SUMMARY AND CONCLUSION

CHAPTER VII
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The main objectives of the present study were to look into the pattern of morbidity and hospitalisation in Kerala; to explore the important factors determining the health care accessibility and to examine the disparity in health care accessibility across different socio-economic groups of Kerala. The study made use of secondary data and conducted a primary survey to examine aspects of health care accessibility in the state of Kerala. The important findings of the study are summarised as follows:

7.1 Summary of Findings

The major findings from secondary data analysis especially NSSO data analysis are as follows:

- The morbidity rate was found to be highest in Kerala, with rural areas more prone (25.5 per cent) compared to rural India (8.8 per cent) in 2004. Similarly, in urban area also Kerala reported high morbidity rates (24.0 per cent) as against 9.9 per cent recorded from all India.

- A caste wise analysis in Kerala shows that SC population were more ailing health wise (27 per cent). In rural area, SC population reported maximum morbidity rate of 27 per cent. While in urban area, Other category reported high morbidity rate (29 per cent)

- Gender wise comparison showed that SC women reported high levels of morbidity with a rate of 29 per cent while among males the category ‘Others’ recorded more ailments with a rate of 25 per cent. In rural area,
SC males (25 per cent) and females (30 per cent) suffered more morbidity when compared to other category.

- In rural area, the highest morbidity rate was reported in the lowest MPCE class, i.e., very poor class, with a rate of 30.4 per cent. But in urban area the highest morbidity rate was reported in the highest MPCE class with a rate of 32.4 per cent.

- Individuals above the age group of 60 reported more illness (57 per cent) compared to all other age groups. The pattern was similar for rural (58 per cent) and urban populations (55 per cent) also.

- An inverse relationship was seen between size of household and morbidity rate. When size of household increases, the morbidity decreases. The highest morbidity rate was reported (33.1%) in household size group of 3 & below.

- While comparing the employment structure highest morbidity was reported (26.3 per cent) in the category of casual labour/other labour, followed by self employed in agriculture (26.1 per cent).

- The major ailment reported was fever of unknown origin (15.9 per cent). Among ST population, 29 per cent suffered respiratory including ear/nose/throat ailments. Among SC population, 20 per cent reported fever of unknown origin.

- In rural Kerala, 87 per cent of ailments were treated, while in urban area it was reported to be 90 per cent. In rural Kerala, among the treated ailments, 37 per cent was treated in government source while remaining 63 per cent were treated through private sources. In urban Kerala, 22 per cent depended on government sources, while 78 per cent relied on private sources.
The average total expenditure for the rural Kerala was Rs. 198, while it is 203 for urban Kerala. Loss of household income per treated persons was Rs. 72 for rural Kerala, while it is Rs. 83 for urban Kerala. The expenditure is much lower in Kerala compared to all India.

In the case of hospitalization, in rural Kerala, 35 per cent treated in government hospital, while in rural area the rate of hospitalization in government hospital was 34 per cent.

In rural Kerala, the percentage of receiving non-hospitalized treatment decreased from 37 per cent in 1986-87 to 32 per cent in 2004, with steep decline noticed during 1995-96 (28 per cent). But, in urban Kerala, a steady increase was seen from 22 per cent in 1986-87 to 28 per cent in 1995-96 which again increased to 33 per cent in 2004.

The major findings from primary data analysis were

Among the sample population, the morbidity rate was reported to be 27.14 per cent. The rate was higher in urban area (30.3 per cent) compared to 30.3 per cent. Among caste group, ST households reported highest morbidity (28.73 per cent). The morbidity rate was higher in low household size. Highest MPCE quartile group and SES IV group reported highest morbidity.

Among the total sample population of ailing persons, the major ailment affected was fever of unknown reason (28.25 per cent) followed by high/low BP with 9.86 per cent. For the ST population, the fever was followed by rheumatism, paralysis (7.30 per cent) and skin diseases (4.38 per cent). SC, OBC and general categories reported high/low BP as the other important ailment besides fever.
The percentage share of monthly per capita health care expenditure is very high in ST category (20 per cent) followed by SC category (14.28 per cent). The share of health expenditure was higher in urban area (15.67 per cent) when compared to rural area (11.83). The daily wage households paid more for health care expenditure (14.87 per cent) than the other occupational groups of the study area.

Among ST households, 80 per cent of the households faced the problem of infrastructure availability in terms of tarred road or improper subway connecting to the tarred road. This percentage was very low in other communities. ST households also faced the problem of getting bus service. Nearly 46 per cent of the ST households faced lack of accessibility to bus services for more than two hours.

About 82.3 per cent of the households preferred allopathic medicine, while 9.8 per cent preferred ayurvedic and remaining 3.5 relied on homoepathy. The reason for their preference was the quick relief factor. The percentage use of ayurvedic treatment was higher in OBC group (14.5 per cent) followed by Other groups (9.8 per cent). The preference of homoepathic treatment was higher in general households and also there was a tendency to use ayurvedic treatment among 13.2 per cent of households.

Nearly 38 per cent of the household had PHC/CHC within 3km and 8 km of their vicinity. Among the ST households 73 per cent were living beyond 8 km from the vicinity of nearest PHC/CHC.

About 75 per cent of the total SES I and SESII are SC/STs population;

80 per cent of the MPCE I comprised of SC/STs;

More than 80 per cent of the coolies and forest related workers are SC/STs.
The factors determining the accessibility among different caste showed that for all the caste groups most of the variable selected have positive impact. Only distance to PHC shows negative relatedness. Religion wise analysis also shows that most of the variables selected have positive impact.

The factors determining availability shows that MPCE, distance to PHC and household size have positive impact in ST and conveyance to health care institutions have positive impact among SC group. Among the OBC category, MPCE, distance to PHCE and type of conveyance have positive impact. In general category PHC, MPCE and household size have positive impact.

The major determining factors to acceptability among ST group are MPCE, female literacy, socio economic status and distance to PHC are determinant factors in deciding acceptability. Among SC groups, the use of traditional medicine and modern medicine taking with the advice of doctors have significant impact. Among OBC, monthly health expenditure has positive impact apart from above factors. Among general category, the main determining factors are MPCE, use of traditional medicines, treatment of drinking water, female literacy and distance to PHC.

Analysis of the disparity in healthcare affordability, availability and acceptability across different socio-economic groups shows that the availability and acceptability are poorest for the STs followed by the SESI, SESII, coolies, forestry related and fishermen.

In the case of affordability SESI and SESII are more vulnerable followed by the STs, coolies, forestry related and fishermen. Therefore, the health care accessibility is found to be much worse in these categories.
7.2 Conclusion

Results of analysis using NSSO survey showed that even with notable improvements in health and demographics indication, Kerala shows high morbidity rate compared to All India level both in urban and rural areas. Another interesting point noticeable was higher morbidity seen among highest income groups. There exists urban-rural as well as gender wise difference in morbidity. Both in Kerala as well as India females are more morbid compared to their male counterparts. Morbidity is seen higher in rural Kerala while it was higher in urban India. The logistic regression model which was worked to find out the effect of selected background characteristics on reported health status and hospitalization showed that morbidity rate is more influenced by the socio-economic variables like caste, area, MPCE, household size, type of household, sex and age group, while the hospitalization is influenced by household size, type of household and sex.

While analyzing the primary data it was observed that highest morbidity among females, Scheduled Tribes, low income people and low SES group was quite evident. Fever of unknown origin, blood pressure, joint pains and diabetics are the more incurred ailments. It is also seen that the affordability of health care facilities to the backward communities and low socio-economic groups is less, through these percentage of health care expenditure is high. The availability of health care institutions in terms of vehicles, road connectivity and communication is also less among backward communities and low socio economic groups. Acceptability in terms of objectives elements like choices and preferences shows that government sector is more chosen than private sector and allopathic system is more preferred to ayurveda and homeo. But, the preferences to homeopathy is highest among the forward caste and high socio-economic groups for their
children and aged. Accessibility in terms of availability is less among backward communities and low socio-economic groups.

Analysis of the disparity in healthcare affordability, availability and acceptability across different socio-economic groups shows that the availability and acceptability are poorest to the STs followed by the SESI, SESII, coolies, forestry related workers and fishermen. In the case of affordability, SESI and SESII are more vulnerable followed by the STs, coolies, forestry related workers and fishermen. Therefore, the health care accessibility in toto is also found to be much worse to STs, SESI, SESII, coolies, forestry related workers and fishermen. However, we may note that about 75 per cent of the total SES I and SESII are SC/STs population; 80 per cent of the MPCE I comprised of SC/STs; and more than 80 per cent of the coolies and forest related workers are SC/STs.

Hence, we may argue that major chunk of the SC/ST population are deprived of health care accessibility in Kerala when looked into any of the three indices – affordability, acceptability and availability.

7.3 Policy Implication

The present study could establish the existence of disparity in health care accessibility across different socio-economic groups. The vulnerable groups are observed as the historically deprived populations such as the SCs and STs. Since the major reasons being the availability and affordability of health care, we may advocate for an active government intervention in enhancing the public health provisioning. This may include better transportation facilities to the interior areas of Kerala, where the Tribes and SC colonies are extended and a more geographical spread of health care institutions.
7.4 Areas for future research

The higher morbidity pattern in Kerala especially among the high income quartile suggests that there is likely to be high correlation between the changes in the consumption pattern and life style on the morbidity pattern. This calls for a detailed study on the nature and causes for the changing morbidity pattern in Kerala.

Our results show that the various government efforts for the welfare for Scheduled Caste and Scheduled tribes failed to the objective of providing basic health care facilities. This calls for further study on the causes for the government policy failure, especially in the provision of basic health care facility to the tribes.