Chapter 6

CONCLUSIONS

"Expansion of human capability can be broadly seen as the central feature of the process of development". [J. Dreze and Amartya Sen 1995]. The expansion of human capability leads to economic growth but there are many influences other than economic growth that work in that direction. The social variables namely education and health, can directly affect a person's effective freedom. Because of the obvious importance of externalities in morbidity, preventive care, curative treatment and expansion of public health facilities can have influences that go much beyond the immediate personal effects.

6.1 The study covers nineteen district of Karnataka to examine the development of public health care infrastructure till 1997. The recent status of the public health care infrastructure for twenty seven districts is also examined for the year 1999-2000. To understand the overall inequalities and backwardness of a district, a composite index of health infrastructure (CIHI) is computed by using Principal Component Analysis. The coefficient of correlation between CIHI and health status indicators is worked our to know the impact of the development of health infrastructure on the health status of the people. Regression analysis is used to know the relative importance of explanatory variables on the dependent variable. This analysis is carried out for the period 1961, 1971, 1981 and 1991. The health infrastructure in Dharwad district in 1999 – 2000 is also examined.
Government of Karnataka, over the years has substantially invested in the expansion of health care infrastructure. The major components of health care infrastructure have improved as also the CIHI. The inter district disparities in the infrastructure development have declined as is evident through a decline in the values of C.V. for most of the variables individually as well as for the CIHI. Following are the conclusions based on the study:

(1) The C.V. of CIHI among the districts of Karnataka for 1960-61 was 56.16 %. It decreased to 25.61 % in 1999-2000 indicating reduction in the inequality in the development of health care infrastructure. It supports our hypothesis that "the disparities in the development of health care infrastructure in Karnataka are reduced over a period of time".

(2) The CIHI for all five period viz; 1960-61, 1970-71, 1980-81, 1990-91 and 1999-2000, show that the top districts are from Southern Karnataka. They are mainly Kodagu, Bangalore, Chikmagalur, Shimoga, Hassan, Mysore, Mandya, Chitradurga and Kolar. The majority districts of North Karnataka viz, Raichur, Gulbarga, Bijapur, Belgaum, Bidar and Uttar Kannada are at the bottom rungs of health infrastructure development.

(3) As indicated by the co-efficient of correlation, the improvement in CIHI has significant influence in reducing the CDR during 1961, 1981 and 1991. The CIHI has also influenced the IMR significantly during 1971 and 1991. A positive correlation between CIHI and LEB was found.
during the study period. However, any conclusive evidence could not be drawn about the coefficient of correlation between health infrastructure and LEB as the coefficient of correlation is not significant either at 1 % or 5 % level. These findings are further supported by two variable regression analysis between CIHI and health status indicators namely CDR, IMR and LEB. This analysis supports our hypothesis that "the development of health infrastructure has positive impact on the health status of the people".

(4) The development of health infrastructure in Dharwad district lagged behind other districts in 1960-61, 1970-71, 1980-81 and 1990-91. However, after the reorganization of the district in 1997, the new Dharwad district showed better health infrastructure in 1999-2000. But the other two new districts namely Gadag and Haveri lagged behind in the development of health infrastructure.

The C.V. values are lower for PHC's and PHU's among the talukas of Dharwad district. But the C.V. values are higher in case of hospitals and dispensaries. The disparity is very high regarding beds availability in hospitals and dispensaries.

6.2 The following conclusions are arrived at after analysing the Illness Prevalence Rate and access to health care facilities. It is also attempted to find out the reasons for not approaching the public health care facilities. Following are the conclusions based on the study analysis:
(1) The Illness Prevalence Rate (IPR) in PCH villages show that females suffer more than the males, from chronic diseases. In PHC near villages the otherwise is true. Males suffer more than females from short duration illnesses in all three types of villages.

(2) The poor households suffer more from short duration illness than the non poor households in all types of villages in the study area.

(3) In PHC villages 70.80 % of poor, 76.92 % of non poor and 86.19 % of SC/ST households approach public health care facilities. In PHC near villages 50.20 % of the poor, 52.50 % of non poor households and 57.50 % of SC/ST households approach the public health care facilities. In PHC far off villages majority of poor and SC/ST households approach the private health care facilities. Where as 50.30 % of the non poor households still approach the public health care facilities. It means, in villages where the public health care facilities are not available the weaker sections (i.e. poor and SC/ST households) are forced to approach the private facilities.

(4) Majority of the poor and SC / ST households travel upto 5-10 Kms. to seek the health care facilities. Where as the non poor households travel greater distances to seek the health care facilities.

(5) In the majority of poor and SC / ST households the deliveries take place at home. Where as the majority of non poor
households approach the private health care facilities for deliveries.

(6) In all types of villages the percentage of births attended by trained midwife is negligible.

(7) In PHC villages the main reasons for not preferring the public health care facilities are non-availability of medicines, long waiting time and inconvenient timings. In PHC near villages inconvenient timings, the distance, non-availability of medicines and long waiting time are important reasons. In PHC far off villages distance, inconvenient timing, long waiting time and non-availability of medicines are the dominant reasons for the households for not approaching the public health care facilities.

Our hypothesis that "people of far off villages from a PHC have poor access to public health facilities" is supported by the study findings.

6.3 The analysis of health care expenditure provides the following conclusions:

(1) In 1960-61 the per capita public health expenditure which was Rs. 0.64, increased to Rs. 389.71 in 1998-99. There has been significant increase in the per capita public health expenditure in Karnataka.

(2) The state average per capita public health expenditure which was Rs. 47.50 in 1988-89 almost remained same till 1991-92. By 1997-98 it increased to Rs. 129.86. In 1988-89 the per capita public health expenditure was higher than
the state average in the districts of Kodagu, Chikmaglur, Hassan, Uttar Kannada and Bidar. In 1997-98 the districts with higher per capita public health expenditure were Uttar Kannada, Tumkur, Shimoga, Mysore, Mandya, Kolar, Hassan, Dakshin Kannada, Gulbarga, Bidar and Bellary. The districts of Raichur, Dharwad, Chitradurga, Bijapur, Belgaum and Bangalore had the per capita public health expenditure lower than the state average. Dharwad district, which is our study area, has the per capita public health expenditure lower than the state average for the entire period of analysis.

(3) The expenditure on health incurred by non poor households, in all three types of villages, is more compared to the health expenditure of poor households. This supports our hypothesis that "higher the household income, higher is the per capita health expenditure". It reflects on the increasing health conscience among the non poor households.

6.4 The pre Independence health policy of India had the following main features. Firstly, it were the British who introduced the Western Medicine in India during the mid 18th century. The British established the cantonments for the rulers and their army, where sanitary practices were adopted on modern lines. Secondly, with the advent of the British and the Western medicine in India, the indigenous medicine system had lost the favour of the Indian elite. On the eve of Independence, medical services were scattered and inadequate. The Indian National Congress had appointed the National Planning Committee which in turn appointed Sokhey
Committee on national health. However it was the Bhore Committee of 1943 which laid down the guiding principles for the health policy of India even after Independence.

Health Planning has become an integral part of national planning in India. As per the recommendations of the Bhore Committee, the office of the Director General of Health Services was established in the country in 1947. Simultaneously the Directorates of Health were established in the states as well. In 1948, India joined the W.H.O. which ensured the free flow of information, initiation of programmes, exchange of personnel and so on. The Mudaliar Committee recommended the strengthening of PHC’s and Hospitals at the district and lower levels. Other Committees headed by Chada (1963), Mukherjee (1965), Jungalwalla (1967), Kartar Singh (1973) and Srivastava (1975) examined various aspects of health delivery system in India and recommended number of measures to improve the efficiency of the system.

The Alma Ata declaration in 1978 and the formulation of National Health Policy in 1983 gave a new direction to the health policy and planning in India, making primary health care the central function and main focus of the national health system. The goal was to attain Health for All by 2000 A.D. The Alma Ata international conference reaffirmed "health for all" as the major social goal and this was to be achieved by providing primary health care at the door steps of the people. This conference called upon the Governments to formulate national policies, strategies and plans of action to launch and sustain primary health care as part
of a national health system. It was left to each country to develop its norms and indicators for providing primary health care to suit the needs and resources. In pursuance of the above objective two important reports were prepared: 1) "Health for All – An Alternative Strategy" sponsored by the ICSSR and ICMR (1981); and 2) "Health for All by 2000 A.D." - a report of the Working Group (1981). Both the reports considered the various issues involved in providing primary health care, and based on these reports, a national health policy was formulated by the Parliament in 1983.

The policy aimed to attain the goal of "Health for All by 2000 A.D." emphasized on the preventive, promotive, public health and rehabilitative aspects of health care. The policy viewed health and human development as a vital component of overall integrated socio economic development and it proposed a decentralized system of health care delivery with maximum community participation. To achieve this, the health policy laid down certain specific goals to be achieved by 1985, 1990 and 2000 A.D. The recent draft National Health Policy (2001) recognises the fact that despite all that may be guaranteed by the Central Government for assisting public health programmes, public health services would actually need to be delivered by the state administration.

Health administration in the erstwhile state of Mysore was well ahead of its neighboring provinces. There was a medical school to train Hospital Assistants. In 1929 the Board of Health was appointed to advise the Government on public health matters. Mysore state was first in the country to establish Rural Health Centers in 1931. These centers worked for the improvement of
village sanitation, investigation and control of the outbreak of epidemic diseases, immunisation services, chlorination of drinking water sources and reporting of births and deaths. Mysore was the first state to establish the official 'family planning clinic' in whole of the world in 1930. After the reorganisation of the state in 1956 the medical department and public health department were amalgamated into a single department – The Department of Health Services.

The main objectives of the health programmes under various five year plans in Karnataka were: Control/eradication of major communicable diseases, provision of curative, preventive and promotional health services, augmentation of training programmes of medical and paramedical personnel and strengthening the PCH's in the rural areas. Many national programmes were undertaken in the state along with the building of health infrastructure. Various India Population Projects I – IX have been implemented which mainly emphasized the building up of health infrastructure in various districts of Karnataka in a phase manner. To improve the quality of health care services the Karnataka Health Systems Development Project (KHSDP) was implemented at sub district and district levels. The Karnataka Panchayat Raj Act of 1993 has delegated the powers of implementing the state sector schemes, national programmes, to Zilla Panchayats. The Task Force (1999) appointed by Government of Karnataka reviewed the various aspects of health care system in the state and also made recommendations for the better working of the system. The Task Force findings corroborate the findings of the present study.
regarding the utilization of health care services and household health expenditure in rural areas.

6.5 Policy Suggestions:

After making the study of access to health care and the health care expenditure in Karnataka State and in the study area the following policy suggestions are made. 1) the health infrastructure should be strengthened by increasing additional beds in PHC's and government hospitals 2) the vacant posts at the primary health care level should be immediately filled - medical, paramedical, and technicians 3) the timings of the PHC's and hospitals should be changed to suit the requirements of the rural people so that they do not lose their work/ wages for having approached the government health care centers. 4) the doctor and other staff should be made to stay at the head quarters to attend any emergency case. 5) the proper and adequate drugs supply should be ensured. 6) the equipments at PHC's and sub centers be modernized. 7) the ambulance services should be provided in the rural areas more so in the remote areas to improve the efficiency of the referral systems. 8) as the number of births taking place at home is large, the services of adequately trained dais should be provided to ensure the safe delivery of babies. 9) keeping in view the requirement of maternal services increased number of lady doctors be appointed at primary level health centers. 10) awareness about the nature of facilities available at government health care centers should be created. 11) the public expenditure at the state level should be based on priorities identified well in advance looking into the region wise needs of the people, instead of simply
following the vertical programmes imposed by the Centre. 12) the public expenditure at the district level should be also priority based considering the objective necessities of people and 13) the health information system should be improved so that the activities of the health department are made transparent and the data is made available to the desired public at regular intervals.

6.6 Areas for further research:

The study finds it essential to have research in the following areas regarding the working of the health care system in Karnataka: evaluation of a PHC in its entirety – at different levels of economic development, efficiency of the referral system, household health expenditure by keeping the record of the health expenditure by the researchers themselves in stipulated time period, Health Care Administration by Panchayat Raj Institutions at village, taluka and district levels and health planning and expenditure by Urban Local Governments.
Reference: