1.1 INTRODUCTION

The word ‘health’ has enjoyed an enormous popularity during the past quarter century. In this century, the social conscience of world society, particularly the developing society like India, needs an awakening because human race has reached a crossroad where its own achievements, ambitions and developments claimed its feet. Hence, the enjoyment of the highest attainable standard of health is in danger (Srivastava and North, 1995).

The World Health Organisation (WHO) has thus done a great service to mankind by ushering an era of international co-operation in the field of health and promoting the concept of ‘one world health’ and ‘health care for all’ by the year 2000. According to WHO “Health is a state of complete physical, mental, and social well being and not merely an absence of diseases” (Srivastava and North, 1995). With this idea in mind, a resolution was adopted by the 30th World Health Assembly, 1977 according to which “the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life” should be the main social targets of all national governments in the coming decades (World Health Organisation, 1998). Thus the ‘Health for All’ plan of action has been adopted at the global level, followed by the formulation of national and regional plans of action.

1.2 DEFINITION OF THE PROBLEM

Since India was one of the signatories to these declarations, the Government of India was no longer far behind in setting the goals to attain health security for all its citizens. Hence, during the sixth five year plan (1980-1985), the National Health Policy (NHP-1983), in a spirit of optimistic empathy for the health needs of the
people, particularly the poor and under-privileged, had hoped to provide ‘Health for All by the year 2000 AD’. Since then, there have been several significant changes in health conditions and the composition of the health sector within the country.

As India now approaches towards the sixty sixth years of independence, it is appropriate to take stock of her achievements in health, which is an important component in raising the well-being of her population. A recent examination of the status of some of the health and demographic indicators in India shows, that West Bengal’s performance regarding health and demographic indicators had always been better than all-India aggregates (Table No. 1.2.1). The inter-state comparison puts West Bengal in a more favourable situation than most of the other states of India.

### Table No. 1.2.1: Health and Demographic Indicators for India and West Bengal

<table>
<thead>
<tr>
<th>Indicator (with year)</th>
<th>West Bengal</th>
<th>All India</th>
<th>Rank in India</th>
<th>States Better than West Bengal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude Birth Rate (2008)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>17.5</td>
<td>22.8</td>
<td>7&lt;sup&gt;th&lt;/sup&gt;</td>
<td>Goa (13.6), Kerala (14.6), Tripura (15.4), Manipur (15.8), Tamil Nadu (16.0), Punjab (17.3)</td>
</tr>
<tr>
<td>Crude Death Rate (2008)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>6.2</td>
<td>7.4</td>
<td>8&lt;sup&gt;th&lt;/sup&gt;</td>
<td>Nagaland (4.6), Delhi (4.8), Manipur (5.0), Mizoram (5.1), Arunachal Pradesh (5.2), Sikkim (5.2), Jammu &amp; Kashmir (5.8), Tripura (5.9)</td>
</tr>
<tr>
<td>Infant Mortality Rate (2008)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>35</td>
<td>53</td>
<td>9&lt;sup&gt;th&lt;/sup&gt;</td>
<td>Goa (10), Kerala (12), Manipur (14), Nagaland (26), Tamil Nadu (31), Arunachal Pradesh (32), Maharashtra (33), Sikkim (33), Tripura (34)</td>
</tr>
<tr>
<td>Total Fertility Rate (2005-06)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>2.27</td>
<td>2.68</td>
<td>11&lt;sup&gt;th&lt;/sup&gt;</td>
<td>Andhra Pradesh (1.79), Goa (1.79), Tamil Nadu (1.80), Kerala (1.93), Himachal Pradesh (1.94), Punjab (1.99), Sikkim (2.02), Karnataka (2.07), Maharashtra (2.11), Delhi (2.13), Tripura (2.22)</td>
</tr>
</tbody>
</table>

Source: 1. <sup>a</sup>SRS Bulletin, October, 2008.  
2. <sup>b</sup>NFHS-3, India, 2005-06.
However, all these indices do not present correct picture of health status within countries like India where rural-urban differences, gender differences and disparities within urban social classes are clearly demarcated (Umashankar, 1993).

The inequality between men and women is one of the crucial disparities in many societies, particularly so in India. In reality, the women in India tend 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).

However, in line with the National Health Policy-2002 (NHP-2002), the Government of West Bengal is now committed to ensure accessible, equitable and quality health care services and has embarked on a mission “to improve the health status of all people of West Bengal, especially the poorest and those in greatest need” (Government of West Bengal, 2004). Therefore, it is expected that the health care facilities in West Bengal is equitably available to the common mass, without showing any sort of social and economic discrimination in this regard.

1.3 OBJECTIVES OF THE STUDY

In general, because of the gendered nature of this patriarchal society, the women in India occupy a subordinate place in the present social structure. Under such circumstances, it is quite apt to explore the position of present urban West Bengal, with respect to the ‘utilisation of’ and ‘access to’ health care facilities in terms of ‘gender equity’. So, the main objectives of the study are:

1. To assess the physical, demographic, social, economic aspects and infrastructural facilities of the study area that probably influences the health needs of the common mass and their access to health care services.
2. To enquire into the health needs of both male and female population of the study area.

3. To investigate the type of health care services availed by both male and female patients of the study area so as to assess the extent of gender discrimination in access to health care services.

4. To examine whether the differential pattern of access to health care practices availed by both male and female patients and the practice of gender discrimination has any consistent pattern in relation to the demographic and socio-economic differences of the sample population within the study area.

5. To explore the extent of gender discrimination, in differential pattern of medical expenditure in terms of type of diseases and type of health care services.

6. To analyze the major sources of finance that are mostly favoured in order to meet the medical expenses, for both the gender.

7. To identify the practice of gender discrimination regarding the access to health care facilities in the study area on the basis of the levels of development.

1.4 LOCATION AND CHOICE OF STUDY AREA

For the purpose of this research work, some towns situated within the administrative boundary of the most urbanised part of West Bengal i.e. Kolkata Metropolitan Area (KMA), have been chosen. Since it is not possible for any individual researcher to conduct an intensive primary level study throughout the whole of West Bengal, three well-known towns of Kolkata Metropolitan Area have been chosen as a representation of urban West Bengal. These selected towns are Baruipur, Kamarhati and Uttarpara-Kotrung, which come under the administrative jurisdictions of their respective municipalities.
With respect to the position of the Hugli River, Baruipur and Kamarhati municipality, lie on the eastern bank of the Hugli River while Uttarpara-Kotrung municipality lies on the western bank of the Hugli River. However, two of these three towns namely Kamarhati and Uttarpara-Kotrung lie adjacent to the Hugli river whereas Baruipur lies quite a distance away from the main river situated on the low-lying eastern slope of the Kolkata district.

Of these three selected towns, Baruipur, is a Class- III town in the Alipore Sadar subdivision of South 24 Parganas district. It extends between 22°20’10” N to 22°22’37” N latitudes and 88°25’50” E to 88°27’30” E longitudes. Kamarhati, a Class- I town in the Barrackpore subdivision of N-24 Parganas district, lies between the latitudinal extension of 22°38’59” N to 22°41’5” N and longitudinal extension of 88°21’45” E to 88°24’12” E. Uttarpara-Kotrung, is the southernmost Class-I town in the Serampore subdivision of Hugli district. It lies within 22°39’20” N to 22°41’35” N latitudes and 88°19’15” E to 88°21’54” E longitudes.

1.5 DEVELOPMENT OF HYPOTHESES

The study is based on a few hypotheses which have been formulated in order to achieve the specific objectives of the study. Some assumptions on the basis of which this research work has begun, are as follows:-

1. Though women are biologically robust than men, yet this advantage is completely cancelled out by women’s social disadvantage.

2. Both men and women are vulnerable to many preventable and curable diseases but in reality the burden of disease tends to be much heavier for women as they suffer greatly from the lack of access to health care facilities or relative inaccessibility of such facilities to them.
3. People in the traditional societies or developing countries like India do not feel the need to visit any health care services unless they become dysfunctional or unable to perform their duties.

4. Females are often provided with cheaper health care services as compared to their male counterparts.

5. The study presumes that the type of health care services availed by both the gender is disease specific. The null hypothesis framed for the analysis considers that access to health care facilities and the type of diseases are independent attributes for both the gender.

6. Access to health care facilities is often determined by their distance from the residence of the ill person, more so for the women.

7. The study pre-supposes that the demographic, social and economic characteristics of the population like the age, education and income are important determinants in the utilisation and selection of the health care services for both male and female ill persons. The null hypothesis framed for the analysis thus considers that access to health care facilities and the age of the patient, educational status of the head of the household and the income level of the household are independent attributes for both the gender.

8. The health care expenditure is primarily dependent upon the type of diseases and the type of health care services availed by both the gender.

9. The mean medical expenditure incurred for the female patients is generally less than that of the male patients.

10. Gender discrimination regarding the access to health care facilities in the study area varies with the levels of development.
1.6 DATABASE

This research study is primarily based on the empirical study conducted by the researcher in Baruipur, Kamarhati and Uttapara-Kotrung municipalities through door-to-door primary field survey during the period of July 2009 to June 2010. However, in order to examine and analyze various objectives of the study, secondary data and relevant maps have also been obtained from disparate government offices. Different statistical methods and techniques have been used for the analysis of the data collected.

1.7 METHODOLOGY

The methodology to be followed in the study has been structured in the following way:-

a) PRE-FIELD SURVEY

- Literature review from the relevant books, journals, administrative reports, government publications etc. has been done to specify the research problem and for the selection of the topic of this research work and the study area.
- Secondary data collection from respective municipality offices, Census Office and KMDA office at Salt Lake and from Human Development Reports of West Bengal and India so as to have a clear view of the geographical set up of the study area.
- Collection of maps from respective municipality offices so as to have visual representation of the location of the study area.

b) FIELD SURVEY:

- Primary data collection from the sample households of the selected wards of the study area through extensive field survey by using appropriate sampling technique
with the help of structured questionnaire. For the purpose of the collecting information a ‘household schedule’ has been designed to meet the objectives of the required study area.

- Visual aids like photographic records of study area have been collected.

c) POST FIELD SURVEY

- Analysis and processing of information collected, using standard statistical software to find out trends and relationships between various parameters.
- Preparation of different maps to represent the data spatially.

1.8 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 gives a clear picture of what has been already done and what can be done in future.

As per World Bank (1993), 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 both significant indicator of human well being and a determinant of poverty. Similarly, Prasad (1969), Rao (1968), Jones (1994) and Curtis (2004) have also specified the importance of health for the nation’s development.

Thus provision of health care services certainly constitutes one of the most important aspects of the right to health. But studies show that the most glaring form of gender discrimination is seen in the health sector, which is visibly manifested through the low female-male sex ratio, the high levels of morbidity and mortality as well as differential access to treatment and care (Eapen and Mehta, 2012).
The health conditions in the limelight of gender issues has been analysed in the studies of Ramalingaswamy (1987), Sumaraj (1991), Rajeshwari (1996) and Gumber (1997). 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, gender discrimination against the females critically depends upon a number of factors like poverty, low level of female participation in economic activity; education, empowerment, kinship system, autonomy and culture. Another study by Ramalingaswamy (1987) have argued that it is the poor availability of health care facilities which adversely affect the gender bias and health status of women. Furthermore, Rajeshwari (1996) and Gumber (1997) have 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. Moreover their studies reflect 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 levels of female health care would be higher and the gender disparity would be lower in such categories.

1.9 SIGNIFICANCE OF THE STUDY

The literature review clearly enumerates that gender issues related to health care services utilization have been conducted in different parts of our country especially in the rural areas e.g. the districts of Uttar Pradesh, Kerala, Haryana, Rajasthan and West Bengal. Studies 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 in the rural areas. 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. 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 urban areas 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.

1.10 PLAN OF THE STUDY

The entire thesis has been arranged in the following sequential order:-

Chapter 1 throws light on the conceptual framework of the health conditions of the world and the developing countries, particularly India. Then the research problem, objective and hypotheses of the study, sources of information, methodology and the limitations of the research work have been highlighted.

Chapter 2 deals with the literature review to provide an insight into the field of study through theoretical and empirical framework. In this literature survey, an attempt has been made to cover the relevant books, journals, reports and previous works on this area of research.

In Chapter 3, the general profile of the study area has been discussed. It deals with the historical evolution of Kolkata Metropolitan Area, physical setup, demographic structure, socio-economic condition and civic infrastructural facilities available within the selected urban areas of study. These are very important for assessing the major objectives of this research work.
Chapter 4 is centred specifically on the health ailments and health action prevalent over the study area, through gender lens. Here onwards, the analysis has been done on the basis of primary data obtained from the field survey.

Chapter 5 mainly highlights the type of health care services available in the area and different types of treatment availed by both male and female patients of the selected study area. It also discusses about the types of treatment availed by distance for both the gender.

Chapter 6 stresses on the importance of the demographic and socio-economic factors that determine the access to health care services for both male and female patients of the selected study area.

Chapter 7 presents the sources, classification and composition of medical expenditure. It mainly deals with the extent of gender discrimination in the health care expenditure pattern and the sources of finance incurred upon both male and female ill persons in the selected wards of the three towns.

Chapter 8 analyses the health care utilisation pattern, the health care expenditure and the sources of finance, through gender perspective, according to the levels of development, as a whole. The test of hypotheses has enabled to assess the degree of dependence of the type of diseases, the demographic and socio-economic factors with the access to health care services, for both the gender, in different levels of development.

Chapter 9 finally focuses on the summary of the entire study and points out the inequalities existing between both the gender in the utilisation pattern of health care services which will bring out the final conclusion and essence of the whole research work.
SELECTED REFERENCES


