
ALLOCATION AND UTILISATION OF BUDGET TO COMMUNITY HEALTH CENTRES IN HARYANA

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(ABSTRACT)

In the present study, an attempt is made to analyze the budget allocated by the government to Community Health Centres (CHCs) and its utilization in the selected districts of the state of Haryana. For this purpose, sample of 50 respondents (doctors) i.e. 13, 12, 13 and 12 respondents from Palwal, Bhiwani, Hisar and Narnaul districts of the state of Haryana, respectively was taken for data collection. The primary data were collected with the help of pre-tested structured questionnaire on five point Likert scale. On the other hand, the secondary data were collected mainly from Ministry of Health and Family Welfare publications such as IPHS Guidelines for Community Health Centres. Statistical techniques such as mean, standard deviation, and t-test and ANOVA had been applied to analyze the data and validate the results of the study. The results shows that mismatch between policy and their implementation is the main reason for non-disbursement of allocated budget in time, followed by delay due to lengthy procedure. Further, it is also found that 'Patient Facility/Swasthya Kalyan Smiti' is given the highest rank, followed by 'Untied' head under which budget allocated is utilised appropriately. It is recommended that the budget should be increased by 20-30 per cent annually or according to inflation for improving the existing health of CHCs. The persons who implement the policy should be involved in decision making to avoid any mismatch between the policy and its implementation. The problem of delay in disbursement of allocated budget due to lengthy procedure should be overcome by use of information technology instead of using manual system of transferring files.

Keywords: Budget, Mismatch, Untied, User Money, Patient

Introduction

India, the land of second most populous country in the world, is a developing country where a large section of population is below poverty line, health and hygiene are not up to the mark and the state government has the onus to take care of the health of people in the state (*Subramani et al., 2014*). It is reported that annually 22 lakh infants and children die from preventable illnesses, 1 lakh mothers die during the child birth and 5 lakh people die of tuberculosis in India. Also around 5 million people suffer from HIV/AIDS and numerous others die of diarrhea and malaria. The plight of the least advantaged is increased because of the poor public health system (*Kavitha, 2012*). Health care delivery in India has been envisaged at three levels namely primary, secondary and tertiary (*Sodani and Sharma, 2012*). The secondary level of health care essentially includes Community Health Centres (CHCs), constituting the First Referral Units (FRUs), Sub-district and District Hospitals (*Pandve and Giri, 2015*). The CHCs were designed to provide referral health care for cases from the PHCs level and for cases in need of specialist care approaching the centre directly (*Vijayakrishnan and Chandrasekhar, 2015*). Four PHCs are included under each CHC, thus catering to approximately 80,000 population in tribal/hilly/desert areas and 1,20,000 population for plain areas (*Mallipedi et al., 2009*). CHC is a 30-bedded hospital providing specialist care in Medicine, Obstetrics, Gynecology, Surgery, Pediatrics, Dental, Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (AYUSH). There are 4,535 CHCs functioning in the country as on March 2010 as per Rural Health Statistics Bulletin 2010 (*Kohli, 2016*). These centres are, however, fulfilling the tasks entrusted to them only to a limited extent. The launch of the National Rural Health Mission (NRHM) gives the opportunity to have a fresh look at their functioning (*Pandve and Giri, 2015*). NRHM envisages bringing up the CHC services to the level of Indian Public Health Standards (IPHS) (*Dhaar and Robbani, 2008*). Although there are already existing standards as prescribed by the Bureau of Indian Standards for 30-bedded hospital, these are at present not achievable as they are very resource intensive (*IPHS Guidelines, 2012*).

Review of Literature

The articles on various aspects of budget allocation to CHCs and its utilization appeared in different journals are restrictive in nature and do not give a comprehensive view. *Green et al. (2000)* found that the resource allocation and budgetary system is a critical, yet often neglected, component of any decentralized policy. Current systems are often based on historical increments

that are neither efficient nor equitable. However, the development of technical system, while necessary, is not a sufficient condition for the implementation of a resource allocation and decentralized budgeting system. This was illustrated by analyzing the constraints that had been encountered in the development of such a system in Balochistan. *Bhat and Jain (2004)* suggested that at state level, governments had target of allocating only about 0.43 per cent of state GDP to health and medical care. This does not include the allocations received under central sponsored programmes such as family welfare. Given this level of spending at current levels and fiscal position of state governments the goal of spending 2-3 percent of GDP on health looks very ambitious task. The analysis also suggested that for every one percent increase in state per capita income, the per capita public health care expenditure had increased by around 0.68 percent. *Rao and Chaudhary (2012)* highlighted that there forms in the health sector need to address increased public spending on health care, focus on preventative health care, ensure greater access to health care by the poor and significantly improve the productivity of public spending. Not only is public spending on health care in India too low, but its distribution across the country is very uneven. Per capita health care expenditure in the poorest state, Bihar was Rs. 166 in 2008-09, whereas it was Rs 421 in Tamil Nadu and Rs 507 in Kerala in the same year, relatively more affluent states. This was in spite of the greater emphasis given by the low-income states to health care spending. The correlation coefficient between per capita expenditures and per capita GDP was 0.7 and 0.8 respectively for 1995-96 and 2004-05 period. It was suggested that additional one percent of GDP would be necessary in the medium term to provide basic health care services as per the norms. Further, it was found that additional fiscal space would be a major challenge. *Uzochukwu et al. (2015)* highlighted that health care in Nigeria was financed through different sources including tax revenue, out of pocket payments (OOPs), donor funding and health insurance. It was found that for achieving successful health care, financing system continued to be a challenge in Nigeria and concluded that to achieve universal coverage using health financing as the strategy, there is a dire need to review the system of financing health and ensure that resources are used more efficiently. At the same time, removing the financial barriers to access by shifting focus from OOPs to other hidden resources is also required. *Mujasi and Puig-Junoy (2015)* realized that there was a significant correlation between per capita district pharmaceutical expenditure and total district population, rural poverty, access to drinking water and outpatient department (OPD) per capita utilisation. The percentage of health centre IIIs (HC III) among each district's health facilities was significantly correlated with per capita

pharmaceutical expenditure. OPD per capita utilisation had a relatively strong correlation with per capita pharmaceutical expenditure; all the other significant factors were weakly correlated with per capita pharmaceutical expenditure. From evaluation of the various models, it was proposed that variables to consider in allocating prospective primary health care pharmaceutical budgets to districts in Uganda were district outpatient department attendance per capita, total district population, total number of government health facilities in the district and the district human poverty index. The foregoing review of literature and other articles reviewed, which could not be cited here, reveals that no concerted efforts were made to analyze the allocation and utilisation of budget to CHCs in the state of Haryana, therefore present study is undertaken.

Scope of the Study

The present study is confined to the analysis of budget allocated to CHCs covering Palwal and Narnaul districts of Gurgaon division, and Hisar and Bhiwani districts of Hisar division of state of Haryana.

Objectives of the Study

The present study aims to achieve the following objectives of the study:

- (a) To study the adequacy of budget allocated to CHCs.
- (b) To analyze the timely disbursement of allocated budget to CHCs.
- (c) To identify the reasons for non-disbursement of allocated budget in time to CHCs.
- (d) To examine the utilization of allocated budget under the various heads by CHCs.

Research Hypotheses

H₀₁: There is no significant difference among the respondents viewpoint towards the adequacy of budget allocated to CHCs by the government of Haryana.

H₀₂: There is no significant difference among the respondents viewpoint towards the timely disbursement of allocated budget to CHCs.

H₀₃: There is no significant difference among the respondents viewpoint towards the reasons for non-disbursement of allocated budget to CHCs in time.

H₀₄: There is no significant difference among the respondents viewpoint towards the appropriate utilization of budget allocated under various heads to CHCs.

Sample Profile

The population for the present study is the Primary Health Care Sector in the state of Haryana. At the first stage, state of Haryana is divided into various divisions and two divisions *i.e.* Gurgaon and Hissar are selected for the purpose of the study. At the second stage, divisions are divided into various districts and 4 districts *i.e.* Palwal and Narnaul districts from Gurgaon division, and Hissar and Bhiwani districts from Hissar division are selected. At the third stage, each district is divided into various community health centres (CHCs), and twenty one CHCs are selected at random. Finally, a sample of 50 doctors of CHCs is selected *i.e.* 12 each from Narnaul and Bhiwani districts, and 13 each from Hisar and Palwal districts respectively. Finally, respondents are selected on the basis of judgment sampling. Out of 50 respondents, 36 are male and 14 female; 28 are between the age of 26 - 35 years, 15 are between the age of 36 - 45 years and 7 are above 45 years; 12 are SMOs and 38 are MOs, 2 respondents are MD, 40 are MBBS, 6 BDS, 1 BAMS and 1 BHMS; 22 are having the experience of less than 5 years, 12 are having the experience of 6-10 years, 5 are having the experience of 11-15 years, 7 are having the experience of 15-20 years and 4 are having the experience of above 20 years.

Data Collection

The present study is of exploratory-cum-descriptive in nature. Accordingly, the primary as well as secondary data were used. The primary data were collected with the help of pre-tested structured questionnaire on five point Likert scale *i.e.* Strongly Disagree (SD), Disagree (D), Neutral (N), Agree (A) and Strongly Agree (SA). Besides questionnaire, interviews and discussion techniques were also used to unveil the required information. On the other hand, the secondary data were collected mainly from Ministry of Health and Family Welfare publications such as IPHS Guidelines for Community Health Centres, and e- journals were also referred to.

Data Analysis

The collected data were analyzed through various descriptive and confirmatory statistical techniques like frequency distribution, percentage, mean and standard deviation with the help of SPSS (20.0 version). For coding and editing the data, weights were assigned in order of importance *i.e.* 5 to Strongly Agree (SA), 4 to Agree (A), 3 to Neutral (N), 2 to Disagree (D) and 1 to Strongly Disagree (SD). Further, t-test and ANOVA technique were used to test the hypotheses and validate the results of the study.

RESULTS AND DISCUSSIONS

The descriptive and confirmatory statistics of the respondents' viewpoint towards various aspects of budget allocated to CHCs are given in Table 1 & 2.

Adequacy of Budget

The analysis shows that Palwal is given the 1st rank (Mean=3.69, SD=0.48), followed by Bhiwani (Mean=3.17, SD=1.12), Hisar (Mean=2.85, SD=0.99) and Narnaul (Mean=1.92, SD=0.79) in terms of adequacy of budget to CHCs. Statistically, the results of t-test show that there is a significant difference among the respondents (males and females) towards adequacy of budget ($p=0.03$) at 5 percent level of significance, therefore the null hypothesis (H_{01}) is rejected. However, age-wise and experience-wise ANOVA results show that there is no significant difference among the respondents towards adequacy of budget at 5 percent level of significance; therefore the null hypothesis (H_{01}) is accepted. Further, district-wise ANOVA results show that there is a significant difference among the respondents towards adequacy of budget ($p=0.00$) at 5 percent level of significance, therefore the null hypothesis (H_{01}) is rejected.

Timely Disbursement of Allocated Budget

The analysis of respondents' viewpoint shows that Palwal is given the 1st rank (Mean=2.77, SD=0.93), followed by Hisar (Mean=2.46, SD=0.87), Bhiwani (Mean=2.42, SD=0.52) and Narnaul (Mean=2.00, SD=0.60) in terms of timely disbursement of allocated budget to CHCs. Statistically, the results of t-test show that there is no significant difference among the respondents (males and females) towards timely disbursement of allocated budget at 5 percent level of significance; therefore the null hypothesis (H_{02}) is accepted. Further, age-wise ANOVA results show that the respondents differ significantly towards timely disbursement of allocated budget ($p=0.01$) at 5 percent level of significance, therefore the null hypothesis (H_{02}) is rejected. However, experience-wise and district-wise ANOVA results show that the respondents do not differ significantly towards timely disbursement of allocated budget at 5 percent level of significance; therefore the null hypothesis (H_{02}) is accepted.

Reasons for Non-disbursement of Allocated Budget in Time

The results of analysis of respondents' viewpoint towards the reasons for non-disbursement of allocated budget in time shows that paucity of funds at government level (Mean=4.00, SD=0.82) is the main reason for non-disbursement of allocated budget in time, followed by mismatch between policy and their implementation (Mean=3.92, SD=0.64) and delay due to lengthy

procedure (Mean=3.77, SD=0.93) in case of Palwal, whereas delay due to lengthy procedure (Mean=3.83, SD=0.58) is given the 1st rank, followed by mismatch between policy and their implementation (Mean=3.17, SD=0.58) and system not working properly (Mean=3.08, SD=0.29) in case of Bhiwani. However, system not working properly (Mean=3.31, SD=0.75) is the main reason for non-disbursement of allocated budget in time, followed by mismatch between policy and their implementation (Mean=3.00, SD=0.91) and delay due to lengthy procedure (Mean=2.92, SD =0.86) in case of Hisar, whereas mismatch between policy and their implementation (Mean =4.67, SD=0.49) is given the 1st rank, followed by delay due to lengthy procedure (Mean=3.33, SD=0.49) and paucity of funds at government level (Mean=3.33, SD=0.78) in case of Narnaul.

Statistically, the results of t-test show that there is no significant difference among the respondents (males and females) towards the reasons for non-disbursement of allocated budget in time; therefore the null hypothesis (H_{03}) is accepted. However, age-wise ANOVA results show that there is a significant difference among the respondents towards the delay due to lengthy procedure ($p=0.02$) as reason for non-disbursement of allocated budget in time at 5 percent level of significance, therefore the null hypothesis (H_{03}) is rejected. Further, experience-wise ANOVA results show that respondents differ significantly towards the mismatch between policy and their implementation ($p=0.00$) as a reason for non-disbursement of allocated budget in time at 5 percent level of significance, therefore the null hypothesis (H_{03}) is rejected. Further, district-wise ANOVA results show that a significant difference is found among the respondents towards paucity of funds at government level ($p=0.00$), delay due to lengthy procedure ($p=0.01$), mismatch between policy and their implementation ($p=0.00$) as reasons for non-disbursement of allocated budget in time at 5 percent level of significance, therefore the null hypothesis (H_{03}) is rejected.

Utilisation of Allocated Budget

The analysis of respondents' viewpoint towards the utilization of budget under various heads *i.e.* 'User Money', 'Annual Maintenance Grant' (AMG), 'Untied' and 'Patient Facility/Swasthya Kalyan Smiti' show that 'Patient Facility/Swasthya Kalyan Smiti' (Mean=4.62, SD=0.51) is given the 1st rank, followed by 'Annual Maintenance Grant' (AMG) (Mean=4.54, SD=0.66) and 'Untied' (Mean=4.54, SD=0.66) in case of Palwal, whereas 'Untied' (Mean=4.23, SD=0.60) and 'Patient Facility/Swasthya Kalyan Smiti' (Mean=4.23, SD=0.60) are given the 1st rank, followed by 'User Money' (Mean=4.23, SD=0.73) in case Hisar. However, 'Patient Facility/Swasthya Kalyan Smiti'

(Mean=4.33, SD=0.65) is given the 1st rank, followed by 'Annual Maintenance Grant' (AMG) (Mean=4.25, SD=0.62) and 'Untied' (Mean=4.08, SD=0.52) in case of Bhiwani, whereas 'Untied' (Mean=5.00, SD=0) and 'Patient Facility/Swasthya Kalyan Smiti' (Mean=5.00, SD=0) are given the 1st rank, followed by 'User Money' and 'Annual Maintenance Grant' (AMG) (Mean=4.92, SD=0.29) in case Narnaul.

Statistically, the results of t-test show that there is no significant difference among the respondents (males and females) towards the appropriate utilization of budgets allocated under various heads at 5 percent level of significance; therefore the null hypothesis (H_{04}) is accepted. However, age-wise and experience-wise ANOVA results show that the respondents do not differ significantly towards the heads under which budget allocated is utilised appropriately at 5 percent level of significance, therefore the null hypothesis (H_{04}) is accepted. Further, district-wise ANOVA results show that a significant difference is found among the respondents towards 'User Money' ($p=0.00$), 'Annual Maintenance Grant' (AMG) ($p=0.01$), 'Untied' ($p=0.00$) and 'Patient Facility/Swasthya Kalyan Smiti' ($p=0.00$) at 5 percent level of significance, therefore the null hypothesis (H_{04}) is rejected.

Conclusions and Policy Implications

It is concluded that the mismatch between policy and their implementation is the main reason for non-disbursement of allocated budget in time, followed by delay due to lengthy procedure. Further, 'Patient Facility/Swasthya Kalyan Smiti' is given the highest rank, followed by 'Untied' head under which budget allocated is utilised appropriately. It is recommended that the budget should be increased by 20-30 per cent annually or according to inflation for improving the existing health of CHCs. The persons who implement the policy should be involved in decision making to avoid any mismatch between the policy and its implementation. The problem of delay in disbursement of allocated budget due to lengthy procedure should be overcome by use of information technology for transferring the files from one department to other for approving and allocating the budget instead of using manual system. The study will be useful to health department, policy makers and doctors to know the present situation of primary health care institutions in Haryana regarding the budget allocated by the government.

Limitations and Scope of Further Research

The primary data in the present study were collected through pre-tested structured questionnaire from the doctors working at various health centres in the selected districts;

therefore the chances of bias cannot be ignored due to their busy and pre-occupied schedule. The size of sample is restricted to 50 respondents only and the area under study is confined to four districts of two divisions of Haryana, therefore present study may be extended to other areas to make comparison between different divisions of the state of Haryana and other states. The sample size may be extended from 50 doctors of CHCs to a larger number for proper generalization of results.

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Table 1: Descriptive Statistics of Budget Allocated to CHCs

S. No.	Statements	Palwal			Bhiwani			Hisar			Narnaul			Total		
		N	\bar{x}	σ	N	\bar{x}	Σ	N	\bar{x}	σ	N	\bar{x}	σ	N	\bar{x}	σ
1.	The budget allocated to CHCs is adequate	13	3.69	0.48	12	3.17	1.12	13	2.85	0.99	12	1.92	0.79	50	2.92	1.07
2.	The CHCs get allocated budget in time	13	2.77	0.93	12	2.42	0.52	13	2.46	0.87	12	2.00	0.60	50	2.42	0.78
3.	CHCs are not getting allocated budget in time due to:															
	System is not working properly	13	3.38	0.87	12	3.08	0.29	13	3.31	0.75	12	3.00	0	50	3.20	0.61
	Paucity of funds at government level	13	4.00	0.82	12	3.00	0.60	13	2.77	1.17	12	3.33	0.78	50	3.28	0.97
	Delay due to lengthy procedure	13	3.77	0.93	12	3.83	0.58	13	2.92	0.86	12	3.33	0.49	50	3.46	0.81
	Mismatch between policy and their implementation	13	3.92	0.64	12	3.17	0.58	13	3.00	0.91	12	4.67	0.49	50	3.68	0.93
4.	Budget allocated is utilised appropriately under the heads:															
	User Money	13	4.46	0.66	12	3.92	1.17	13	4.23	0.73	12	4.92	0.29	50	4.40	0.83
	Annual Maintenance Grant (AMG)	13	4.54	0.66	12	4.25	0.62	13	4.15	0.80	12	4.92	0.29	50	4.46	0.68
	Untied	13	4.54	0.66	12	4.08	0.52	13	4.23	0.60	12	5.00	0	50	4.46	0.61
	Patient Facility/Swasthya Kalyan Smiti	13	4.62	0.51	12	4.33	0.65	13	4.23	0.60	12	5.00	0	50	4.54	0.58

Source: Survey, N = No. of Respondents

Table 2: Confirmatory Statistics of Budget Allocated to CHCs

S. No.	Statements	Gender		Age		Experience		Districts	
		t-test (df=48)		ANOVA (df=2, 47)		ANOVA (df=4, 45)		ANOVA (df=3, 46)	
		t	Sig.	F	Sig.	F	Sig.	F	Sig.
1.	The budget allocated to CHCs is adequate	2.18	0.033*	1.69	0.195	1.14	0.348	9.03	0.000*
2.	The CHCs get allocated budget in time	0.85	0.484	4.62	0.015*	0.32	0.865	2.16	0.106
3.	CHCs are not getting allocated budget in time due to:								
	System is not working properly	0.62	0.671	0.08	0.919	0.95	0.443	1.13	0.346
	Paucity of funds at government level	1.00	0.606	2.56	0.088	2.02	0.107	4.87	0.005*
	Delay due to lengthy procedure	0.60	0.230	3.87	0.028*	2.15	0.090	4.11	0.011*
	Mismatch between policy and their implementation	0.16	0.126	2.26	0.115	3.94	0.008*	15.60	0.000*
4.	Budget allocated is utilised appropriately under the heads:								
	User Money	0.23	0.574	0.80	0.454	0.54	0.708	4.37	0.009*
	Annual Maintenance Grant (AMG)	0.26	0.888	0.46	0.636	0.27	0.897	3.67	0.019*
	Untied	0.22	0.847	0.38	0.685	0.48	0.753	7.34	0.000*
	Patient Facility/Swasthya Kalyan Smiti	0.24	0.700	0.15	0.859	0.56	0.690	5.56	0.002*

Source: Survey, df = Degree of Freedom, * = Significant at 5 percent level