CHAPTER X

SUMMARY & CONCLUSION:

Health is a major instrument of social and economical development and it can play a very important role in the creation of a new world. The level of development achieved by a society is often determined on the basis of the level of health and system of health prevalent in the society. According to the “Right to Health”, in the universal declaration of human rights, everyone has the right to a standard of living, adequate for the well being of himself and his family. In a developing country like India, medical practitioners can no longer confine their role for diagnosing ailments. They have to play the role of educators, counselors and as the agents of social change. Health has evolved from being only an individual concern to that of a major social goal and an important factor, which encompasses the quality of community life.

Health Centres (PHC, CHC and Sub-centres) are part of the civilized society throughout our history. They are as old as the human society and has its own identity from the beginning of the civilization. They are developed and progressed enormously and had its impact on society. Today, PHCs are receiving greater attention in the social and economical scenario. It is essential and socially accepted primary health care which is made accessible to individuals through their full participation.

Research in the discipline of primary health centres is growing contributing to academic knowledge and is also providing practical solution to specific health problems. Present study has tried to look at the multi dimensional character of the disciplines of health. 1963 is the year which is considered as the starting period of scientific discussion on health economics. This study is considered to be relevant in the context of indices of health care development in Mangalore Taluk from 2000-01 to 2003-04.
Methodology:

These has been a view that primary health has not served its objectives owing to inherent problems in the system and apathy of community towards them, which leads them to private health services. This study intends to study the extent of accessibility and usefulness of the primary health services to both rural and urban communities. The specific objectives are:

1. to assess the performance of public health care system with reference to activities like nutrition, supply of water, sanitation, child health, supply of drugs, prevention and control of diseases in PHCs, CHCs and SCs.
2. to assess the health service provided in public health care system with reference to major and minor health problems and their benefits to the patients.
3. to assess how the government spends money for the establishment cost and recurring costs towards health care in primary health institution.
4. to assess the infrastructure facilities available in PHCs, CHCs and SCs.
5. to study the cost and benefits for the beneficiaries of PHCs, CHCs and SCs and quality of services provided by these institutions as perceived by the beneficiaries.
6. to find out direct and indirect costs and benefits arising out of public health and to calculate the health cost benefit ratio.

Major Findings

a) Health Education: Generally health education is provided to patients and public in different ways. Various media are used effectively for promoting health. Print media are used effectively for giving health information and promoting health. Newspapers, magazines as well as electronic media are giving more information on health monitoring. Media provide information regarding health and its services available in
health centres. Health promotion in schools include all activities that a school can do to make the children healthy and to spread the message of healthful living and practice to all those who attend and work in the school and their families and communities. The important health aspects covered in school health education are:

a) Safe and healthy school environment.
b) Availability of safe drinking water and good sanitary arrangements like toilets.
c) Sound nutrition practices.
d) Practice of good health services.
e) Effective health education.

Training programmes to anganavady and school teachers like mother and child health, food and nutrition are undertaken in each health centres. Training to people working in NGOs on mother and child health has become a major primary health education programme.

b) Cost and Expenditure in health centres:

i) Cost and Expenditure in Rural PHCs

The cost analysis of 8 rural PHCs reveal that huge amount of money goes to salaries, which comes to above 80% of the total expenditure. Medicine cost comes next to cost towards salaries. Bajpe PHC records lowest amount of money spent for operations (0.20%) and total cost per patient recorded was Rs. 62.14 per year. In Boliyar PHC, minimum amount of money is spent for wages (0.10%) where per head expenditure recorded was Rs. 90.60 per year. In Amblamogaru PHC, lowest percentage of money is spent for wages (0.12%) and repairs (0.12%) where per head cost comes to Rs. 117.45 per year. In Kateel PHC, lowest percentage of money is spent for wages (0.12%) and repairs (0.06%) where per head cost is Rs. 165 per year. In Ganjimutt, lowest cost goes to operation
(0.24%) where per head cost is Rs. 75.44 per year. Kotekar PHC has
recorded highest staff salary cost (90.36%) and Natekal PHC has
recorded the lowest (85.52%).

ii) Cost and Expenditure in Urban PHCs

The cost and expenditure in 5 urban PHCs are not uniformly
recorded. In Adyar PHC, annual expenditure on salaries goes up to
94.16% of the total expenditure. The lowest cost is spent on repairs.
The cost per head comes to Rs. 276 per year. Kudupu PHC spends
94.48% of the total expenditure on salary and minimum amount is
spent on repairs. The per head cost recorded in this PHC is Rs. 292.90.
Bondel PHC spends 93.56% on salaries and minimum percentage
(0.27%) of money is spent on operations. The per head cost in this
centre comes to Rs. 256.6. Ullal PHC recorded 93.93% of the total cost
on salaries with minimum cost spent on repairs. The per head cost in
Ullal PHC is Rs. 193.4 per year. Cost analysis of Surathkal PHC shows
that 93.40% of the total expenditure goes to salaries minimum amount
going to repairs. The per head expenditure in this centre has been to
Rs. 160.2 per year. From these results, it can be concluded that
Kudupu PHC has the highest per capita spending and Surathkal and
Ullal PHC have lowest per capita spending.

iii) Cost and Expenditure in CHCs : Cost and expenditure in 5 CHCs
vary according to the infrastructural facilities and programmes
available. The cost analysis of Mulky centre shows that 90.2% of the
total expenditure goes to salaries and operating cost comes to 0.2%.
The per head cost in this centre has been Rs 335.42 per year.
Moodbidri CHC spends maximum amount (93.1%) towards salaries and
0.1% of the total cost on operations. The per head cost in this centre
recorded was Rs. 238.07 per year. The Urban Family welfare
Programme, Kadri was recorded maximum cost for salaries and
minimum for operations (0.1%) and repair (0.1%). The per head cost
in this centre comes to Rs 157.16 per year. The Wenlock District
Hospital spends maximum percentage of money on salaries and
minimum for operations (0.04%). The per head cost comes to Rs. 165.14 per year. The University Health Centre’s cost analysis shows that 82.75% has been spent on salaries and 0.2% on operations. The per head cost recorded was Rs 625 per year. These results reveal that in all CHCs, a major share of money goes to the salaries component.

iv) Cost and Expenditure in Sub-centres - The cost and expenditure of 15 sub-centres shows different values for different health services. Here again the major share of money goes to the salaries. In Amblamogaru, Haleyangadi, Munnur, Pavoor, Ullal (B), Kotekar (A) and Permannur sub-centres, more than 90% of the total expenditure goes to salaries whereas in Kenya, Bondel, Someshwara, Konaje and Harekala, it was more than 80%. A lower amount was spent on operation and repairs. The per head cost in 15 Sub-centres shows that Kotekar (A) sub-centre recorded high per head cost (Rs. 605 per year) and Belma sub-centre recorded lower per head cost (Rs. 109 per year).

c) Cost and expenditure of beneficiaries
The study of 330 beneficiaries purports to the selected 33 health centres. In the age group of 30 to 40 year most of the beneficiaries complain fever, cold and other minor and major health problems. A closer observation of the beneficiaries cost reveal that all the PHCs are not similar in terms of cost and expenditure incurred by beneficiaries. In PHCs like Kudupu, the cost is as high as Rs. 292-90 per head while in Bajipe PHC, it is as low as Rs. 62.14. Among the five CHCs studied, the cost and expenditure rate of each centre varies significantly. Highest per head cost was found in University Health Centre (Rs 625 per year) and lowest in Kadri (UFWP) (Rs. 157.16 per year). The study on sub-centres reveal that cost and expenditure per head was found highest in Kotekar (A) sub-centre (Rs.605 per year ) and lowest in Belma SC (Rs. 109 per year).

d) Sanitation facilities in health centres - In addition to the basic infrastructure, each health centre has adequate sanitation facilities.
However, some health centres do not have proper drainage and waste disposal systems. The supply of drinking water is not systematic in some PHCs and CHCs. Among the 15 sub-centres, six have no proper sanitation facilities.

In all community health centre, good ventilation, good food and nutrition are being provided. In most of the health centres, four types of waste disposal methods are adopted.

1. Throwing the waste away from the centre
2. Burying of waste
3. Burning of waste and
4. Recycling of waste

The Bajpe PHC has adequate supply of water for both clinical and drinking purposes. The waste disposal method adopted in this centre is burying. Boliiyar PHC shows inadequate supply of water. The waste disposal method followed is throwing away the waste. Amblamogaru, Kateel, Kotekar, Katipalla, Ganjimutt PHCs have recorded adequate water supply. Natekal PHC reports inadequate supply of water and waste disposal technique and it follows burning. Amblamogaru and Ganjimut PHCs follow throwing method of waste disposal, whereas, Kotekar and Katipalla PHCs follow burying method, Kateel PHC follows burning method of waste disposal. In Mulky CHC, wastes are disposed out of the centre and reusable wastes are recycled. Most of the sub-centres follow burning method of waste disposal.

**e) Health services available in health centres**

1) Health services available in PHCs

The PHCs render comprehensive health care services comprising mother and child health programmes, family planning programmes, all health services, health education and other health related services. The PHCs at Boliiyar, Amblamogaru, Kateel and Natekal perform their health programmes well whereas Ganjimutt PHC lags behind in mother child health programme. Bajpe PHC performs well in mother and child health programmes but it lags behind in family planning programmes.
The important health services available in PHCs include immunization, pulse polio, vaccinations and injections. Pulse polio and immunization are the two major programmes having maximum number of beneficiaries in urban PHCs.

ii) Health services available in CHCs: The important health services rendered by the CHCs consist of preventive and curative measures of health care. Mulky CHC offers good service in both these fields and the centre provides quick services without undue delay whereas, Moodbidri centre experiences shortage of facilities.

iii) Health services available in SCs: All 15 sub-centres perform several health programmes, of which 12 have mother-child health programmes. Other programmes include discussions, propaganda and awareness programmes as part of their activities towards health services. Immunization, pulse polio, vaccination and infection are other programmes undertaken in the sub-centres.

f) Availability of health services

The various health services provided by the rural PHCs and urban PHCs differ significantly in terms of social composition of beneficiaries. The rural PHCs have large number of cases of TB, malaria, dengue fever and other minor health problems. In rural areas, super specialty health services are not available as in the case of urban PHCs.

g) Accessibility of health services – The rural and urban PHCs differ one another in term of accessibility of health services. Certain services like medicines are supplied in plenty to the rural PHCs but the benefits of these facilities do not reach the beneficiaries. The important impediments for this are lack of transport facilities, lack of awareness of the programme, dis-belief about the programme and lack of publicity.

h) Affordability of health services: The health services available in rural PHCs are not accorded fully to the beneficiaries. Regarding the
individual PHCs of rural areas, Ambiamogaru PHC is the remotest one and therefore it is not affordable to the beneficiaries. Boliyar PHC is also not well placed regarding people’s approachability and communication. On the other hand, some rural PHCs like Natekal PHC is well located and is being utilized completely by the beneficiaries. PHCs in Kateel, Bajpe and Ganjimutt have on an average good facilities. Katipalla and Kotekar PHC are not qualitatively good despite their easy accessibility through national highways.

i) Benefit Cost Ratio (BCR): The technique of benefit cost ratio is adopted to evaluate the primary health which includes direct and indirect cost and benefit. Direct cost includes the total money spent on drugs, salaries, establishments and treatment to diseases. Indirect cost refers to the total money spent on maintenance, electricity and power, transportation and storage of medicines. Expenditure is calculated by adding direct and indirect cost required for health services in each CHC, PHC and SC. Economic benefit is calculated by adding direct benefit and indirect benefit available from health services in each PHC, CHC and SC. Direct benefit includes free supply of medicine and certain services made in house. Indirect benefits include education and advice from the doctors and medical officers.

BCR in PHCs: The total cost recorded was highest in Bajpe PHC (Rs.511.1) and lowest in Natekal PHC (Rs. 143.3) The total benefit recorded was highest in Kateel PHC (Rs 596.0) and lowest in Ganjimutt PHC (Rs. 245). BCR in 8 PHCs based on the benefit cost obtained for beneficiaries reveal that highest BCR was recorded in Natekal PHC (1.99) and lowest BCR was recorded in Ganjimutt PHC (1.44).

BCR in CHCs: Among the 5 CHCs studied, University Health centre recorded highest total cost (Rs.1070) and benefit (Rs.1115) whereas Kadri CHC recorded lowest total cost (Rs. 643.2) and benefit (Rs. 846). BCR was recorded high in Kadri CHC (1.32) and lowest in University Health Centre (1.04).
BCR in Sub-centres: Among the 15 sub centers, highest total cost (Rs. 701.6) and benefit (Rs. 630.6) are recorded in Kotekar SC and lowest total cost (Rs. 162.7) and benefit (Rs. 251.5) in Someshwar SC. BCR is found highest in Someshwar sub-centre (1.55) and lowest in Kotekar sub-centre (0.90).

Conclusion

Health centres like PHC, CHC and sub-centres are playing a major role in development. Hence, the people should have access to the services available in health centres through their full participation. In Mangalore taluk, the health services available in public health centres are significant compared to private hospitals. All 13 PHCs, 5 CHCs and 15 Sub-centres are performing 85% of achievement in health services, even though they are not spending the whole money sanctioned from the government. Some health centres are undertaking proper health services, especially for people who are economically and socially poor. The health services in all health centres are important for the better health of beneficiaries which indirectly helps for the economic development of a country.

In this, adequate encouragement of the primary health care system, along with effective functioning are required.

Suggestions:

Health is very important for all human beings. Education and awareness of health is mediated through Television, newspaper etc. to circularize the importance of health to public. The major suggestions of the present study are:

1. Total expenditure in the health center, since a greater part goes to salaries, it is essential that the proportion spent on medicines and disease control measures is incurred substantially so as to attend the rural people to the health centers. In sum centers excess availability of medicines has to be properly treated to deficit centres.
Whenever the cost incurred by the beneficiaries is high the provisions of health services in such health centers has to be strengthened. Proper waste disposal and drainage system have to be constructed.

In the remotest areas, primary health services to be unaffordable and in these regards measures have to be initiated to make such center rural friendly.

2 There is less confidence among the people about the services of government hospitals like PHCs, CHCs and SCs. This is mainly due to the low level of cleanliness, non-availability of free medicines and services. Therefore, PHCs, CHCs and SCs should receive minimum charges on medicines, blood testing, injections etc.

3 There is a shortage of medicines in PHCs. The supply of medicines from the directorates are not properly matched to the indent medicine list sent by the hospitals. So, the patients are suffering from the shortage of required medicines. So, government should supply necessary medicines to the health centres.

4 The doctors servicing in PHC and CHCs also serve patients by keeping private clinics. Hence, they are not concentrating fully on the duties at health centres.

5 Most of the health services are not available to the patients. This is because the money sanctioned by the government for health programmes are not used completely for the programmes, instead they are partly used by the doctors and other staff, so that the target of this programmes are not reached.

6 Absence of doctors in duty hours and emergencies are more in health centres. Lack of quarters or accommodation to the doctors is the main reason for this. Therefore, patients are suffering from the absence of doctors and loose confidence on health centres, select private hospitals for their treatments.
7 Hence, minimum price rate on medicine and health services, availability of doctors and better health services in health centres are important for the better health of people which indirectly helps for the national economic development.