LITERATURE REVIEW
CHAPTER 2

LITERATURE REVIEW

Literature review is the critical analysis of the available literature related to the topic on which the research is to be conducted. It is essential as it gives us an insight into the field of study and also the direction of our progress.

2.1 INTRODUCTION

Health is an important aspect of human life for promoting human resource development and economic growth in a country. Thus ill health or diseases is increasingly being recognized as a significant indicator of human well being and a determinant of poverty. Haq (2005) thus opines that right to live a healthy life is the most basic human right and increased investment in health leads to increased worker productivity. In general terms, better health status of individuals reflects in reduced illnesses, low level of morbidity and less burden of disease in a given population. Hence good health is an end in itself. Freedom from illness and diseases of a population would imply increased time and better utilization of both physical and mental resources and better education, acquisition of further skills, as well as increased participation in economic, political and social life (World Bank, 1993). Thus that, health is an indicator of well-being with a direct implication for the quality of life and the indirect implication for the production of economic goods and services is a well known truth to all of us (Shariff, 1999). Hence in order to improve the overall health conditions of the world, several Bureaus and Commissions were formed and World Health Organisation (WHO) is one of them.
2.2 THEORETICAL PERSPECTIVE

This section throws light on various theoretical concepts and literary works of different scholars, their opinions and ideas regarding health, health care services, medical expenditure and gender perspective. It also aims to view the health and health care facilities through gender lens.

2.2.1 HEALTH

According to the WHO ‘health’ is considered ‘as a state of complete physical, mental, social well-being, and not merely, the absence of disease and infirmity’. However while studying health conditions of the populations at large; it is essential to develop a set of indicators that are quantifiable. According to WHO, Crude Death Rate (CDR), Crude Birth Rate (CBR), Infant Mortality Rate (IMR), Child Mortality Rate (CMR) and the life expectancy at birth are the basic indicators of general state of health (GOI, 2010). These are important as they reflect the crucial aspects of health of a society. But in the recent past, the measurement of ‘morbidity’ or ‘state of ill health’ is being increasingly used as an indicator of the level of well being of the population in place of conventional indices like death and infant mortality rates that were used to measure social development and personal well being. This is because morbidity is relatively more common than death and infant mortality and it can also be measured cost effectively (Shariff, 1999). Thus one is often restricted to a set of few quantifiable aspects such as morbidity rates and the nutritional status which can be broadly termed as health outcomes (Panikar and Soman, 1984).

To be more specific, health status of the society largely depends on a variety of factors like household income, awareness, food availability, nutrition, access to safe drinking water, housing conditions, sanitation facilities, environment, type of
shelter, medical technology and of course on the ‘access to’ and ‘utilisation of’ the health care services (Baraik and Kulkarni, 2006).

Though the relationship between the health status of the population and these socio-economic determinants of health is becoming accepted as a part of planning in health policy, yet provision of health services, is considered to be the chief preoccupation of health policy formulation in any country of the world.

2.2.2 HEALTH CARE SERVICES

Thus provision of health care services certainly constitutes one of the most important aspects of the right to health. Medical care is necessary in terms of dealing with morbidity, both to reduce the quantum of disease and reduce suffering. Depending on the stage of treatment, health care services are basically of three types namely - preventive, promotive and curative. The preventive health care is made up of those aspects of health services which deal with the prevention of ill-health. It includes health supervision or health check-up from time to time and immunization services, especially for children and pregnant women (Yesudian, 1988). The promotive care involves those promotional programmes which include adequate health awareness among the people to promote hygienic practices and consciousness about nutritional intake e.g. Vitamin A supplementation among the children below the age of five so as to avoid illnesses like blindness at an early age. All these factors significantly contribute towards promoting health status of the population and reducing its disease burden (Baraik and Kulkarni, 2006). The curative health service is that aspect of health service which repairs the damage caused to one by illness through proper treatment and puts him or her back to the normal life. Curative care is considered to be more important than preventive and promotive care as it alleviates one’s suffering caused by illness. The treatment under curative health services largely
depends on the type of diseases suffered by the individual e.g. the curative treatment for a sick person suffering from the communicable diseases is totally different from that of the person suffering from chronic diseases or that of physical disability and other diseases as well (Yesudian, 1988).

Most of the countries including India have a mix of both public and private healthcare institutions. A few decades ago, we had mostly government healthcare institutions-subcentres, primary health centres, taluka and district hospitals, medical colleges and speciality hospitals. Private sector institutions were basically meant for the voluntary and not-for-profit category- for example, ‘mission hospitals’ filling the gaps of access to health care and of training of nurses and doctors. They were, therefore, located predominantly in rural communities or small towns. The Health Policy (1983 and 2002) recognized the need and allowed the growth of private sector healthcare. Many mission hospitals that catered to poor people could not survive as the costs of quality care increased. The private for-profit hospitals have replaced the voluntary health care institutions that catered health care services at low cost. For a semblance of equity, the government introduced the clause that they ought to earmark a proportion of their services-including hospital beds, for “charity” (John, 2010). Therefore, over the past six decades, there has been an expansion of health care facilities both in the public and private sectors. However, by and large, this expansion has been inadequate to ensure universal coverage and access to quality care (Baru, R. et al, 2010).

Studies have shown that preventive, promotive and curative health care services are available in both the Government-run health institutions most commonly known as ‘public facilities’ as well as in the individual owned health institutions or ‘private facilities’. In general ‘private facilities’ include all the nursing homes,
dispensaries and clinics run by private practitioners, charitable institutions and Non-Governmental Organisations (NGOs). Besides these, the medical and para-medical personnel giving treatment and collecting fees as a result of private practice are also included in this category (Sodani and Gupta, 1998). Both the government and private health institutions provide a wide range of health services to meet the various health needs of the population. The health services in the government institutions are available free or are highly subsidized while health services in the private institutions are generally very expensive. As the weaker sections of the society, the poor have difficulty in obtaining preventive, promotive and curative health care from fee charging private sources; the public health services were instituted to provide many of these so that these sections were not deprived of essential health care.

But the utilization of health care facilities depends on various factors like availability, access, awareness and affordability (Baraik and Kulkarni, 2006). The health care institutions are not always well-distributed, especially in the rural areas. Lack of availability of proper and adequate health care facilities within the locality is a common problem faced by most of the people of the developing countries. Moreover, accessibility to these health care services is often a common threat to the rural people. They often avoid seeking treatment, due to long distances or difficulty in access to these health care institutions as they have to pay a huge transportation cost.

Unlike the rich classes of the society, the economically weaker sections cannot afford to seek treatment and enjoy personal care from the private health services, especially when they are suffering from serious illnesses mainly because of two reasons- firstly, as the treatment in such cases seems to be quite prolonged and secondly, treatment of such diseases in the private hospitals are very expensive. But this does not mean that poor people do not use private facilities at all. For instance, if
they perceive that government health services are less effective or for emergency purposes, they often shift to these private clinics and once they develop confidence in the doctor of these clinics they visit them for all health needs.

Moreover, though the government health services are freely available to the poor, yet they are not fully utilized by them. It is usually observed that only the out-patient department is usually used by these poor people, and they fail to make use of other freely available health services to the maximum extent. This is because these people are not even aware of the existence of other departments in the government hospitals other than the out-patient department which might be attributed to their poor educational status (Yesudian, 1988).

Thus, though the treatment at government hospitals are either free or highly subsidized, yet people have increasingly shown the preference to seek treatment from private facilities, because of poor quality of care, absence of doctors, paramedical staff and shortage of medicines in public health facilities, while private facilities though expensive are mostly better equipped with modern medicines.

Now, apart from different type of health care services, there are various systems of medicinal treatment available in different parts of the world. The most common of them is the Allopathic system, which most people use to meet their health needs followed by Homeopathic, Ayurvedic and Unani system of medicine (Yesudian, 1988). Treatments by these systems of medicines are widely practiced in both developed and developing countries of the world. Besides the above mentioned systems, medicines given by unqualified medical personnel or folk-healers or hakeems through ritual practices are also in vogue mainly in the developing countries, where less educated and poor people believe or are often forced to believe in such unscientific systems of medicine.
The present status of health service delivery in India has its roots in the policy and practices during the British colonial period. Many of these policies were pursued even after independence and health services were marked by inequities in availability and accessibility. Consensus is that even during the post-independence period, health services were under-financed and biased towards allopathic medicine, urban areas and curative services. Indigenous systems like ayurveda, siddha, unani and homeopathy, continue to play only a marginal role in health service delivery (Baru, R. et al, 2010).

2.2.3 MEDICAL EXPENDITURE

Sodani and Gupta (1998) have commented that the escalation of health care costs and growing egalitarian concept that all members of the society deserve adequate medical care have promoted economists and other social scientists to study the health care sector extensively.

The medical expenditure is generally defined as the expenditure incurred on various items to recover from illness during the reference period of twelve weeks. This has been divided into two major categories - direct expenditure i.e. the expenditure incurred on items that are directly related to the treatment during the reference period of twelve weeks. It includes doctors’ fees, medicinal expenses, hospitalization charges, surgery expenses, diagnostic test expenses etc. and indirect expenditure which include the expenditure incurred on items that are not directly related to the treatment but are associated with the treatment during the reference period of twelve weeks. It includes special diet expenses, transport costs, ritual expenses etc (Duggal, 1989).

There are three models of health care financing practiced the world over. In the Beveridge model, all care is financed directly by the state, as in the UK and Cuba. In the Bismarck model, the State insures everyone for healthcare but does not
necessarily provide care in public sector. Instead the private sector is encouraged to cater to every one’s healthcare need, but with mechanisms to audit the quality of services. Many European countries and Canada have more or less perfected this model and the “rights approach” to healthcare is by and large fulfilled. The third model is really no model- it is the inequity model, in which the rich pay for their own healthcare but the not-so-rich are left to their own devices. India practically comes under this model where about 70 per cent of healthcare costs are borne by individuals-called out-of-pocket. When low-income families face the consequences of loss of earning capacity or to spend available assets or to borrow to meet the immediate need and then face the consequences of depleted resources in future (John, 2010).

According to Mahmood and Ali (2002) the utilization of health services and preference of people to use certain facilities are not only determined by accessibility and good quality of services but the economic level of the household and the cost of treatment appear to be equally important factors. In fact Coe and Wessen (1965) have observed, that, though the upper classes spent more for health services, the amount they spent represented a smaller proportion of their total income; while the lower class spent a small amount for health services, but this amount formed a larger proportion of their total income.

Hence these studies clearly reveal that though the higher classes consume more health services and pay more from their pockets, it is not a financial burden for them. On the other hand, the lesser amount paid by the lower class takes a substantial portion of their small income, thereby causing financial stringency in the household and most of the time they fall into the debt trap.
2.2.4 GENDER AND HEALTH

The studies regarding ‘gender’ can be dated as recently as the late 1960’s. Prior to the 1970’s, the social sciences in general and sociology in particular largely ignored gender. The ‘people’ it studied were mainly men and the topics it focused on were aspects of the social world especially significant for men, such as paid work and politics. Women were almost invisible in pre 1970’s gender blind sociology, only featuring in their traditional roles as wives and mothers within families. Differences and inequalities between women and men at this time were not recognized as an issue of sociological concern and were not seen as problems to be addressed. In the context of second wave feminist critiques, however, a number of disciplines across the social sciences, the arts and humanities began to pay increasing attention to gender. Thus, in sociology during the 1970’s, differences and inequalities between women and men came to be regarded, especially by women sociologists, as problems to be examined and explained. Initially studies were focused on ‘filling in the gaps’ in knowledge about women, gaps left by the prior male bias. Since then the attention gradually moved to those aspects of experiences especially significant to women, including paid work, housework, motherhood and male violence (Pilcher and Whelehan, 2004).

In general women are biologically more robust than men and consequently have a natural edge in terms of expected life span. But, in many South Asian societies, this biological advantage is completely cancelled out by women’s social disadvantage till date. Haq (2000) in his study has elaborated that in most regions of South Asia, women are mostly deprived of the rights and privileges afforded to their male counterparts, both within and beyond the domestic sphere. Throughout their lives, women endure discrimination based on gender, which range from preferential treatment of boys in provision of food and health care, to rape, dowry death and
female infanticide. They are expected to eat last, leave the best food for the men of the family and to ignore their illnesses, while managing the entire household. These often result in malnutrition, one of the main reasons behind the high rate of morbidity and mortality of women in South Asia. Hence, higher morbidity and mortality rates among women are largely due to discriminatory practices, particularly when women are perceived as an economic burden.

To be more specific, studies show that though ill-health affects both men and women, the problems get compounded for women due to higher morbidity in both rural and urban areas, lack of access to and control over resources, restrictions on mobility, unrecognized care work burden, high levels of anaemia and greater fear of stigma. Additionally, women are victims of domestic and other forms of violence (Eapen and Mehta, 2012).

Sen (2002) has also stressed on the study of health equity in terms of gender. She has viewed health through a gender lens and has commented that greater privatization has led to gender and class equity i.e. patients with higher economic status especially males generally seek better medical facilities as compared to their female counterparts and people of low economic class.

Despite greater longevity in a given set of socio-economic conditions women in most communities around the world report more illness than men. The nature of this disproportionate female morbidity clearly shows that women’s lives seem to be less healthy than those of men. Hence in order to emphasize on sound health for both men and women equally, a resolution was adopted by the 30th World Health Assembly (1977) ‘to attain a level of health for all the citizens of the world by the year 2000’ that will permit them ‘to lead a socially and economically productive life’. India was no longer far behind in setting the goal to attain health security for all its
citizens. ‘Health for All by the year 2000’ was a national goal set by the Indian policy makers in Alma Ata Conference in 1978 (Shariff, 1999). As the programmes and professional education in the health field is fundamental for the development of health care services, the National Health Planning Programmes in the name of National Health Policy (1983) was also framed by the Indian policy makers and several committees have been formed accordingly.

But sound health cannot be achieved only by policy making and programme formulation. Studies regarding health and health care services are also essential to adjudge how far the goal has been achieved. Such studies have been conducted in developed countries since late fifties. In the edited volume by Paine (1978), the existing pattern of available health care services, their organization, community participation, health related agencies, financial planning regarding the medical expenditure available in different cities of Paris, Mexico, Sao Paulo, Hong Kong, Tokyo, London, New York, manilla, Phillipines etc have been vividly studied upon. But it is only since the past three decades, this type of work has been initiated in the third world countries like India, Sri Lanka and Pakistan both at macro and micro level.

2.3 EMPIRICAL WORKS

A number of empirical works on health, health care delivery system, health care expenditure and gender disparity in utilization of health care facilities have been reviewed to have a better understanding of the research topic.

In this context the works of Prasad (1969), Panikar and Soman (1984), Duggal (1989), Sumaraj (1991), Rajeshwari (1996), Pieris (1999), Gumber (1997), Soman (1997), Sodani and Gupta (1998), Sen (2002), Mahmood and Ali (2002) are worth mentioning. All of them have studied upon the existing health systems and various
aspects of health related issues of the developing countries especially India, Pakistan, Sri Lanka at different point of time. Each of their research works have been explicitly discussed so as to see how far the health goal has been achieved till recent days and what is yet to be done.

2.3.1 HEALTH

Most of the developing countries of the world have been passing though a phase of health transition which is quite different from the one experienced by today’s developed world.

The studies regarding morbidity pattern in India (Gumber, 1997), Sri Lanka (Pieris, 1999) and Pakistan (Mahmood and Ali, 2002) have pointed out that high levels of morbidity is prevalent mainly among children and women of the reproductive ages and the elderly particularly belonging to the poor households. The communicable diseases or minor illnesses like fever, diahorrea, cough and cold, which are preventable with better health care and hygiene, are reported mostly among the children and youth, while the middle-aged and older population suffers mostly from the non-communicable or chronic degenerative diseases such as cardio-vascular problems, hyper-tension, diabetes, kidney problems, arthritis, cancer etc (Saxena, V. et al, 2012).

Studies by Desai, S. B. et al (2010) have revealed that economic and social disadvantages bring health constraints with them as well. Dalits are somewhat more likely to experience short term or minor illnesses than forward caste Hindus. Individuals of the highest income group are less likely to be ill with short term maladies (91 per thousand) than those in lowest income quintile (159 per thousand). Moreover the respondent’s high educational attainment is strongly associated with lower morbidity e.g. of the surveyed population, only 52 college graduates per
thousand population were reported ill as against 171 uneducated individuals. However, it is the working age adults especially the elderly and not the children whose morbidity declines with household education. Similarly, Shariff (1999) in his study on the morbidity pattern in India has stated that household income has a strong influence on the morbidity pattern. He has shown that the short term diseases declined with the increase in levels of household income e.g. in the lower income group the morbidity prevalence rate of the minor diseases at the national level was 129 per thousand while it was 91 per thousand in the higher income group. However this pattern was found in cases of illnesses like diahorrea and cold and cough while the incidence of fever showed no association with income levels. On the other hand, the prevalence rate of some of the major diseases generally increases with household income e.g. diseases like hypertension, diabetes, heart diseases etc. has been reported to be high for the salaried and professional class even in the rural areas. But the prevalence of certain major diseases like tuberculosis, leprosy etc falls as household income increases. This is because all these diseases are related to poverty, low levels of living and consequent malnutrition.

In this regard Mahmood and Ali (2002) have pointed that the adverse effects of ill health may hit the poor people the hardest way mainly because they are ill more often and partly because they have limited economic and human resources to cushion their risks of illness and bear high cost of treatment. Casual labour and self employed households with limited resource base suffer considerable hardship due to frequent and prolonged illness and chronic diseases (Gumber, 1997).

Another study on the existing morbidity pattern of some villages of Mirzapur district in Uttar Pradesh by Prasad (1969) has clearly specified that malnutrition is the main cause of ill-health of this poverty stricken area. Thus the medical approach to
improve the people’s health and efficiency through proper diet, proper medication and by increasing awareness through education is essential because modern medicine lays greater emphasis on prevention than on cure.

2.3.2 HEALTH CARE SERVICES

Several studies regarding the existing pattern of the health care services in different third world countries like India (Desai, S. B. et al, 2010), Sri Lanka (Pieris, 1999) and Pakistan (Mahmood and Ali, 2002) have been carried upon at different point of time. All these studies have emphasized on the existence of both government as well as private health services side by side. Besides, the existence of traditional practitioners, folk-healers, hakeems, exorcists has also been mentioned in the works of Sodani and Gupta (1998) and Pieris (1999). According to the East India Human Development Report (2004), a three-tier integrated health care system has been set up in the states of India comprising of Primary Health Centres (PHC’s), Community Health Centres (CHC’s) and sub-centres in the rural areas while the urban areas consist of hospitals, dispensaries and health posts. All these studies have pointed out that most of the people of these third world countries prefer to seek medical care from private doctors or health services because of poor quality of care and absence of doctor and paramedic staff and shortage of medicines in public health facilities. This is true for both short-term and long-term illness, although slightly less so for long term illness (Desai, S. B. et al, 2010). In fact the study on tribal areas of Rajasthan by Sodani and Gupta (1998) have mentioned that in comparison to public facilities, people spent more on treatment from private facilities even in the rural areas also. But at the same time, Gumber (1997) in his study on India has also highlighted the same fact stating that unlike the better-off sections of the society with higher purchasing power, poor families with their economic constraints in accessing health care facilities
tend to resort to traditional healers and hakims and home remedies and substantial proportion of population report as not using any health facility at all mainly among females. The single most important reason for the non-treatment of reported illness in rural areas was that the ailment was ‘not considered serious’. ‘Financial reasons’ were generally, the second most important and they were cited more often by the households falling in lower income group. This has been supported by Mahmood and Ali (2002) in their study on Pakistan, where they have also stressed on the positive association between the cost of treatment and type of health facility accessed. Furthermore, Desai, S. B. et al (2010) have opined that it is the poor, the elderly and the women who make somewhat more use of the government services, in general, but majority of all groups use private sector care for most illness. Government provided medical care is more common in some parts of India, but only in a few areas it is the most common choice for medical care.

2.3.3 HEALTH CARE EXPENDITURE

It is quite obvious from the earlier discussions that cost of treatment is a prime factor in determining the type of health care services to be availed. This is evident from the works of Yesudian (1988) in the city of Madras, Sodani and Gupta (1998) in their studies on the tribal areas in Rajasthan and Mahmood and Ali (2002) in Pakistan that the medical expenditure of a sick person would be definitely lower if he prefers to seek treatment from the public health institutions rather than a person seeking treatment from private facilities. Thus the people belonging to the low economic status would have lower medical expenditure, if they seek free treatment from public health services. On the other hand, the high and middle class families who mostly use private health services have higher medical expenditure.
Apart from the health care services utilized, Sodani and Gupta (1998), in their studies on the tribal areas in Rajasthan have clearly said that the average medical expenditure is also determined by the morbidity pattern. The health care expenditure was generally higher for chronic illnesses as compared to the minor illnesses in both the rural and urban areas of Rajasthan. This is mainly due to the nature of illnesses and their continued treatment. Their study has further shown that the direct health expenditure accounted for about two-thirds of the total health expenditure. The main reasons for increased direct expenditure were that the people of the tribal areas believe in performing rituals for early relief from the illness which aggravates the situation more. Thus delayed reporting led to progress of the disease to severe form coupled with frequent consultation and hospitalization.

Affordability of health services is determined by the cost of treatment, households’ ability to manage these costs, and its impact on the livelihood of households. A study conducted by National Sample Survey Organisation (2006) revealed that the high burden of expenditure on health care is largely financed through two major sources: a) household’s own resources and b) borrowings. In rural areas, close to a fifth of the health expenses for outpatient care is financed through borrowing; the corresponding percentage for hospitalization is much higher at around 40 per cent. The recourse to borrowing, while being substantial even in the urban areas, is of a lower order compared to the rural areas. The reliance on borrowing is significantly higher for the poorer sections of the population compared to the better off with sharp differentials, especially in the urban areas. In reality, the out-of-pocket payments in India form a disproportionately large component of total health expenditure. Out-of-pocket expenditures include direct payments for consultations, diagnostic testing, medicines and transportation. Indirect costs, such as loss of
earnings due to the illness, are not included in calculating out-of-pocket expenditures. It is estimated that 80 per cent of total health expenditure and 97 per cent of private expenditure are borne through out-of-pocket payments. The largest component of out-of-pocket expenditure is on the purchase of medicines. Estimates from the National Sample Survey for 1999-2000 show that 70 per cent of the total out-of-pocket expenditure in urban and 77 per cent in rural areas are spent on medicines (Baru, R. et al, 2010).

Desai, S. B. et al (2010) in their study on medical expenditure has shown that Indian households spend surprisingly a large proportion of their income on medical care. In fact nearly 16 per cent of households reported that their largest loan in the preceding five years was taken for medical expenses. They have shown that on an average, each Indian household spent Rs. 190 on minor illnesses during the year and even more than Rs. 1680 on major illnesses. In fact for minor illnesses the expenditure does not vary by household income but for the major illnesses the expenses vary substantially by household income. This is not surprising because for minor illnesses, the costs are mostly medicine related whereas the major illnesses require more expensive tests and treatment options.

Apart from out-of-pocket expenses, a small segment of the population is brought under the coverage of several public insurance schemes for their employees in the organized sectors such as the employees’ state insurance scheme, central government health scheme, railways and posts and telegraph services. But such public and private insurance schemes cover barely 11 per cent of the total population and consequently, healthcare is financed substantially through out-of-pocket payments by the respective individuals and households (Baru, R. et al, 2010).
Furthermore, Yesudian (1988) in his study on Madras city has opined that since different economic classes avail different type of health facilities and also their health problems differ markedly, their medical expenditure items would definitely vary accordingly. The poor people who go for free health services, they may not spend money on medicines, tests and consultations but because of long distance and difficult access to services, a large part of expenditure on health goes to travel or transport costs to distant health centres. On the other hand, the high and middle classes who go for private health services would spend a good amount for consultation, medicines, tests and special food.

Apart from the income, medical expenditure also depends on the educational status of the household. Yesudian (1988) has observed that the better educated high and middle class households, being more aware about the importance of the sound health give a higher priority to medical expenditure as compared to the less educated sections and, hence medical expenditure is generally higher among the households having literate men and women (Shariff, 1999).

2.3.4 GENDER DISCRIMINATION AND ACCESS TO HEALTH CARE FACILITIES

So far the health status of the developing country like India has been assessed only from the view point of prevalent morbidity pattern, different type of health care services available and the cost of treatment incurred for ailment and so on. But the health conditions in the limelight of gender context date back only to the early nineties.

Inequality between men and women is one of the most crucial disparities in many societies, and this is particularly so in India. In most countries women tend in general to fare quite badly in relative terms compared with men even within the same
families. This is reflected not only in such matters as education and opportunity to develop talents, but also in the more elementary fields of nutrition, health and survival (Dreze and Sen, 1995).

Studies show that both the women and men in South Asia are vulnerable to many preventable and curable diseases – tuberculosis, malaria and hepatitis, which become life threatening when the diseases are exacerbated by lack of information, poor health facilities, lack of proper sanitation facilities and dearth of safe drinking water. But in reality, the burden of disease tends to be much heavier for women as they suffer greatly from lack of access to health care, based not only on an absolute lack of health facilities – particularly in rural areas – but also on the relative inaccessibility of such facilities to them. They often face traditional taboos, based on cultural practice and religious beliefs, against consulting doctors. The situation becomes more adverse as women do not possess the authority of decision-making power which undermines their efforts to seek timely health care for themselves and their daughters. Hence it can be rightly concluded that the reasons for women’s ill health often lay within the gender roles they play (Haq, 2000).

Shariff (1999) has clearly shown that gender disparity in minor illnesses is very high in India especially among the 15-34 years age group in comparison with the 35-59 and 60 and over age groups. According to him, such morbidity is related to pregnancy and childbirth related problems which are not considered to be serious cases in Indian scenario. This has been supported by the study of Haq (2000) who has opined that often the most trivial health problems and normal processes of child bearing become a cause of mortality as large proportions of women do not seek proper pre and ante natal care. Furthermore, majority of women suffer from chronic
energy deficit due to insufficient daily calorie intake (500 to 700 calories less than the recommended daily adult minimum intake of 2250 calories UNICEF, 1996).

The works of Sumaraj (1991), on the women of Kerala has clearly specified that the preferences of access to health agencies for treatment for the women largely depend on their educational status as well as their income level. In fact the women’s access to health care services in the Indian society is largely determined by the economic viability of the family and permission for whether a woman can or cannot seek health services is solely a function of woman’s social status. The gender restrictive social norms thus act as critical factor in determining women’s health at family level. This has been further exemplified from the works of Soman (1997) on rural areas of Birbhum in West Bengal. Her study is basically based on three different case studies on women’s health belonging to low socio-economic status where she has shown that the health service system as a whole has kept the poor from exercising their right to health care. Women’s access to quality health care is even much poorer in this regard. Even if they want to seek treatment because of their strong desire to live a healthy life, they are often forced to use the services of the private practitioners for outdoor treatment, because the government health service network is marked by poor outreach and lack of co-ordination within, while the few unevenly distributed NGOs offer limited services. But seeking treatment from these private practitioners in the town is often not affordable by them. Under such circumstances, the self-trained healers who are available at the door-step at a much lower cost often seem to be a practical answer, more so for the women. Furthermore, the women’s health in the villages are left at the mercy of the family, primarily in the hand of their husbands and other family members. Even the socio-political institution like the village panchayats never felt the need to intervene in such family health matters except when some
emergency arises. Such a social situation where the disadvantaged are deprived of their rights to quality health care is no doubt a violation of the norm of social ethics. Thus Soman (2002) on her study on rural West Bengal has rightly commented that there is a sharp division in the availability and quality of health care as a consequence of the socio-economic and gender differentials in the society.

Similarly, Rajeshwari (1996) while explaining the conditions of medical treatment in districts of rural Haryana has highlighted that medical treatment is in fact biased in favour of males while females are discriminated in the allocation of food and health care within the households. This has led to adverse sex ratio and excessive increase in female mortality. According to her study on rural Haryana, improvement in female health status critically depends upon a number of factors namely poverty, low level of female participation in economic activity; education, empowerment, kinship system and autonomy and culture. All these factors not only determine the health status of women but also affect the selective biasness against them. She has shown that educational status is an important factor in improving the health care of women and there is a decline in sex disparity as one move up from lower education status to higher one. In cases where the head of the households have attained educational status above matric, almost all the females who experienced illness were treated medically, whereas the households where the head of the family is illiterate then the females have not availed any medical treatment during their illness episode. Moreover her study reflects that better income has a positive impact on the women’s health status. It can be said that higher income leads to better exposure and opportunities which ultimately leads to better understanding of health and allied issues and thereby the level of female health care would be higher and the gender disparity would be lower in such categories.
Shariff (1999) has also discussed about existing gender disparity in health care expenditure in India. He has shown that household expenditure on health care in India is higher for males in the early ages which subsequently falls and increases again as the age increases. While 10 per cent higher expenditure is incurred on males in the age group 0-4 years, it declines to less than 5 per cent in the middle years and increases to 11 per cent in the 60 and above age group.

Thus by surveying different research works it is quite obvious that gender discrimination in utilization of health care services is widely practiced in India, more so in the villages. Thus women’s health in India is at great stake. Furthermore, studies have clearly revealed that access to health care services, mostly in case of women, is largely influenced by different socio-economic factors like education, income etc.

2.4 RESEARCH GAPS AND RELEVANCE OF THE STUDY

The literature review clearly depicts that studies regarding the health and utilization of health care services have been age-old in the cities of Paris, Mexico, Sao Paulo, Hong Kong, Tokyo, London etc but are comparatively much recent in Indian scenario. Though recently in the past few decades such studies have been conducted in different parts of our country especially in the rural areas of the districts of Uttar Pradesh, Kerala, Haryana, Rajasthan and West Bengal but are rare in Indian cities. Studies in the rural areas have shown that being entangled in the patriarchal family dynamics and norms, in most cases, women across different socio-economic categories got a worse deal. But the proposed study area is the age-old conurbation formed by the cities and towns, which have grown together in one linear and continuous pattern of urban development (extending from Bansberia to Uluberia on the western bank and from Kalyani to Baruipur and Budge Budge on the eastern bank of the River Hugli) over a span of five decades and undoubtedly the most urbanized
part of West Bengal. Hence it is expected that health care facilities should be equitably available for both the gender in such urban areas, especially when our nation has promised to achieve “Health for all by the Year 2000”. Thus a recent exploration especially in the most urbanized part of West Bengal is necessary to have a clear idea about the present health status of our state and with the wider perspective of our nation too.

Moreover it has been already established from various studies that different socio-economic and demographic factors especially education, income and age have a strong influence on the access to health care services in India. But among these factors, which one is more dominant in determining the health care utilization in Indian scenario has not been discussed in any earlier works. Thus this research work not only aims at studying the extent of gender discrimination regarding the access to health care facilities in Kolkata Metropolitan Area but also considers degree of association of the demographic as well as the social and economic factors in this aspect.

REFERENCES


