CHAPTER VII

SUMMARY OF FINDINGS, CONCLUSION AND SUGGESTIONS

7.1 INTRODUCTION

Human health has come to be regarded as a pre-requisite for optimum socio-economic development. Human resource development of which health is an important aspect, has been instrumental in accelerating economic development. The problem of under development in “health” in developing countries like India is not only an economic but also a technical problem. The Government’s efforts of providing health care services free of cost or at low cost and making them easily accessible have their impact on the health status of the country. This situation has urged the researcher to select a topic relating to health issues. The people living below poverty line in India, mostly avail public health care services. Hence, the present study is an attempt to analyse and compare the primary health care services of Tirunelveli and Sankaraokeil units of Tirunelveli district. The specific objectives of the study are:

1. To study the trends in health indicators in Tamil Nadu and Tirunelveli district.

2. To analyse the determinants of health status of people in Tirunelveli district.
3. To study the revenue villages covered, staff pattern, beds, budget allocation and number of out patients treated at the selected PHCs.

4. To discuss the socio-economic conditions of the sample users of PHC services.

5. To analyse the morbidity level and health awareness among the sample respondents.

6. To examine the reasons for preferring health care services by the sample respondents.

7. To offer a few suggestions to the policy makers based on the findings to improve the health status in the study area.

For this purpose, 500 sample respondents (users of PHCs), 250 each from Tirunelveli and Sankarankoil units of Tirunelveli district were randomly selected. The personal interview method was carried with a pre-tested schedule. For the purpose of analyse the functions of the selected PHCs, total of 100 staff working in PHCs namely 40 medical officers and 60 paramedical staff were randomly selected from 10 PHCs. The secondary data relating to life expectancy, birth rate, death rate, IMR and the like were obtained from the records, reports and various publications for the period of 15 years from 1995-96 to 2009-10.

In the foregoing chapters, evaluation of health status in Tamil Nadu and Tirunelveli district, working performance of the selected PHCs, socio-economic
conditions of the respondents (users) and health awareness were discussed. In the present chapter, the major findings along with conclusion and suggestions based on the study are presented.

7.2 SUMMARY OF FINDINGS

In Chapter IV, health status is evaluated by assessing the movement of health indicators and health determinants in Tamil Nadu and Tirunelveli district for the period 1995-96 to 2009-10.

It is inferred from the analysis that the life expectancy at birth had increased from 60.78 to 67.98 in Tamil Nadu and from 59.71 to 66.91 in Tirunelveli district.

The average life span had increased by 7.20 years both in Tamil Nadu State and Tirunelveli district during the study period of 15 years. The life expectancy at birth thus shows an increasing trend.

The birth rate had decreased from 24.91 to 19.15 in Tamil Nadu and it had decreased from 22.14 to 17.50 in Tirunelveli district. The rate of change in birth rate for Tamil Nadu was –0.4231 and for Tirunelveli district it was –0.0038.

The total death rate had fallen from 9.50 to 7.20 in Tamil Nadu and from 9.10 to 7.00 in Tirunelveli district during the study period.
Infant mortality rate in Tamil Nadu had declined from 54 to 37 in Tamil Nadu and from 55 to 36 in Tirunelveli district. The above trends imply a remarkable improvement in health status in Tamil Nadu and Tirunelveli district, for the period 1995-96 to 2009-10.

Regarding the movement of health determinants per capita income at current prices had increased from Rs.7352 to Rs.18314 during the study period in Tamil Nadu and it had increased from Rs.4450 to Rs.9977 in Tirunelveli district.

Public health expenditure had risen from Rs.13071.34 lakhs to Rs.58624.19 lakhs in Tamil Nadu. It has also increased from 603.15 lakhs to Rs.29915.15 lakhs in Tirunelveli district. There had been ten fold increase in public health expenditure both in Tamil Nadu and Tirunelveli district.

It is observed that villages covered for provision of safe drinking water increased from 8134 to 19341 in Tamil Nadu and they increased from 416 to 967 in Tirunelveli district.

The female literacy rate had been accelerated and augmented from 55.41 to 68.91 in the State and from 54.35 to 71.99 in Tirunelveli district.
The per capita food availability in the State increased from 143.00 kilograms to 152.43 kilograms, whereas it increased from 70.50 kilograms to 89.41 kilograms in Tirunelveli district.

PHC per million was 0.040 in 1994-95 in Tamil Nadu and it had declined to 0.047 in 2009-10 due to growing population, low commitment to open up new additional PHCs and cut in health budget during the last decade since the advent of New Economic Policy in 1991. PHC per million population also declined from 0.043 to 0.048 in Tirunelveli district.

It is understood that the fertility rate in Tamil Nadu had decreased from 3.20 to 1.70, whereas in Tirunelveli district, it had decreased from 3.50 to 1.80.

The per capita income in Tamil Nadu had increased from Rs.7352 to Rs.18314 but in Tirunelveli district it had increased to Rs.9979.

In Tamil Nadu, per capita income, public health expenditure and number of villages covered for provision of protected drinking water had shown the highest growth rate, female literacy rate, literacy rate, couple protection rate, sex ratio and number of hospitals had shown the lowest growth rate. In Tirunelveli district also, similar trends were observed.

The second objective of the study is to focus on the influence of health determinants on health indicators, through multiple regression analysis.
Multiple regression analysis unfolds the following inferences:

Number of PHCs have significant influence on life expectancy at birth both at State level and district level.

Female literacy rate and per capita food availability played a major role in determining the birth rate.

At State level as well as at district level, PHC per million population did play a vital role in minimising the death rate.

The female literacy rate at State level and PHC per million population at district level were dominant and influencing factors in reducing the infant mortality rate.

The district shows the negative correlation between female literacy rate and infant mortality rate. The value of correlation coefficient is –0.8753. It is observed that infant mortality rate goes on decreasing as the female literacy rate increases in the district.

As per the Table, the calculated ‘t’ value is 2.2427 which is significant 5 per cent level, and since the calculated value is greater than the tabulated value (2.120), the null hypothesis is rejected. Thus, it may be concluded that the infant mortality rate is highly influenced by female literacy rate in Tirunelveli district.
In Chapter V, working performance of the selected Primary Health Centres in Tirunelveli and Sankarankoil units in Tirunelveli district was discussed.

In order to identify the important activities and functions of the selected PHCs, Garrett’s Ranking technique has been used. For this purpose, a total of 100 respondents, 40 medical officers and 60 paramedical staff in 10 PHCs were randomly selected.

In Tirunelveli units, 19.67 per cent of the PHCs is equipped with minimum 30 beds facility, no operation theatre for family planning, 19.67 per cent of the PHCs clean labour rooms are available, 16.39 per cent working ambulance, no blood bank is created in PHCs in Tirunelveli, 9.84 per cent of the PHCs provided staff quarters fully used and in 14.75 per cent of the PHCs essential drugs 60 are available.

In Sankarankoil areas of Tirunelveli district the following are the infrastructural facilities provided by PHCs. 14.29 per cent of the PHCs possess operation theatre for family planning, 14.29 per cent of PHCs have clean labour room, 14.29 per cent of the PHCs are equipped with working ambulance facility, no blood bank, 26.98 per cent of the PHCs are provided with staff quarters and 15.87 per cent of the PHCs are provided with drugs 60. More funds need to be spent on infrastructure and drugs.
In Chapter VI, socio-economic conditions and health awareness of the sample respondents (users of PHCs) were discussed.

It is inferred from the analysis that a majority of the respondents belongs to the age group of 40 to 50 years in both Tirunelveli and Sankarankoil units.

In the Tirunelveli units, majority of the respondents (57.60 per cent) are backward community, followed by forward community. In the case of Sankarankoil units, majority of the respondents (134 out of 250) are from backward community.

The sex-wise analysis revealed that female was higher in number for using PHCs for both Tirunelveli and Sankarankoil units.

As per Table 6.4, educational qualification revealed the fact that a very few are illiterate. Majority of the respondents (40.40 per cent) attended 6 to 10th Std in Tirunelveli unit and in the Sankarankoil units. 36.40 per cent have studied upto 12 Std.

Regarding the employment level, farmers and agricultural labourers dominated (31.60 per cent) in Tirunelveli unit whereas in Sankarankoil units, employees in private sector were in large numbers followed by farmers.
Regarding the housing status, majority of the respondents lived in tiled house (71.60 per cent) in Tirunelveli unit and pucca house (61.20 per cent) in Sankarankoil area. The electricity facilities were found exceeding 95.00 per cent in both Tirunelveli and Sankarankoil units.

The analysis revealed that about 95.00 per cent of the sample respondents used protected water for drinking purpose from public water tap.

Regarding the monthly income, about nearly 93.00 per cent of the respondents have monthly income below Rs.15000 in the case of Tirunelveli units. In the case of Sankarankoil unit, a majority of the PHCs users are having income range Rs.10000 to 20000.

The average monthly expenditure was found high in Sankarankoil than Tirunelveli area.

The majority of the Tirunelveli units (67.20 per cent) comes to PHCs more than 3 kms., where it was found less in number (40.40 per cent) in Sankarankoil. Mostly the mode of travel was bus by the users of both Tirunelveli and Sankarankoil.

Garrett’s rank results revealed that Tirunelveli respondents preferred to avail of the services of PHC. If the morbidity existed for than a week, they preferred to avail the services of Government taluk hospital. Third preference
goes to private clinics, fourth preference goes to Ayurvedic system of medicine or house remedy and fifth preference goes to charitable hospital. So the majority of the people in villages prefers to avail of the services of PHCs in Tirunelveli district.

The respondents have stated that people prefer the services of PHC because of the availability of free treatment and free medicines, supplied by the PHCs. Thirdly PHCs are accessible in about half an hour time. Transport cost in villages is low in Tamil Nadu since they are interconnected with link roads and service of mini-buses is available.

The ‘felt need’ of the respondents and their idiosyncrasy about the services of PHCs are revealed. The respondents expect the services of PHCs in the evening also, since the villagers return from the agricultural work only in the evening. So government should make arrangement to attend the Doctors in PHCs in the evening also. Secondly, they expect more drugs from PHCs. The drugs supplied to the chronic patients are insufficient. Thirdly, they expect minimum facilities in labour room. Delivery cases can efficiently be attended to only if minimum facilities like water, tools and medicines are available in PHCs at all time. The respondents also expect sufficient buildings, blood bank, in-patient care and X-ray facilities from PHCs.
The respondents stated that they prefer the services of private hospitals because of personal attention to patients, the role of emergency ward, safe delivery arrangement and availability of specialised doctors in private hospitals.

7.3 RESULTS OF TESTING OF HYPOTHESES

The first hypothesis namely ‘infant mortality rate is highly influenced by female literacy rate’, was statistically tested, and empirically verified. This hypothesis was accepted. Therefore there is negative correlation between female literacy rate and infant mortality rate.

The second hypothesis namely ‘total government spending for health care, improves the life expectancy at birth of the people’, was rejected, after statistical verification. This implies that the government expenditure did not make much impact on life expectancy at birth, in the study area.

The third hypothesis namely ‘among the users of the health services of primary health services, females outnumber males’, was accepted after empirical verification. It was revealed that female members were dependent on male members on economic and social ground. Hence a large number of female members avail of health care services from PHCs.

The fourth hypothesis namely ‘distance (proximity) is an influencing factor in making use of health services provided by Primary Health Centres’,
was rejected after statistical verification. It was found that distance was not a problem in getting health care services from the PHCs in the study district.

And finally the fifth hypothesis namely *getting immunisation to the children in the age group of under five, reflects the level of health awareness among the people*, was accepted after empirical verification. There is high health awareness in getting immunisation to the children in the age group of under five.

### 7.4 SUGGESTIONS

Based on the findings of the study, the following suggestions have been made to improve the health status of the people in the study area.

#### 7.4.1. Suggestions to Government

The following suggestions are placed before the Government for enhancing the health status of the state further.

The number of PHCs and HSCs emerged as a crucial factor in maintaining and enhancing the health status of Tirunelveli people and Government should give priority to open some more additional PHCs and HSCs in Tamil Nadu State. The ratio of PHC per million populations, both in the state and Tirunelveli district, has been decreasing.
Government should earmark more funds for the procurement of drugs and medicines.

The Government should make an arrangement that Doctors to attend in the evening also, to cater to the felt need and expectations of Tirunelveli people.

Productive public health expenditure should be encouraged. Wastages if any should be minimised. Government should reprioritise the resources in the health sector in favour of the poor.

Government should also concentrate on non-health sectors namely agriculture, food availability through public distribution system, provision of protected drinking water, housing, sanitation and education, as suggested by Panicker and Soman (1984).

The user fee concept should not be implemented since it will affect the PHC users, who are already poverty-stricken people.

State Government should allocate at least 15 percent of the state revenue towards health budget.

Minimum power-cut may be effected in PHC area so as to maintain and preserve immunisation vaccines.
7.4.2. Suggestions to the Medical and Paramedical Staff

Since a large number of out-patients turn out at PHCs, the medical and paramedical staff should pay personal attention to the patients.

PHC buildings are maintained by the Public Works Department. The Medical officer should bring to the notice of the Government to repair the buildings and ensure water supply in PHC to facilitate clean and safe delivery at labour room.

7.4.3. Suggestions for the Society

People should approach Village Health Nurse for immunisation to their children.

Pregnant women should contact Village Health Nurse and have periodical antenatal check-up at the PHC.

If any epidemic or environment pollution is found in their area, it should be informed to the Health Inspector.

7.5. CONCLUSION

From the foregoing summary and findings of the study, the following important conclusions emerge. Regarding the health care services, in India the role of Primary Health Centres and Health Sub-Centres cannot be belittled. In the
present scenario of globalisation, public health sector in India is facing a cut in the health budget. India, being the second most populous country in the world, cannot shirk its responsibility of delivering the primary health care, through PHCs and HSCs free of cost or at low cost. In India, ‘Health for All’ can be attained only through the judicious blending of public health care services and private health care services. Opening up of additional PHCs in the study area, namely in Tamil Nadu State and in Tirunelveli district, is the need of the hour to enhance the health status further. The findings of the study substantiating the efforts of increase female literacy rate in the study area, have multifarious impact on health status. The central and state governments have bounden duty to impart and encourage female literacy in the area.

7.6. SCOPE FOR FURTHER RESEARCH

There is ample scope for further research in Health Economics in the context of a proliferation of private practitioners in the health sector. Economics of regulating the private practitioners in health sector in India, is the proposed area for further research. The prices of medicines have gone up. The cost of treatment in private hospitals has become a nightmare for rural people. Social science researchers may attempt to analyse the problems in private health sector and suggest possible lines of approach to control and regulate private health sector.