming number of respondents in all the three districts have negative perceptions on this issue. Such a situation is totally unacceptable and the concerned authorities need to take corrective action on top most priority. The policy makers should develop ‘monitoring and
review system’ to check availability and the consumption of medicine at PHCs so that essential medicine are available at right time and in right quantity.

36. Availability of all drugs. Hospitals (especially the rural ones) need to monitor the stock position of at least the essential medicines so as to replenish the deficient ones. There is also a need for suitable arrangements with nearby PHCs to offset each others’ shortages. Table 5.35 presents a rather dismal picture in that the majority of respondents in all the three districts have negative perceptions on this issue. The concerned authorities need to examine this issue on priority and reduce the lacunae to the extent possible.

37. Promoting universal immunisation. ‘Prevention is better than cure’ and ‘A stitch in time saves nine’ are some adages that have stood the test of time. These are especially true in the case of health related issues. The Central and State Governments have from time to time been launching vigorous immunisation campaigns like the ‘Pulse Polio’ one. There are a number of other ailments too to which children (especially infants) are very vulnerable. Time action can help in reducing the number of deaths or disablements due to such diseases, which include TB, MMR (measles, mumps, and rubella) and whooping cough. Many parents may be blissfully unaware of the consequences of these ailments and the preventative measures available.

38. There is need for spreading awareness on issues such as these so that the infants can be properly immunised. There is also the risk of epidemics spreading rapidly in the wake of natural calamities like floods and earthquakes. Mass immunisation measures can greatly help in arresting the spread of epidemics. PHCs can play a major role in spreading mass awareness about the immunisation facilities available for the lay public. Table 5.36 presents a contrasting picture across the three districts. In Guntur and Anantapur districts, a little more than 50 percent of the respondents have a positive perception on this score. In Mahaboob Nagar district, the generally positive and negative ratings are almost equal. Such a state of affairs is totally unacceptable since the life and good health of many of our future citizens may be at stake. The PHC staff need to be exhorted to do much more to promote universal immunisation.
39. **Promoting construction of household toilets.** Defecation in the open (due to the shortage of household toilets) is the bane of many rural areas. Such a practice can be both socially and physically unsafe (due to the risk of insect and reptile bites). PHCs are expected to do much more than be mere dispensers of medicines. They should take the lead in promoting healthy practices like construction of household toilets. Table 5.38 presents a very dismal picture with the negatively inclined ratings far outweighing the positive ones. A silver lining, however, is the reasonably high number of respondents in Mahaboob Nagar (36.7 percent) who gave the rating ‘Good’ on this parameter. To ensure provision of certain minimum level of sanitation at the household level, a multi pronged and sustained programme is needed. It is necessary to rationalise the present approach in terms of different programmes and strategies. The experience so far suggests that the role of education, leadership, finances and social mobilisation are all important factors in promoting sanitation practices by the households. Therefore, the multi-pronged strategy should include a strong and sustained mass education campaign, backed by efforts to mobilise communities to take it up as a mission, rather than a programme.

40. **Coordination with panchayats and SHGs.** Panchayati Raj institutions (PRIs) and self help groups (SHGs) have been in existence for many years. During this period, these have gained some degree of acceptability among the rural masses. It would be very advantageous if PHCs ensure a greater degree of coordination with PRIs and SHGs for dissemination of messages regarding healthy life styles. Table 5.38 depicts the perceptions of the respondents on the issue of coordination with panchayats and self help groups. It emerges that the positive ratings are more in number than the negatively inclined ones in all the three districts. However, a slightly disquieting fact is that the negative ratings in all the three districts are still quite noticeable. The message that emerges is that government needs to take proper initiatives to promote better coordination between the PHCs and the panchayats and self help groups, which will strengthen management of rural healthcare.

41. **Coordination with anganwadi workers.** Anganwadi workers are today accepted as important links in the social fabric of rural societies. Since they belong to an almost similar milieu and can converse in the local lingo of most villagers, their messages
carry greater conviction than those of the city-bred expert experts who may be dismissed as outsiders trying to impress them with high flown language. Yet another advantage that the anganwadi workers have is that since most of them are females, they can easily approach women villagers. It is an established fact that any social development message has a greater chance of success if the willing partnership of women is secured. What is the perception of the respondents on this issue? Table 5.39 reveals that the generally positive perceptions outweigh the negatively inclined ones in all the three districts. A slightly disquieting fact is that even the negative ratings are quite noticeable. An interesting feature is that in Anantapur district none of the respondents have given the rating ‘Very Poor’. The message that is that the potential of anganwadi workers should be properly tapped. Government, on its part, should do its bit to raise the morale of such workers by providing better infrastructure and service benefits to them so that they would be better motivated to effectively disseminate the social development messages to the rural folk.

42. Monitoring of water quality in the villages. Many ailments can be substantially reduced if the water used for drinking, cooking, washing, etc., is of a reasonably good quality. In a rural setting, which may not have the benefit of running water (as in urban areas), those engaged in the task of monitoring the quality of water in rural areas need to look for parameters like Biological Oxygen Demand, quantity/quality of pollutants, dissolved solids, etc., before certifying that the water is fit/unfit for consumption by humans and their livestock. As already mentioned, the role of a PHC goes far beyond that of being a mere health centre. It needs to ensure that the quality of water in the nearby water sources is of a reasonably good quality. How do the respondents in the three districts perceive the efforts towards monitoring the water quality in their respective areas? Table 5.40 brings out that the generally positive ratings outnumber the negative ones in all the three districts. However, the negative perceptions are quite noticeable. Vigorous efforts are, therefore, required to significantly increase the satisfaction levels on this score.

43. Providing Primary medical care. The major task of a PHC, especially if it is located in a rural area, is to serve as the first ‘port of call’ to look after the health needs of its vast clientele. It is never intended to take on the role of a super-specialty
hospital. The PHC should be able to handle relatively common ailments/conditions and render preliminary care in case the patients are required to be shifted to specialised hospitals. Table 5.41 brings out the perceptions of the respondents on this issue. It is seen that majority of the respondents have given the rating ‘Fair’. An interesting fact that has emerged is that none of the respondents in Anantapur district have chosen the rating ‘Very Poor’. Still, the concerned authorities cannot afford to sit on their laurels. Vigorous efforts are needed to significantly improve the level of satisfaction of the beneficiaries.

44. Is there any improvement in the quality of delivery of health-care services?
Medical centres have been operating in rural areas for a fairly long time. In these years, the expectation levels of the beneficiaries have risen phenomenally – largely due to the increase in awareness as a result of growing literacy and the reach of the media. How do the respondents react to issue of improvement in quality of delivery of services by health-care workers? Table 5.42 brings out a rather disquieting fact in that, across the three districts, there is a greater inclination towards negative ratings than the positive ones. This is even more pronounced in the case of extreme ratings. In Mahaboob Nagar district, ‘Very Poor’ is nearly four times ‘Very Good’. In Anantapur district, it is nearly twice. In Guntur district, it is nearly seven times. The concerned authorities need to sit up and take urgent measures to correct this sorry state of affairs.

45. To test the hypothesis seven components of services have been selected which are relevant for services provided by the rural healthcare services: healthcare promotion awareness through the program, the efforts taken by health servants, the degree of cure of the diseases, the help of doctors and nurses, cleanliness in health-care centres, and the medical staff efficiency and follow up monitoring of patient. The table 5.57 indicate the complete result of health-care programme awareness, cleanliness in health-care centres, and the medical staff efficiency variables are accepted, remaining four variables are the efforts taken by the health-care servants to the beneficiaries, the degree of cure of the diseases, the role of the doctors and nurses to the beneficiaries, and monitoring of patient are rejected. Hence out of 7 variables majority number four variables are rejected. It says the hypothesis “Beneficiaries are not satisfied with
services provided by the rural health-care centres”. Since the calculated majority of variable values are greater than table value alternative hypothesis is rejected. It shows that services provided by PHCs are not up to the satisfaction level of the respondents.

46. The Table 5.78 shows the complete result of resources of staff services, adequacy of rooms, availability of beds, mobile medical vans; neat and clean hospital and availability staff services in the mobile medical van are accepted. The remaining four variables - availability of medicines, adequacy of laboratory services, and proper disposal of waste and availability doctors for women - are rejected. Hence, out of 10 variables, majority number of six variables are accepted. Thus, it can be inferred that the hypothesis “Beneficiaries are highly dependent on availability of facilities in rural health-care centres” is true. Since the calculated value is less than the tabulated value, the alternative hypothesis ‘there is significant the results indicate that management of healthcare centre require improvement in supply and availability of medicine, capability of laboratory services, proper management of waste, the results also indicate that women doctors need to be employed at primary healthcare centres between availability of facilities in rural health-care centres and satisfaction level of the beneficiaries’ is accepted.

47. The analysis reveal that initial sub scale: infrastructure facilities influences factors, primary healthcare delivery services, financial and physical access to care and PHCs healthcare personal conducted and drug availability. These entire four factors have been mentioned in the form of a scree plot depicted in page no 228. It can be seen from that diagram that after the four major variables that curve becomes parallel to the horizontal and the variables on it are negligible contributing to the dependent variable. Since calculated value is more than the tabulated value alternative hypothesis is rejected. There is no significant deficiencies of providing Delivery Services Improvement on Time to the Beneficiaries at Primary Health-care Centre Level.

48. Table 5.101 Summarises the analysis on: (i) promoting universal immunization, (ii) promoting construction household toilets, (iii) coordination with panchayat rajainstuition, (iv) coordination with anganwadi workers, (v) is looking after
maternal care properly to mother, (iv) providing primary medical care to beneficiaries from primary health-care worker team and (vii) Improvement in access to health-care services Of these variables, only the hypothesis at monitoring of water quality this variable is rejected, the other seven are accepted. The conclusion drawn is: “Involvement of the community participation will help improve the overall health-care delivery”. Since the calculated value is less than the tabulated value, the alternative hypothesis is accepted. There is significant improvement between Involvement of community participation and improvement in quality of the overall health-care delivery.

49. The increased public health spending should finance infrastructure improvements in the rural sub-centres, primary and community health centres and the district hospitals. Additionally, a much higher level of spending is needed for higher salaries to be paid to doctors working in remote and inaccessible rural areas, essential drugs and supplies, vaccines, medical equipments, laboratories, and the like. In terms of human resources in the health centres, state governments need to appoint more auxiliary nurse midwives, trained birth attendants, technicians, pharmacists, doctors, and specialists. In the lagging states, governments need to provide cell phones to doctors and ANMs in rural PHCs. These measures will help increase the utilisation of the public health centres and consequently bring down the rather high out-of-pocket expenses of their rural residents.

6.2. Conclusions
Primary health-care is a vital aspect in rural health-care delivery system. Therefore, the study analysed various factors that contribute to the performance of primary health-care centres. It can be concluded that reliability in a PHC’s delivery, providing infrastructure facilities, involvement of and coordination with the community are influencing the performance of primary health-care services. The study also attempted to identify the factors influencing rural health-care delivery services and concluded that lack of effective delivery services in primary health-care on various aspects of health-care in rural areas of Andhra Pradesh. Majority of the respondents have pointed out that those deficiencies in vital resources and poor coordination in administering the levels of staff required are
having an adverse effect on the primary health-care services. Insignificant impact on the rural health-care delivery services. Several hypotheses have been tested using Chi-square, factor Analysis and, at the final stage, correlation coefficient analysis test. The majority of analysis variables results are found to be insignificant.

What was most astonishing was the finding that the overall quality of health-care services is perceived to be higher in primary health centres than in community health centres. Inadequate availability of doctors and medical equipments, poor clinical examination, and poor quality of drugs were the important drawbacks reported at community health centres. This appears shocking as community health centres form the uppermost tier of the primary health-care system in the country and therefore medical specialists comprising surgeons, physicians, gynecologists, and pediatricians supported by twenty-one paramedical and other staff are supposed to be in charge of each community health centre, whereas just one medical officer, supported by fourteen paramedical and other staff is in charge of the primary health centres. However, the current study seems to corroborate the findings of other researches (Choudhury et al., 2006; Bhandari and Dutta, 2007) on the current scenario of rural healthcare centres. According to Bhandari and Dutta (2007), nearly 50 per cent of the sanctioned posts of specialists at community health centres were vacant in 2005 and the absenteeism rate among the primary health providers in India was the highest (40%) among the surveyed countries (Chaudhury et al., 2006). The fact that the patients opined that the financial feasibility was low in community health centres, in comparison to primary health centres, need further exploration. As these centres are government-owned, only a nominal amount is charged for the various medical facilities. This finding contradicts the government’s objective of making health facilities available at a very low cost to the common man. The inadequate availability of doctors for women was also reported at primary health centres. It may be pertinent to note that there is no provision for gynecologists at these centres.

ASHA doing outstanding work in terms of Janani Suraksha Yojana, sanitation and other responsibilities. However, in terms of promoting community-based health insurance, ASHA is yet to go a long way. Participation in community financing schemes requires resources, i.e., time and money, which the most disadvantaged group in societies often does not possess. Donors and policy makers should hence be aware that it might be
very difficult, even impossible, to reach the poorest sections of the population when promoting participation in these kind of local organisations. In order to both promote these initiatives and lower the barriers to participation, well-targeted subsidies and a linkage to social funds is a possible solution. As one major objective of social funds is to finance investments benefiting the poor and, since in most parts it is the public sector, which administers social funds, such a support would also strengthen the linkage to more formalised health care systems.

This suggests that, further research is needed, how theses schemes (community insurance, healthcare insurance and Rajiv Aarogyasri) can be scaled up and replicated as well as how to link them to social risk management instruments, e.g., social funds to broaden the risk pool and increasing coverage rates. Future research should also address the question of how subsidies for the poorest in a community can be designed in order to preserve the incentives for a viable management of the schemes and to achieve optimal targeting. In addition, more research is needed on other promising measures to fight social exclusion in access to social protection in low-income environments. Finally, the study can say that there is an immense need for massive publicity to spread greater awareness among the people regarding the need for financing health-care in the context of high out-of-pocket expenses on health. If we can successfully use insurance in covering our health hazards, we might make headway in successfully tackling this formidable challenge to the society.

6.3. Direction for Future Research

The current study demonstrates that the instrument employed was reliable and possessed the power to discern differences in the opinion of people on the basis of demographic factors and point out the quality and delivery differences in different health-care centres. The selection of the respondents on the basis of convenience may have limited the precision of the study, but the findings urge the government and policy makers to consider the perceptions of patients as well in order to bring about improvements in the delivery of services and subsequently increase their utilisation levels. Immediate steps need to be undertaken to ensure availability of doctors, medical equipments, and good
quality of drugs. The study was however, limited to certain areas of Andhra Pradesh (Mahaboob Nagar, Anantpur and Guntur districts). Therefore, it is suggested that similar studies be carried out in other rural and urban regions of the country and include the private health-care service providers as well. Further, researches could be conducted on: Primary health-care infrastructure development and health-care financial management. There is a pressing need for a research infrastructure which will provide information on access to primary medical care, and the kind of services medical and allied health professionals who can be accessed by that the hitherto deprived sections of society.