CHAPTER-6
SUMMARY AND CONCLUSIONS
6.1 SUMMARY

In this chapter we deal with the main aspects and analysis undertaken in the earlier chapters.

Chapter – 1: This chapter is concerned with definitional aspects of health. After the discussion about various aspects of health, the researcher ultimately accepts the definition of health as given by the World Health Organization. According to which health is defined as a “State of complete, physical, mental and social well being and not merely the absence of disease or infirmity. In the section related to importance of health for human capital an development role of health as input, output, health in the context of human development and capability enhancements are discussed apart from health being a central part of interlocking deprivations. As to why health matters is being discussed in the subsequent paragraphs. We observe from this chapter how health contributes to the workers’ productivity, benefits for next generation, educed medical care and mortality. What is the role of the State given the importance of health ? we find answer to this question by considering health as a public good, where in government action may be needed to provide cost-effective health services to the poor, compensate for the problems generated by uncertainty and the insurance market failure, and providing services such as health related information and control of contagious diseases, and promotion of positive externalities emanating from investing in health. Two important charts in this chapter depict the relation between investing in health care and the health status, apart from the GDP-HEALTH-GDP relationship and development –health- development linkages.

Chapter – 2 deals with the review of literature which forms the base for better understanding of the issues pertaining to health. The researcher has consulted various articles and research papers along with reports. Some sections are devoted to utilisation of health services in different states and samples. A separate section on the literature pertaining the Gujarat and a study on Surat is included in this chapter.

Chapter 3. Deals with methodology adopted for the study. The chapter finds discussion on the process of selecting the sample size. One will observe in this chapter that a
stratified sampling method has been adopted. Samples have been selected out of the strata of primary health centers, villages. Further households have been selected out of the villages comprising of maximum and minimum households. Questionnaire was randomly administered to the households at these villages. Prior to administering the questionnaire, the same was put forth before the experts in the field. After subsequent revisions, the questionnaire was finalized and administered.

The Objectives of the study were (a) to understand the utilisation pattern of the public and private health services, study the delivery of critical reproductive and child health care services, understand the rural urban disparities, along with the disparities among the various social strata. The researcher also tried to understand the health indicators at the all India, Gujarat and Surat.

Some of the hypothesis which were put to test among many were the testing of relationship between education, income. Rural urban classification of the respondents, the income status vis-à-vis the health utilisation patterns.

**Chapter four** is about the discussion on the health status at the international, all India, inter-state, inter-district – within Gujarat State, and inter-taluka and Surat district. After a brief review of health status among the major countries, the chapter deals with the NFHS data at the all India Level with a comparison with data on Gujarat pertaining to major indictors. As far as the aspects concerning the major group of nations is concerned it can be inferred from the data that wherever the percapita income is high the core indictors have performed better. In other words high percapita income of a nation has revealed low maternity and birth rates. Expenditure on health is high compared to the medium and low income countries. The access to sanitation is also better. The analysis here shows that there is an established link between GDP/Income and the performance of the health indicators.

Data on NFHS I, II, and III is used in this chapter to have a brief comparison of Gujarat with the overall national figures brought out by the survey. The indicators pertain to
basic services related to antenatal care. It is found from the data analysis there has been an improvement in the percentage of population taking the benefit of antenatal care over the surveys. However, there persists a serious rural-urban cap in taking the benefit of services. This is also observed in the number of visits to the doctors, increasing the awareness among the women. Going by the rural urban gap in percentage points, it has grown from 9.5 to 31. In the case of immunization status the gaps were persistent though the overall percentage of immunized went up. The average rural urban gap was to the extent of 20 percent. There is a significant shortage of personnel at the All-India and Gujarat level too. From the related table we observe that the shortage of specialists at the all India level is lower compared to Gujarat. In terms of fulfilling the number of health centers Gujarat is better placed than the All India Position.

With regards to antenatal care in Gujarat as a whole, though the gaps in the utilisation of major services exist, the performance is better than the all India level. This is observed in the case of similar services. But like All India level situation, there are serious disparities between the rural and urban areas. While the percentage of births delivered in a health facility has gone up from 36.8 percent to 54.6 percent, an average of around 35 percentage point gap between the rural and urban area is very pertinent.

Certain interesting aspects are also revealed while making and inter-state comparison vis-à-vis all India and Gujarat. The researcher has taken only the NFHS 3 data here. Comparisons with NFHS I and II have not been taken up due to the reasons of space. The performance of Gujarat in the case of using the family planning method was better. However it is quite behind highest ranked Himachal Pradesh. While the national average for ANC visits for Gujarat (64.9) was higher than the all India level, the same was far, far behind the highest attained by Tamil Nadu (96.5). Gujarat was slightly ahead (45.2) in the terms full immunization compared to all India status (43.5), again far behind the highest of 80.9 in the case of Tamil Nadu.

This chapter also analyses the inter-district disparities in important health indicators in Gujarat. The data used for this purpose is based on District Level Health Surveys 2 and
3. With regarding the usage of ANC services Surat District topped all the districts under the DLHS 3. The performance of Surat district as a whole was better than the All-Gujarat Average in the case of ANC aspect of health indicators. In the case of this indicator – Antenatal care, out of twenty six districts fifteen districts had lowered their performance, Surat district was one which performed better under the DLHS 3 over the DLHS-3.

There was an improved performance of Surat District in the case of the women taking TT injection compared to Gujarat. While the performance at all-Gujarat level was poorer between the two surveys, Surat could improve. However the performance of other districts is better between the two surveys in the case of this indicator.

In the case of contraception by the population Surat district topped during both the surveys. The case of Dangs is serious since only 53 percent of population could have some form of contraception. Overall twenty districts out of twenty six could improve their position. It is worth noting here that the performance of rural Surat is better than the urban areas.

In the case of institutional delivery by the population concerned Dangs District had performed the worst between the two surveys, while Mehsana performed the best. In the case of All Gujarat there was an improvement in the performance from 50.2 percent to 59.4 percent between the surveys. However the performance of Surat district was better than the Gujarat average, there was a marginal deterioration in the case of Surat district. With regards to immunization the performance of Gujarat and Surat district marked a significant improvement between the surveys.

The chapter also finds an inter-regional analysis of these indicators in Gujarat. The entire state is divided into four regions, the South Gujarat, Central Gujarat, North Gujarat and the Central Gujarat region. Inter regional comparisons of the above indicators have been made vis-à-vis the Surat district. In the case of antenatal care, TT Injection, Contraception, Institutional Delivery, Full Immunisation, and adoption of family
planning are concerned, the best performance under DLHS 3 over DLHS 2 were in the regions of Saurashtra (66.6 percent), Saurashtra (80.1 percent), South Gujarat (67.36 percent), Central Gujarat (67.4). Saurashtra region (62.7) and Central Gujarat (20.3) percent respectively.

In this chapter the researcher also attempted inter-taluka analysis of the various health indicators in the Surat district. With regards to the full immunization the district as a whole performed the best between the two surveys. It is to be noted that while the district as a whole performed poorly in terms of home deliveries, i.e., there was a rise in the number of home deliveries, in the case of Olpad Taluka the percentage of home deliveries had come down. In terms of using the private health facilities Olpad Taluka saw an improvement, while the usage of government facilities was very poor. The highest percentage of Ante Natal Care early registrations occurred in Vyara Taluka (81.0 percent). There was a marginal rise in the early ANC registrations for Olpad taluka.

Chapter V: This is the core chapter of the thesis. In this chapter we have the utilisation of the various types of core health services. These are the services which are very important for the population. These are some of these which have already been discussed in chapter four. Some of them are (a) ANC Registration, (b) TT Injections and Iron Tablets, (c) Immunisation aspects and (d) Knowledge about HIV/AIDS. Utilisation of these services by the variable of Caste, Education, Income, Rural Urban, by the Primary Health centers.

As far as utilisation of ANC services by the respondents i.e., taking benefit of the Immunisation services, utilisation of services vis-à-vis income levels, taking the benefit of TT Injections and Iron tablets, and Knowledge about HIV/AIDS by the social strata – by caste is concerned the results are as follows.

The least utilisation of the ANC services was by the respondents who belonged to the SC category. Similarly a least number of respondents went for ANC check up for at least three times. In terms of taking TT Injections the category of SC respondents was
highest. With regards to awareness about immunizations the least awareness was among the OBC respondents while the maximum being among the respondents from general category. With regards to taking treatment from private sources, 63.5 percent of the respondents took treatment from private sources while only 28.62 percent from the government and allied sources.

Utilisation of ANC services by the respondents i.e., taking benefit of the Immunisation services., utilisation of services vis-à-vis income levels, taking the benefit of TT Injections and Iron tablets, and Knowledge about HIV/AIDS by the level of education is concerned the results are as follows.

**The least utilisation of the ANC services was by the respondents who had education up to** primary level while the highest belonged to those who were educated above graduation. Similarly a least number of respondents who went for ANC check up for at least three times were from the category of highest education, and the least, who were educated upto primary level. Similar trend was observed in the case of taking TT Injections. Almost equal awareness was observed with regards to awareness about immunisation. Those who were highly educated took treatment from private sources, unlike those who were less educated – i.e., upto primary (51.8).

In the following section utilisation status of the various services have been assessed based on the rural urban status. With reference to utilisation of ANC services we have observed that people in rural areas (88.6 percent) have taken benefit of ANC services unlike Urban areas (83.9 percent) However though the rural respondents took more benefit of ANC services, but when we tried to find out which category of respondents visited more than thrice for ANC check-up it was the respondents from urban areas who visited more than thrice for ANC Checkup rather than the rural area. Signifying, a qualitatively better awareness than the rural areas. With reference to consuming the Iron tablets the utilisation of the of the rural and urban areas has been very poor. Only an average of 17 percent took to full completion of taking the tablets for more than three months. In terms of being aware of vaccination the urban areas were more aware of the
vaccination aspects (78.7 percent) rather than rural areas (50.8 percent). With regards to the sources of treatment both the urban and rural respondents preferred private sources to the government sources of treatment.

The results of the utilisation of the health services in terms respondents under various PHCs are presented as follows. The highest utilisation of ANC services was by the respondents under Dihen PHC while the least was for the respondents falling under Kim PHC. Who took the ANC Check for at least three times. 59.1 percent of the respondents under Kim PHC visited at least or more than three times for ANC check up, while the least in this case was for Dihen PHC. As far as consuming the iron tablets are concerned the performance has been poor under all the PHCs. In this regard Karanj PHC performed the best with 29.1 percent respondents having said that they took iron tablets for more than three months the poorest performer was Erthan PHC. The awareness about vaccination among the respondents under the various PHCs was highest among the Erthan PHC while the least was under Kim PHC.

In terms of vaccinating the child 57.9 percent of the respondents under Erthan PHC preferred the private doctors for vaccination while the least preference for the same was under Dihen PHC (34.7 percent).

Utilisation of health services by income category showed that the preference for ANC services was more (over 40 percent) for the respondents having income over one lakh rupees while the was for those whose income was below one lakh. As far as treatment from private doctors was concerned people with income less than the income of Rs. 50,000 opted for government sources. The consumption of iron tables for more than three months was just 17.60 percent in the case of the income group of less than Rs. One lakh whereas the same was high among the income group one lakh and above. Respondents whose income fell beyond one lakh, the awareness was quite high compared to those who fell in the income group of less than Rs. 50,000. One interesting feature about the sources of treatment by the category of income was that, 62.4 percent of the
Some important results of the hypothesis tested are as follows. There appeared to be a strong relationship between the utilisation of services vis-à-vis caste, income, Rural-Urban and education levels of the respondents. These associations have already explained in the summary on chapters.

**6.2 CONCLUSIONS**

From the above analysis we have found a strong relationship of the utilisation of health services vis-à-vis caste, income, education, rural urban areas and by the respondents under PHC. In some cases the registration of ANC services did not matter in terms of caste, however as far as availing the treatment via-ANC checkup was concerned the caste factor did matter. People from the open category opted for more number of checkups than those falling under the non-open category. There was not much difference in terms of opting for treatment is concerned. Both the non-open and the open category respondents opted for private sources of treatment and was not responsive to the treatment mechanism provided by the government agencies. There were inter-PHC variations in the case of utilisation of ANC related services.

What is the significance of this for the economic development of this area? In the initial chapters we tried to show that health sector is very important aspect for the overall economic growth of the nation, and that it directly or indirectly affects the human resources.

Given certain disparities, it is necessary to understand the attitude of the respondents by caste as to why sometimes they have opted for private services, despite a wide network of government services. We have also observed that respondents irrespective of caste have opted for private sources of treatment. This means that there is more of out-of-pocket expenses by the people who cannot afford. Thus, cutting into the living standards of
these people. There is a need to increase the investment in health not only in infrastructure but also the quality of services. There are lot of inter-state, district and taluka level variations in various important health indictors. This has lead to a skewed growth of health sector. To remove the skewed growth for a better quality of human resources. Only then the contribution to productivity and growth will be visible.

Some percentage of respondents under some PHCs have performed poorly in terms of utilizing the health services compared to others. One will have to find out why it is so. Why do people with low and high income go to privates sources treatment? what are the reasons for the state not being able to reach them. These are some of the questions which are open for further research.