INTRODUCTION
CHAPTER 1

INTRODUCTION

Health is one of the important indicators that determine the nation’s level of development. Each country undergoes through a process of development and change, and health is an important part of this process. Health and medical care services can accelerate or retard the national development and some aspects of economic and social change can improve or detract from the health status of the population, e.g. health status of the people not only determines the life expectancy at birth, but it also considers the productive age and economic productivity, employment and earning capacity, which in turn have implications for economic and social well-being of the population at large. On the other hand, several economic variables like income, employment, purchasing power and poverty in turn determine the health status of the people. This is indeed is a vicious circle present in the developing economies (Rani Gopal, 1987). Hence investigation in health is vital for promoting human resource development and economic growth in a country.

1.1 CONCEPTUAL FRAMEWORK

The World Health Organisation (WHO) has 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’ (Srivastava and North, 1995). In general ‘health’ implies a sound mind in sound body, in a sound family, in a sound environment. However, the most widely accepted definition of health as given by WHO is “Health is a state of complete physical, mental, and social well being and not merely an absence of diseases” (Sharma, 2000). Moreover, the WHO in the preamble to its constitution has declared that “Governments have a responsibility for the health for
their people, which can be fulfilled only by a provision of adequate health and social measures”. Hence, in 1970, the World Health Assembly adopted a resolution to the effect that right to health is a fundamental human right. Thereafter, in 1977, the 30th World Health Assembly had decided to launch a movement known as ‘Health for All by 2000 A.D”. In 1978, the Alma Ata Conference reaffirmed that ‘Health for All’ is a basic human right and a worldwide social goal, that it is essential to the satisfaction of basic human needs and quality of life, and that it is to be attained by all the people.

The concept of “Health for All” embraces the following ideas (Asnani, 1988):

i. Everyone without exception has the right to health care

ii. Everyone without exception has the right of access to the different levels of complexity of the health system

iii. Everyone without exception has the right to live in a cultural, social, economic and physical environment, inherently conducive to health

iv. Everyone without exception has the right and duty to be an active and decisive partner in looking after his or her own health and that of the community

v. There must be a significant reduction in the enormous and disgraceful differences in the health levels of different population groups, both between countries and within countries

vi. There must be a significant reduction in the enormous and disgraceful differences in the way national societies allocate resources for the health care of their people

vii. To sum up, “health for all” a concept that incorporates a way of implementing a human right- the right to health- within principles of universality, equity and social justice.
Therefore, the World Health Assembly has called for the vigorous transformation of existing health care strategies in order to facilitate the attainment of “a level of health that will enable every individual to lead a socially and economically productive life” by the year 2000. In other words, as a minimum, all people in all countries should have at least such a level of health that they are capable of working productively and of participating actively in the social life of the community in which they live (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 RESEARCH PROBLEM

Since India was one of the signatories to these declarations, the Ministry of Health and Family Welfare, 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.

With time, the circumstances related to the health sector of the country have changed a lot since 1983. This has generated a situation, in which, it was necessary to review the present health status of the country and to formulate a new policy framework by the name of the National Health Policy- 2002 (NHP-2002). The NHP-2002 therefore has attempted to accelerate the achievements of public health goals in the socio-economic circumstances currently prevailing within the country. The main objective of this policy was to achieve an acceptable standard of good health amongst
the general population of the country. The approach aimed to increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions. Overriding importance was given to ensure a more equitable access to health services across the social and geographical expanse of the country, which would reduce the inequities and allow the disadvantaged sections of the society to enjoy a fairer access to public health services.

As India 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 many states of the country lag far behind the national average thereby revealing the prevalence of huge regional disparity regarding health conditions, within the country itself, even in this 21st century (Fig No. 1.1.1, 1.1.2, 1.1.3, 1.1.4). However, it is noteworthy to mention that West Bengal’s performance regarding health and demographic indicators had always been better than all-India aggregates (Table No. 1.1.1). The inter-state comparison puts West Bengal in a more favourable situation than most of the other states of India.

Apart from inter-state regional disparity regarding health and demographic variables, there exist marked disparities between groups within the regions in India, which make some sections of the population highly vulnerable. In addition to rural-urban divide, the caste, class and gender disparities in health persist, leading to a situation in which people in the same country live in entirely different worlds in terms of health (Dasgupta, M. et al., 1996).
Fig No. 1.1.1: Crude Birth Rate in India (2008)

Fig No. 1.1.2: Crude Death Rate in India (2008)

**Fig No. 1.1.3: Infant Mortality Rate in India (2008)**

**Fig No. 1.1.4: Total Fertility Rate in India (2005-06)**


Source: NFHS-3, India, 2005-06.
Table No. 1.1.1: 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)(^a)</td>
<td>17.5</td>
<td>22.8</td>
<td>7(^{th})</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)(^a)</td>
<td>6.2</td>
<td>7.4</td>
<td>8(^{th})</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)(^a)</td>
<td>35</td>
<td>53</td>
<td>9(^{th})</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)(^b)</td>
<td>2.27</td>
<td>2.68</td>
<td>11(^{th})</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. \(^a\)SRS Bulletin, October, 2008.
2. \(^b\) NFHS-3, India, 2005-06.

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

Therefore, the World Health Organisation (WHO) has begun a series of small studies looking at the women’s health status in the developing countries, as well as at the meaning and effect of illness on women’s lives through their care-giving roles. According to WHO, women generally bear a great burden with regard to illness because of their gender related roles. They seek care for themselves belatedly, cannot take time from their work roles for proper recuperation, and provide most of the care to others in their families (Stein, 1997). Hence, the Department of Gender and
Women’s Health, a wing of WHO, has taken several initiatives in order to increase the awareness of health professionals regarding the role of gender norms, values and inequality in perpetuating disease, disability, death and to promote societal change with a view to eliminate gender as a barrier to good health (Dalal and Ray, 2005).

Source: Census of India, 2001

**Fig No. 1.1.5: Sex Ratio in 2001**

In spite of all these efforts, the 2001 census shows that except for Kerala, the sex ratio in India is not in favour of females in any other states (Fig No. 1.1.5). In fact, many states in the country have sex ratio far below the national average. However, a comparative analysis between India and West Bengal shows that the state has slightly higher sex ratio than the national average. According to 2011 Census, the state-wise sex ratio of India has also shown a similar trend (Appendix I.i). Furthermore, Table No. 1.1.2 depicts that though the sex ratio of India has increased with time, but, the percentage increase has been only by 0.65 per cent in a decade, whereas, West Bengal has shown remarkable improvement in sex ratio with 1.86 per cent change over the same period. This implies that the average condition of women in the state of West
Bengal is comparatively better than the country at large. This is possible because of the successful implementation of several health initiatives adopted by the Government of West Bengal who have 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).

Table No. 1.1.2:    Decadal Change in Sex Ratio

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>927</td>
<td>933</td>
<td>0.65</td>
</tr>
<tr>
<td>West Bengal</td>
<td>917</td>
<td>934</td>
<td>1.86</td>
</tr>
</tbody>
</table>


However, apart from the implementation of various health programmes by the state government, the expansion and utilisation of health facilities is another important factor that determines the health status of the common mass. The adequate availability and effective use of health facilities will reduce mortality, morbidity and debility and thereby promote the welfare of the people of the state at large (Rani Gopal, 1987). Hence, access to adequate health facilities are very essential to promote the health conditions of the state as a whole. Since the Government of West Bengal is now committed to ensure accessible, equitable and quality health care services to both the rural and urban population of the state, it is expected that the health care facilities should be available to the common mass of West Bengal, 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 influence 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. 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:-

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

- 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.

- 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.

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

- 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.

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

- 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.

- The health care expenditure is primarily dependent upon the type of diseases and the type of health care services availed by both the gender.
- The mean medical expenditure incurred for the female patients is generally less than that of the male patients.
- Gender discrimination regarding the access to health care facilities in the study area varies with the levels of development.

1.5 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 (Fig No. 1.5.1). 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 (Fig No. 1.5.2).

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. The main reason behind the choice of the study area is the geographical position of these towns in the lower Gangetic Plain of
Fig No. 1.5.1: Location of the Study Area
THE SELECTED TOWNS IN THE STUDY AREA

Fig No. 1.5.2: The Selected Towns of the Study Area
West Bengal along the Hugli river. Being situated on the low-lying marshy area of 24 Parganas (North and South) and Hugli district, this area is affected by improper drainage conditions resulting in water-logging, unhygienic sanitation and inadequate solid waste disposal system and shortage of pure drinking water supply. Moreover smoke and wastes from increasing number of industries, vehicles, domestic and hospital wastes of the study area lead to environmental pollution to a great extent. All these result in serious adverse health impact on the common mass. Thus, when any area is prone to such ill-health conditions; the objective of the research work in terms of the access to the health care facilities can be best analyzed in this selected study area. Another reason behind such choice of the study area is the nearness of these towns to the city of Kolkata. All the selected three towns are well connected to the city of Kolkata, the dominant urban centre of the eastern region of India, both by the line of the Eastern Railways as well as roadways. Since Kolkata is well provided with all possible health care facilities, it is quite apt to expect that any place which is well connected to the city of Kolkata, will also be adequately served by better ‘access to health care facilities’ for all without showing any sort of ‘gender discrimination’.

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. It is situated on the main line of the southern section of the Eastern Railways of Sealdah Subdivision (South), about 25 Km south of Kolkata. Two lines, one up to Lakshmikantapur and another up to Damond Harbour branch off from the Baruipur junction. The municipality is also connected to Kolkata by the Kulpi road. According to the old Gazetteer, this town was situated “on the bank of the Adi Ganga, an old channel of the Ganges now almost entirely silted up” (De, 1994).
Kamarhati, a Class- I town in the Barrackpore subdivision of N-24 Parganas district, is situated on the east bank of the Hugli River, with the latitudinal extent of 22°38’59” N to 22°41’5” N and longitudinal extension of 88°21’45” E to 88°24’12” E. It is bounded on the north by the Panhiati municipality, on the west by the Hugli River, on the east by the North Dum-Dum municipality and on the south by the Baranagar municipality. The Barrackpore Trunk Road (B. T. Road), connecting Kolkata with Barrackpore, passes through this municipality in a clear north-south direction, separating the municipality in almost two halves. By road Kamarhati is only 12 kms away from Kolkata. The municipality is also served by the Eastern Bengal State Railways from the Sealdah subdivision by the distance of only 14 kms. The railway line takes a sharp bend towards left in the south eastern corner of the municipality and continues towards the Dankuni Junction via Dunlop Bridge and Vivekananda Bridge and acts as the southernmost boundary between Kamarhati Municipality and Baranagar Municipality.

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. Previously the town was confined between the river Hugli in east and the railway track on the west, but now it has crossed the railway boundary and has included Makhla (N.M.) within its municipal boundary from 9th August, 1991. At present the municipality is bounded by the Konnagar Municipality and Kanaipur Gram Panchayat on the north, River Hooghly on the east, Bally Municipality and Bally Canal on the south and the Raghunathpur Gram Panchayat on the west. The historically famous Grand Trunk Road (G.T Road) also known as NH-2 cuts through the municipality in a clear north-south direction. By road Uttarpara-Kotrung is only 11 kms away from Kolkata. The municipality is also served
by Eastern Railways from Howrah by the distance of only 10 kms. The main line passes through the municipality in north-south direction separating the city in two halves, Makhala in the western side and Uttarpara Kotrung and Bhadrakali in the eastern part.

1.6 DATABASE

This research study is primarily based on the empirical study conducted by the researcher in Baruipur, Kamarhati and Uttarpara-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, several secondary data has also been collected from following disparate sources:

1. Secondary data regarding the demographic structure, size of the population and associated information about the study area has been collected from the Primary Census Abstract, 2001, from the census office. Other related official records of different municipalities have been obtained from the respective Draft Development Plan collected from the respective regional planner of the Kolkata Urban Services for the Poor (KUSP) Department of the respective municipality offices. Other information regarding these three towns has also been obtained from the District Gazetteers as well as the District Statistical Handbooks of the concerned districts.

2. The administrative map of the Kolkata Metropolitan Area has been obtained from the office of the National Atlas and Thematic Mapping Organisation (NATMO) as well as has been downloaded from the official web page of Kolkata Metropolitan Development Authority (KMDA). The administrative maps of different towns namely Baruipur, Kamarhati and
Uttarpara-Kotrung have been obtained from the respective municipality offices.

3. Other relevant information required for the theoretical and conceptual framework of the study are obtained from the endless literary works available from different libraries viz. the Kolkata Metropolitan Development Authority library and Institute of Local Government and Urban Studies (ILGUS) at Salt Lake, Centre for Urban Economic Studies at Alipore, Centre for Studies in Social Sciences at Baishnabghata-Patuli, Bureau of Applied Economics and Statistics at New Secretariat Building, All India Institute of Hygiene and Public Health (AIHPH) at C. R. Avenue and last but not the least the National Library at Alipore.

1.7 METHODOLOGY

The entire research work is based on the empirical study which has been diagrammatically shown in the Fig. No. 1.7.1.

At the beginning intensive 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.

After the selection of study area, an intensive secondary data work has been done by obtaining information from disparate sources, so as to have a clear view of the geographical set up of the study area. It deals with the physical, social, economic, demographic and cultural settings as well as the environmental conditions of the study area, in great details. Thereafter, in order to analyse the basic objectives of the study, an empirical study is essential. In fact the whole analysis of the study is mainly based
on the primary survey conducted in the three towns namely Baruipur, Kamarhati and Uttarpura-Kotrung. But since the resources and time span is limited, all the wards of these three selected towns could not be surveyed. Thus, for the selection of the wards, three indicators namely sex-ratio, literacy rate and work participation rate has been chosen for all the wards of these three towns. The reasons behind such choices are as follows:-

- Sex ratio is one of the most significant socio-demographic indicators that help in estimating the nature of population structure often apprehending gender biasness over the study area.

- Literacy rate is another important factor that increases mass awareness among the population regarding access to health care services as well as to avoid any sort of discrimination against the female population.
Percentage share of working force within the population ensures the economic status and income of the household which has again a relevant importance in determining any discrimination against the female population in terms of allocation of health care facilities.

Table No. 1.7.1: Categorization of the Wards of the Selected Towns
According to the Levels of Development

<table>
<thead>
<tr>
<th>Category (Values of Composite Score)</th>
<th>Name of the Selected Towns of Kolkata Metropolitan Area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baripur</td>
</tr>
<tr>
<td>High (&gt; +1)</td>
<td>Ward No: 1, 2, 3, 4, 12, 13, 14</td>
</tr>
<tr>
<td>Medium (0 to +1)</td>
<td>Ward No: 7, 15, 16</td>
</tr>
<tr>
<td>Low (&lt; 0)</td>
<td>Ward No: 5, 6, 8, 9, 10, 11, 17</td>
</tr>
</tbody>
</table>

Source: Computed by the Researcher on the basis of 2001 Census data.
Ward Numbers in bold indicate sample Wards.

Scaling of all these three indicators has been done by standardisation method and all of them have been given equal weightage because of their equal relevance in the study. Then the composite score [Appendix I.ii (a,b,c)] of each ward of the selected towns has been computed and the wards of all three towns have been categorized under three heads namely High, Medium and Low as shown in Table No. 1.7.1.

After the categorization of these wards, one ward from each category from each town has been chosen, if at least one hospital or nursing home is located within that ward boundary e.g. Sevathirtham and Globe Nursing Home in Ward No 3 (High Category), Baripur Sub-division Hospital in Ward No 15 (Medium Category) and New Life Nursing Home and New Baripur Nursing Home in Ward No 11 (Low Category).
Fig No. 1.7.2: Categorisation of the Wards of Baruipur Municipality According to the Levels of Development
Fig No. 1.7.3: Categorisation of the Wards of Kamarhati Municipality
According to the Levels of Development
Fig No. 1.7.4: Categorisation of the Wards of Uttapara-Kotrung Municipality According to the Levels of Development
Plate No. 1.7.1:
Globe Nursing Home in Ward No 3 (High Category) of Baruipur Municipality

Plate No. 1.7.2:
Baruipur Sub-Division Hospital in Ward No 15 (Medium Category) in Baruipur Municipality
Plate No. 1.7.3:
Dr. B. C. Roy Seva Sadan in Ward No 10 (High Category) of Kamarhati Municipality

Plate No. 1.7.4:
Sagar Dutta State General Hospital in Ward No 5 (Low Category) in Kamarhati Municipality
Plate No. 1.7.5:
The Care Nursing Home in Ward No 15 (High Category) in Uttarpara-Kotrung Municipality

Plate No. 1.7.6:
Uttarpara State General Hospital in Ward No 19 (Low Category) in Uttarpara-Kotrung Municipality
Category) of Baruipur Municipality. Similarly, in Kamarhati Municipality, Dr. B. C. Roy Seva Sadan in Ward No 10 (High Category), New Panasea Nursing Home in Ward No 14 (Medium Category) and Sagar Dutta State General Hospital and E.S.I. Hospital in Ward No 5 (Low Category). Likewise, in Uttarpara-Kotrung Municipality, Shyamoli Care Nursing Home in Ward No 15 (High Category), Neelima Matrisadan in Ward No 17 (Medium Category) and Uttarpara State General Hospital and Arogya Niketan Private Nursing Home in Ward No 19 (Low Category).

Table No. 1.7.2: Sample Size of the Selected Wards of the Study Area

<table>
<thead>
<tr>
<th>SELECTED TOWNS</th>
<th>SELECTED WARDS FOR SURVEY</th>
<th>NUMBER OF HOUSEHOLDS PRESENT (2001 Census)</th>
<th>SURVEYED HOUSEHOLDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baruipur</td>
<td>3 (High Category)</td>
<td>540</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>15 (Medium Category)</td>
<td>428</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>11 (Low Category)</td>
<td>457</td>
<td>45</td>
</tr>
<tr>
<td>Kamarhati</td>
<td>10 (High Category)</td>
<td>2040</td>
<td>102</td>
</tr>
<tr>
<td></td>
<td>14 (Medium Category)</td>
<td>1512</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td>5 (Low Category)</td>
<td>1565</td>
<td>78</td>
</tr>
<tr>
<td>Uttarpara-Kotrung</td>
<td>15 (High Category)</td>
<td>1305</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>17 (Medium Category)</td>
<td>1471</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>19 (Low Category)</td>
<td>1613</td>
<td>80</td>
</tr>
<tr>
<td>TOTAL (Nos.)</td>
<td></td>
<td>10931</td>
<td>617</td>
</tr>
</tbody>
</table>

Source: Compiled by the Researcher

Then primary data has been obtained through intensive field survey in these selected wards of the three municipality towns. For the purpose of the collection of the information, a structured questionnaire has been designed to meet the objectives of the research work. The method of simple random sampling technique has been opted taking five to ten per cent of the total number of the census households (2001) in the selected wards of the three municipality towns. The ward-wise details regarding the sample size of the surveyed households of the study area has been given in Table.
No. 1.7.2. As a whole, a sample size of total six hundred and seventeen (617) households has been covered during the survey period of 2009-2010.

After each round of fieldwork, the filled up interview schedule has been checked thoroughly and coded for electronic data processing and subsequently converted to Statistical Package for Social Sciences (SPSS) system for tabulation and data analysis. First frequency counts for all the variables have been listed. Cross tables of the main study variables with selected dependent variables have been prepared to find out the results of the study. The tabulated data have been quantified, analysed, discussed and synthesized by using different cartographic techniques, suitable statistical methods e.g. chi-square and visual aids like photographic records, along with the critical appreciation of pertinent literature in order to draw certain conclusions from it.

1.8 LIMITATIONS OF THE STUDY

In India survey methods have several limitations. The very nature of the survey method is mechanistic and thereby prone to approximation on the part of the respondents and ‘taken for granted’ and ‘assumptions’ attitude among the interviewers. This is something very difficult to evaluate but one knows it happens (Duggal, 1989).

Theoretically, the eldest member of the house is generally considered to be the head of the household and the final decision maker of any household issues. But in reality, the main earner of the household and his or her spouse happens to be the ultimate decision makers within the household. Therefore, it is quite difficult for the surveyor to decide whom to consider as the real head of the household. Now, even if the main earner of the household and his or her spouse is taken to be the real head of the family, then both of them are preferred to be taken together at the time of
interview since they are the decision makers, more so the men. But in reality, this is not possible because most of the bread earners of the family are not available in the home during daytime. In such cases, it must be assured, to a large extent that at least one of them must become the main respondent.

Other than this, recording the right income is a real challenge for the surveyor. This is because, though, the wage earners and most salaried employees give more or less an accurate estimate of their income but those having income through business or self-employment poses a major problem as they give a rough approximation of their income. This may make the study quite distorted as the income distribution gets skewed. But this is very important because access to the type of health care services is related to the households’ economic status to a great extent.

Furthermore, it is quite difficult for a single respondent to recall and report the health care expenditure amount incurred for any member of the family and thus they often provide with the rough approximation of the actual expenditure. Sometimes the surveyor has to assume certain amount rather than collecting the exact figure. In either situation the study may become distorted. So, in order to avoid these difficulties, it is better to interact with the ill person directly, which is again not always possible.

Moreover, it is a well known fact that the interviewees of the urban areas do not take keen interest in surveys which are generally meant for academic purposes, since they are not benefitted from these types of studies, in any way whatsoever. Thus, in most cases, they are often reluctant to respond to the questions of the surveyor and hence, it becomes quite difficult for the surveyor to collect the information accurately from the individual households because of their non-responding attitude or ignorance.
Last, but not the least, another difficulty which is mostly faced by the surveyor is the non-co-operative attitude of the clerk of the various offices. Apart from a very few exceptional cases, most of them often want to avoid the surveyor by giving lame excuses and as a result full information or complete data set is often not available to the surveyor.

However, all these methodological difficulties are obvious for any field survey but as far as possible such limitations have been avoided. Since it is basically a generalized study of the area rather than any theorization, these methodological drawbacks will not affect the study to a large extent. Hence the result will not be distorted or biased by any means whatsoever.

Moreover, though Census 2011 has been enumerated but the ward level data has not yet been published and so it was not possible to update the data for all parameters. But still attempt has been made to collect the recent details as far as feasible, with utmost sincerity.

1.9 ORGANISATION OF CHAPTERS

The entire work has been systematically arranged in nine chapters which are organised in the following sequential order:-

The first introductory chapter throws light on the importance of the role of health in determining the nation’s future. It stresses 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.

In the second chapter, critical review of the literature has been done. The review provides an insight into the field of study through theoretical and empirical
framework. It is also essential as it points out the gaps of the earlier studies and shows the direction of the progress of this present research work. 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 the third chapter, the general profile of the study area has been discussed. This chapter mainly 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. This is very important for assessing the major objectives of this research work because civic amenities often play a vital role in maintaining the quality of life as well as the health and hygiene of the inhabitants of the urban areas. Moreover, the demographic status of any area reflects the health conditions of the area in disguise while socio-economic aspects are seen as responsible determinants that influence the access to health care services and their utilization pattern, for both the gender.

The next chapter is centred specifically on the health ailments and health action prevalent in the selected wards of the three towns, through gender lens. Here onwards, the analysis has been done on the basis of primary data obtained from the field survey.

The fifth chapter mainly highlights on the type of health care services availed by both male and female patients of the selected wards of the three towns. It also discusses about the type of treatment availed by the distance, for both the gender, in the study area. This chapter mainly focuses on the practice of gender discrimination in the access to health care services.
The sixth chapter 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 wards of the three towns.

The next chapter 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.

In the eighth chapter, the health care utilisation pattern, the health care expenditure and the sources of finance have been analysed 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.

Finally, the concluding chapter reviews the whole findings and focuses on the summary of the entire study. Further, this chapter points out the inequalities existing between both the gender in the utilisation pattern of health care services. Here, a few suggestions have been put forward in order to awaken the society to bring forth gender equity in access to health care services.

REFERENCES


