CHAPTER VII
SUMMARY OF FINDINGS & POLICY SUGGESTIONS

SUMMARY

Economists have long recognized the fact that population, more specifically labour force is an integral and important component of wealth of nation. Among the various forms of human capital, improvement in health is an important aspect. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic and social conditions. Hence, in the Indian context, as a welfare oriented government, it is the bound duty of the government to provide health for all. To achieve this end, access to essential health facilities is the most important element of health care delivery system. More specifically, an efficient health care delivery system is an important requisite to achieve health for all.

It is a well-known fact that India is, next only to China, the second largest country in terms of population in the world. But the health status of a great majority of the people is far from satisfactory as compared to China and other developed countries. However, over the last five decades or so, India has built up health infrastructure and manpower at primary, secondary and tertiary care in government, voluntary and private sectors and made considerable progress in improving the health of its population. However, India is one of the major countries where communicable diseases are still not under control. The incidence of new fatal diseases such as AIDS/HIV, hepatitis-A is on the increase and tuberculosis and malaria still take a high toll. Chronic non-communicable diseases such as heart diseases, diabetes and cancer are also on the rise. Health risk due to
high prevalence of alcohol and tobacco consumption is also increasing. India’s dream of “World Class” health care delivery system is difficult to achieve. On the other hand, the economic reforms that have been introduced in the country since 1991 have brought changes in all the sectors of the Indian economy. It is the social sector, particularly health and education, which is financially getting affected, among others. The share of public expenditure as a percentage to GDP on health and education at higher level has been gradually declining. The health sector, therefore, faces “dual” challenges: while control of communicable and non-communicable diseases is of paramount importance, the budget allocation by the government is on the gradual decline in recent years. Hence, India faces the daunting challenge of meeting health care needs of its vast population and ensuring accessibility, efficiency, equity and quality of healthcare and thereby achieving the objective of growth with equality and social justice.

Among the various states of India, the government of State of Tamil Nadu, realizing the need for improving the health status of the public has developed and implemented various strategies of health care provision. This has resulted in the increased health status of the public. Given this strong background of development in health and health related infrastructure, a pertinent question that arises in this context is whether the Primary health centers which operate at the village level could enjoy the increasing concern of the government in terms of the receipt of required infrastructure. In the present chapter it was attempted to examine the patients’ opinion on the facilities available in the selected PHCs of Nagapattinam district, a district that has one of the highest number of villages whose share of populations is also the highest.

Based on the logic, the objectives framed for the study were as follows: 1) to analyze the trends in the health facilities of the districts of Tamilnadu and to
identify the extent of inequality in them, 2) to examine the socio economic status of the patients depending on the PHCs for treatment, 3) to trace out the opinion of the sample patient respondents on the availability of health personnels and the effectiveness of treatment, 4) to understand the opinion of the patient respondents on the health infrastructure facilities of the PHCs of the district, 5) to portray the problems faced by the health institutions in obtaining the required health inputs from the government and 6) to draw policy implications.

To study these objectives both primary and secondary data were collected. To analyze the trends in the growth of health infrastructure among the districts, the secondary data pertaining to the number of doctors, number of nurses and other health personals, the number of beds, number of health institutions in the district, the health related indicators like, the birth rate, death rate, IMR, MMR number of inpatients and outpatients by morbidity were collected from various published sources like, directorate of Medical services Reports, Chennai, Annual Statistical Abstract of Government of Tamil Nadu. To obtain the respondents’ views on working of the health institutions namely, the PHCs in the district of Nagapattinam, primary data from 600 patient respondents who are taking treatment from the nearby PHCs were collected. To minimize the sampling error, the ration shops operating near the PHCs are approached and a list of household residing nearly the ration shop that is, the PHC is prepared. From this list, 75 households were selected from each of the randomly selected 8 sample PHCs. The identified sample households are met and the information pertaining to the socio economic background, nature and frequency of visit and access to the nearby PHCs, opinion on the availability of health infrastructure, amount of expenditure incurred on private health institutions, nature of ailment and the reason for which the nearby PHC is approached and reason for visiting the private
health clinics etc. are collected with the health of a pre tested questionnaire that elicited the above information.

The collected data were analyzed using the simple tools like, percentage method, simple arithmetic mean, and the techniques like, instability index, linear growth rate, compound growth rates, chi square test and a logit model to estimate the demand for PHCs with independent variables like, age of the respondents, education of the head of the household (in years), years of experience in the occupation (in years), number of dependents (in numbers), per capita family income (in Rs. per month), agriculturists/non agriculturists/agricultural labour, nature of income, level of satisfaction on services of PHC were included in the model.

VII: 1 MAJOR FINDINGS

VII. 1. Health Facilities of the Districts of Tamil Nadu

A comparative analysis of the health related performance of the State of Tamil Nadu has been compared with the all India level.

It is found out from the analysis that the average level of birth rate, the growth in the birth rate were all favorable to the state Tamil Nadu when compared with all India. In terms of death rate, the state of Tamil Nadu has recorded the least average and the rate of growth recorded was also found to be the least in the case of the State. A close perusal of the infant mortality rate is found to be far lower in Tamil Nadu when compared to all India level.
VII. 2 Findings Related to Health Indicators by Districts of Tamil Nadu

Birth rate

An examination of the birth rate district wise revealed that Thiruvallur district has recorded the least average of 4.06 percent. In term of co-efficient of variation Thivannamalai district has registered the least and in term of growth rate, Thoothukudi has shown the highest negative growth rate of 10.54 percent.

Death rate

The death rate is another important indicator of the health status. From the analysis it is found that in term of the average level, Nagapattinam district has registered the least of 3.53 percent. From the analysis on the death rate by districts, it is identified that the average death rates for the entire study recorded the least in the case of Sivagangai district with 4.50 per cent. In terms of co-efficient of variation, Erode district has recorded the least volatility in the death rate of 1.787 per cent and Namakkal district has recorded the least but positive growth rate of 1.11 percent.

Infant mortality rate

Infant mortality rate (JMR) is the another indicator of health status of a particular place. In term of average level, the district of Nagapattinam has recorded a moderately high average of 5.43 per cent, indicating the moderate achievement in terms of health status. The linear growth rate calculated reveals that the district of Nagapattinam district ranked 17th in term of growth achieved though the growth rate is negative.
VII. 3. Findings related to trends in Health Infrastructure by Districts of Tamil Nadu

Population Doctor ratio

From the analysis it is identified that the district of Nagapattinam has registered a moderately lower average of 15782.80, indicating moderate achievement in term of this health indicator. The linear growth of the District of Nagapattinam calculated also indicated that it is in the middle implying the moderate performance though as found in the case of other districts, the growth has increased.

Growth of Population - Bed ratio

It is clear from the analysis that the District of Nagapattinam has recorded a moderately higher average indicating relative poor achievement in terms of health indicator. The linear growth of the District of Nagapattinam calculated falls in the 5th rank indicated that it is better in term of the growth performance of this indicator.

From the analysis it is concluded that the district of Nagapattinam is in the 11th position among the various districts of Tamil Nadu indicating the moderate performance recorded in term of health related indicators.

VII. 4. Findings related to Socio-economic Status and Access to Public Health

Age group

Out of 600 sample respondents, the majority of the sample respondents (58.60%) who Visit the primary health centres fell in the age group of 45 years. A taluk-wise examination of the distribution of sex shows that Mayiladuthurai
has the highest female respondents (13 %) approaching the PHCs for treatment to
their morbidity.

**Education**

A taluk-wise distribution of Education of the respondents helped to understand that Mayiladuthurai has the highest number (13.20) of respondents, who have completed secondary level education.

**Occupation**

From the above analysis, it is observed that majority (24.69) of the sample respondents family heads of the family are agricultural collies.

**No. of Members in the Family**

An examination of the number of members in the selected taluks indicates that Mayiladuthurai has the highest number of (17.20) respondents who have the family member ranging from 4-6.

**Income**

It is clear that 52.80 % of the sample respondent’s families earn a monthly income of RS. 2000-2500. Majority of the family respondents due in Mayiladuthurai taluk (14.06) they lived in their owned houses which is attached.

From the analysis it is clear that the socio economic status of the people who visited PHCs are lower middle class people.

**VII. 5 Findings Related to Accessibility to Public Health**

Out of the 600 respondents, majority of the respondent (549) visited PHCs regularly once in the three weeks to get treatment for themselves.
The study revealed that 77.40% felt that morbidity got cured in one single consultancy. At the same time, the study noted that the respondents were highly satisfied with the availability of medicines.

From the analysis it is clear that the majority (7.80%) of the respondents are moderately satisfied with the patient listening of the doctors of PHCs to the problems. It is identified that only 48.20% of the respondents are moderately satisfied with the availability of doctors.

VII. 6 Findings Related to Patient Care Indicators

Time Spent on PHCs

It is clear from the study that the patients have experienced 20 minutes to get out-patients slip and to receive the medicine. They needed to wait for 20-30 minutes. The study revealed average waiting time for the entire sample was 34 minutes.

Analysis of Consultancy Made in Private Clinics

From the study it is identified that only 35.80 per cent have visited the private health clinics atleast once to cure acute diseases. Most of the respondents were visiting PHCs for consulting.

A higher share of respondents felt that they spent about Rs. 125 - 150 in the private clinics for their morbidity.
VII. 7. Quality of Health Care Services

The study disclosed that 93.02% of the sample PHCs are operating in own building, out of which 75% have at least one toilet. It is clear that most of the PHCs have electricity connections for storage of vaccines. Out of the 8 Taluks, a majority of (79.09) PHCs do not have a labour room for delivery. It is observed that only 81.50 per cent of the PHCs do not have a laboratory facilities for MCH Services.

It is seen from the analysis that out of 43 PHCs operating in the district only, 4.65 per cent of the PHCs have vehicle facilities. The study revealed that 95.35 per cent did not have a telephone connection.

It is stated that the majority of the paramedical staff have not attended any training programme related to their work or profession.

It is clear that the 41 PHCs have the smooth supply of vaccines.

It can also be seen that as in the case of the other inputs with regard to the supply of these critical kits/ vaccines/ contraceptives, there was no much variation among the PHCs. Which spoke for the significance of PHCs and their effective functioning.

SUGGESTIONS

The following suggestions emerge from the study carried out:

1) The Government of India may consider funding the appointment of Male health workers. The study indicated that in the case of sample PHCs, a majority of the workers are female workers. The opinion indicated that for certain ailment, the male workers are reluctant to approach and get treatment
from ANMs who are females. Hence, flexibility may be given to the states to either opt for male health worker or additional ANMs.

2) Strengthening of Management and Supervisory Assistance at the CHC/FRU level is recommended as this is needed for efficient functioning of National Health Programmes and ASHA.

3) Although the numbers of doctors sanctioned are more than requirement, the opinion of the patients indicated that the about 45 of PHCs are without a doctor because of mal-distribution, improper transfer policy of the State Government, political interference, lack of basic amenities and incentives for working in rural/difficult areas. Hence, attempt can be made to increase the doctors.

4) To strengthen the management and supervision at the PHC level, it is recommended to have a Programme Manager with public health background, who can supervise and coordinate all Public Health activities.

5) A list of essential drugs, equipments and other supplies can be prepared depending on the weekly or monthly needs and orders can be placed well in advance to avoid shortage.

6) A flexi-fund for meeting the cost of drugs and other supplies during epidemics/natural disasters may be permitted to be created at the district level.

7) For quality services, the skill of the health personnel needs to be improved. The attitudinal changes in the health personnel to be responsive to the health needs of the community will require orientation of health personnel. In this context, the induction training, in-service skill development training, and management training of the health personnel becomes essential and hence arrangement can be made at the district level.
8) Primary Health care, which is currently being funded predominantly by the State government (85%) should be funded fully by the Central Government after ensuring that the funds are utilized by the States for the purpose intended.

9) Support facilities like transport, electricity, telephone, potable water, etc. will have to be ensured in all the centres if utilization is to be improved. Computerisation should be encouraged in CHCs. Intersectoral coordination at all levels is to be strengthened like water supply and sanitation, nutrition and other health determinants.