INTRODUCTION

India is witnessing rapid urbanisation. The total urban population has increased from 28.6 million to 37.7 million during the period from 2001 to 2011 whereas, the rural population increased from 74.3 million to 83.3 million during this period. However absolute increase in urban population is 9.1 million which is one million more than increase in the rural population. It is for the first time in history of India that absolute increase in urban population has been more than the rural population. The annual growth rate of urban population is 3.2 percent per annum during 2001-2011. The number of census towns have also increased from 1362 to 3894 which is addition of 2532 (Government of India, 2011:NP). The distribution of population varies across different cities. There are three 10 million plus cities which are called Mega cities that includes Mumbai, Kolkata and New Delhi. There are 53 million plus cities out of which two are located in Punjab one Ludhiana and Amritsar having population of 1,613,878 and 1,132,761 respectively based on census 2011 and they constitute 26.7 percent of the total urban population of Punjab. Thus key feature of urbanisation in the state is the emergence of these million plus cities indicating Metropolitisation of Punjab.

The process of urbanisation tends to pick up with rapid economic growth which is projected at 5.6 percent for 2014. Thus these growth figures related to process of urbanisation indicate that it will have profound stress on the urban infrastructure on which Indian government spends US$ 17 per year (Anonymous, 2010:NP). The metropolitization drive will lead to increased demand for basic services that include water supply, sewerage, sanitation, solid waste management which are awe fully inadequate and deficient in service delivery. The population of slum dwellers in India is 104.7 million as per 2009 figures which constitutes 29.4 percent of the total population. (UN 2012, Nandi & Ghamkar, 2013:60). The inadequacies of basic services affect the poor slum dwellers more as they forced to live in unsanitary living conditions. It enhances slum dwellers vulnerability to fall sick. The problem is accentuated because primary health care system is ill-equipped to meet their needs. The number of doctors available per thousand population as per Ministry of Health and family welfare,
government of India is 0.5 per 1000 population in India which is below W.H.O benchmarks of 1:1000. The Ministry has set targets to meet the W.H.O standards by 2031. The national scenario withstanding there are differences at regional as well the state level in terms of number of physicians serving. There is skewed ratio for serving the urban and the rural the differences which are more glaring between slum and non-slum population. This brings in plethora of issues relating to personal health of slum dwellers in particular and public health in general.

The issues which have become relevant in view of rapid socio-economic and demographic changes tackling urbanisation has become formidable task where public health is the key problem. For building better India and to overcome the challenges of providing shelter and healthcare has become essential. The campaign by Prime minister of India Narinder Modi for cleanliness and sanitation proves that Swachta hai to Sehat Hai. Thus there is a need for examining the complex relationship between urbanisation and health in a comprehensive manner as both have emerged important elements within the development agenda pursued by nations across the globe. The fast pace at which urbanisation is occurring has impact on urban environment which directly or indirectly affects the human health. The impact is felt greater by those who are living in slums as they do not have access to basic necessities of life. This in turn has multiplier effect of creating poor neighbourhoods which led to poor health and well-being thereby affecting life chances of individuals. In this regard it is appropriate to examine health of urban slum dwellers within emerging metropolitan city of Amritsar.

1.1 OVERVIEW OF URBANISATION

Urbanisation stands for increase in urban population over the total population in demographic manner. Urbanisation is also defined as a process of change in terms of values, attitudes and styles of those who migrate into cities and their impact on individuals left in the villages. The process of urbanisation has been centuries old but its impact has been more profound in the last two hundred years. The process of urbanisation has facilitated change in social reality by restructuring the existing ones and at times creating new problems (D’souza, 2003:51). In the 21st century the cities have emerged as major centres of demographic and economic transition accompanied
by challenges of sustainability. At present more than 3.4 billion people inhabit towns and cities across the world and it is assumed that by 2050 they will be 6.4 billion. At this juncture urbanisation is more pronounced in Asia and Africa followed by Latin America. There are glaring differences in the level and pattern of urbanisation between and within countries. The urbanisation in regions of Asia and Africa is accompanied by urban growth rather than urban development which happened in developed countries (Martine et al., 2008:1-7). It is estimated that at the global level urban population will grow by about 1.5 per cent from 2025 and 2030. At this point both Asia and Africa are least urbanized having 42 per cent and 40 per cent urban population respectively. However it is estimated that by 2050 the urban population will be 65 per cent in Asia and 62 per cent in Africa. The likely scenario is that in future out of every ten urban inhabitants seven will be in Asia and Africa (UN Habitat, 2012:4-5). In Asian cities the percentage of total population classified as urban is generally low and the normal rate of population increase is high which means that growth of the urban population as a percentage of the total population is not in tune with overall However, the pace of urbanisation is faster than the rate of industrialisation which creates problems in context of Asian cities (Narain, 2003:75-76). The urbanisation discourse has been occupied by the concept of the Meta and Mega cities. The earlier concept of, Meta cities referring to 20 million plus cities such as Tokyo which has 35 million residents equal to population of Canada. The later concept focusing on, Mega cities which have more than 10 million urban residents at World level. This includes Asian cities like New Delhi, Mumbai, Shanghai, Beijing which being large in size has become center of economic and commercial activity and has emerged as zones of affluence playing active role in liberalisation process of nations. At world level the number of Mega cities is twenty two (22) and they constitute nine per cent of the world’s population. However, they are unlikely to absorb the rapid growth of population in the coming years. In fact it is growing number of million plus cities along with rapidly emerging cities which are absorbing greater number of population thus becomes the centre to urban growth. According to World Habitat Report 2012 half of urban population of the world lives in Asia. This region accounts for 65 per cent of demographic expansion in this century.
The cities in Asia are having larger concentration of population in their cities (UN Habitat, 2012:28). As a result they are faced with the problem of scarce resources for growing numbers which further results in jeopardizing health care services along with the inadequacy of housing, lack of piped water supply, sanitation and waste collections. All these factors have a bearing on the overall health of the city residents (Martine et al., 2008:4-7). These concerns do find reference in United Nations Development Report of 1999 where it is assumed that urbanisation would bring economic gains which would have profound impact on the lives of individuals in relation to their health outcomes. However, contrary to was assumed the people living in developing countries face inequalities which are detrimental to the overall quality of life in terms of medical care, health seeking opportunities and basic environmental standards.

Thus we are witness to the process of Urbanisation of poverty where cities are expanding exponentially but the basic provisions are eroding, thus affecting urban dwellers accessibility to the basic necessities of life. The disparity is growing in the urban areas at a fast rate which is manifested by emergence of distressed neighborhoods. The slums are places where real manifestation of poverty and deprivation are felt by the residents in terms of crumbling infrastructure. People living in the slums are exposed to risks associated with the urban environment. There is huge gap between supply and demand with regard to the basic health care services. Over a period of time the problems associated with habitat have been raised by United Nations reiterating its aim of development for all. It has been expected that the world population will rise to nine billion by 2050, out of which six billion will be residing in urban areas. Within this six billion population three billion will reside in slums for this very reason various thematic issues have been discussed at international summits. The summit related to children held in the year 1990 highlighted the plight of children which comprise 50 percent of country’s population suffering from malnutrition, inadequate access to safe water, sanitation, homelessness etc. The United Nations conference on environment and development forwarded Agenda 21 “dealing with issues such as accessibility to basic social services, issues related to poverty which has bearing on women, creating viable mechanisms to empower poor people”. Similarly world
conference on human rights highlighted how risks created by unhealthy urban backgrounds posed threat to people living in slums. The United Nations conference on Human settlements Habitat-II which took place in Istanbul in June 1996 emphasised how quality of life could be ensured by improving health care and reproductive health. It also identified vulnerable groups of society should to be kept in mind while framing policies. Within urban populations there has been shift in the incidence of diseases from communicable to non-communicable ones. However some problems still persist especially in case of children. The slum dwellers bear brunt of the diseases. The situation becomes grim for slum dwellers due to inequalities in distribution of resources within a city (UN Habitat, 2008:106).

Studies bring out that there are greater urban intra differences among different groups in terms of nutritional status. The issue of socio economic status, environmental factors and accessibility are the key factors which serve as constraints for the urban poor (Ibid: 109). The issue of inequity brings into focus how institutionalized mechanisms in terms of governance, urban management and empowerment are vital for urban health.

Health problems are also resulting in social problems like urban violence. It has been stated that severe mental diseases due to poverty and lack of support systems that increases the chances of individual committing violent act (UN Habitat, 2008:220-225). The State of the world cities also takes into consideration the issue of inequality and its impact on health, nutrition, gender equality and education. The report expresses its concern on every third person in the world living in slums. However not everyone living in slum is poor. In India 45 percent of the households live in slums however the number of poor are on the higher side i.e. 49 percent (UN Habitat, 2008-9:112-114). The global report on human settlements entitled Challenges of slums states that failure of governance in relation to framing of urban policies, housing, law, delivery system related to basic services in relation to poverty are factors which promote emergence of slums. Thus urban poor fail to access formal institutions because of living in areas which are unauthorized hence are denied appropriate life chances due to poverty or class based inequalities. Concerns with this kind of urbanisation led to setting of Millennium Development Goals by United Nations. There are eight Millennium
Development Goals, with priority on reducing child mortality, improving maternal health, combating HIV and AIDS, malaria and other diseases. The goal of eradication of extreme poverty and hunger is aimed at improved health as poor health is both the cause and result of poverty and hunger. Similarly the goal of ensuring environmental sustainability is linked to improving accessibility to safe water, so as to prevent breakout of water borne diseases. Around one third of the urban population at world level is forced to live in the slums. Those living below poverty line are 828 million (UN Habitat, 2012:8-10).

The Millennium development goals emphasize on improving the lives of at least 100 million slum dwellers under goal seventh where issue of accessibility to safe drinking water and proper sanitation facilities are underlined. The issue of poverty, hunger, maternal and child mortality and combating diseases are highlighted in first, fourth and fifth and sixth goals respectively (UN Habitat, 2003:7-9) (Bajpai, 2003:3-5). The health care system should have clinical and public health interventions along with community based primary care so as to achieve better health results. It is important to have interventions placed on behavioral front for having safety along health parameters (Jailly, 1999:352).

The World Health Organization (W.H.O) has also expressed concerns about health issues. As a result health issues have become part of heated debate among different stake holders such as state, its institutions, policy makers, professionals, citizens and academicians. The report published in 2000 had the objective of improving the health system with emphasis on of fairness, responsive to individual needs and ensuring good health. They were dependent on three factors namely, service provision, resource generation, government financing for appropriate delivery of health care. Similarly the 2008 W.H.O Report entitled Primary Health Care –Now More than Ever, highlights how primary health is important component of health care. However, even after three decades Alma-Ata declaration has not been fully implemented. The essence of this report has been to provide common health across nations by focusing on universal coverage, service delivery, and public policy and leadership reforms so as to provide health for all. All this has not been achieved.
According to the Report by the French Government *Commission on the Measurement of Economic Performance and Social Progress* (2009), quality of life constitutes an important attribute which gives “life its value” for Amartya Sen the available opportunities help individuals in gaining freedom which is essential for ensuring quality of life. The capability approach emerges due to freedom of choice availed by residents at political, social and economic levels along with the issue of transparency and security. At the same time it helps in overcoming primitive issues related to development. Therefore quality of life has evolved into wider concept which encompasses health, education, housing, income employment along with the freedom to work.

The governments use this as an indicator to ensure the proper functioning of cities which also gets reflected in various policy documents. For the residents of 75 cities in Europe three factors determine quality of life. The foremost being availability and quality of health services, followed by educational facilities which facilitate job creation hence reducing unemployment. It has been stated by the experts that technological cities of South India such as Bangalore receive water for just two to three hours which speaks about the enormity of the problem and the situation in which residents’ live. No South Asian city can supply water to its residents 24/7. Often these shortages occur due to inefficient handling by local administration and prevailing local conditions of water resources which are dependent on level of precipitation as well as existing ground water tables (UN Habitat, 2012:50-51). Thus the increased population in cities find infrastructure in shambles, whether it is water supply, roads, bridges drainage all are unable to sustain growing population pressures hence affecting the quality of life of large number of urban residents.

As a result, the governments in developing countries fail to figure out how quality of life has to be defined and delivered in policy outcomes. Some experts are of the opinion that the rewards of development should be equally distributed by ensuring both equity and quality of life (UN Habitat, 2012:5). Thus issues of urban poverty and slums depict the poor living conditions which have impact on health of urban poor. These issues are not being adequately addressed through the decision making process.
The lofty ideas fail to provide blue print necessary for their implementation. In India prosperous cities are yet to emerge as they are confronted with problems of infrastructure and delivery of basic services. The degree and dimensions of problem vary from place to place (UN Habitat, 2012:10-15). Thus with the advent of urbanisation health care services are under stress due to increase in population. Over a period of time the number of health institutions has not increased in the same proportion as growth of urban population has occurred. This often leads to situation where people face lack of access to health care services and this becomes more profound in case of those who are living in slums. Slum dwellers are the ones who not only suffer from adverse health conditions but also face problem of timely access to health care. Thus slum dwellers fate is even worse than those faced by the rural people (Aggarwal, 2007:125). We can therefore arrive at conclusion that health is an important component of social development as healthy bodies and minds would be a yardstick to measure overall progress in society. Thus health is an important attribute for overall growth of individuals (Mehta, 1992:124).

1.2 OVERVIEW OF HEALTH

There are different interpretations of health: Biomedical approach rests upon the germ theory of disease (Koch’s) whereby health is defined as the complete absence of disease. The disease is conceived as a pathological state of the body (Bernard’s conception) whereby it affects the structure and functioning of the body. The disease is manifested through certain signs and symptoms associated with illness which requires to be treated by drugs. This approach facilitated the growth of the contemporary medical system which is based on mechanistic and an individualistic model where technological solutions are offered as a solution to illness (Bolaria, 1994:68, Mathew, 2011:388)

On the other hand there is an ecological approach which tries to explore the relationship between the individual and its living environment. Any maladjustment between the two often leads to outbreaks of disease. This approach is exemplified with the scope of public health where solutions for illness are looking outside the human body. The other two approaches looked at psychological input where health body
relationship is explored in relation to healthy mind (Akram& Advani, 2007:3). The social cultural approach, which falls within the domain of social anthropology analyses health as social cultural context which evolves over a period of time. This emerges due to regular interaction at individual and collective levels as how health and illness are defined as social trajectories based on narrations which are contested and reorganized (Smelser & Balles, 2001:6495). Thus health is multi-dimensional construct involving state of complete physical, mental and social well-being and not mere absence of disease as advocated by world health organisation.

The health system includes all those activities which aim at promoting, restoring and maintaining health. In order to meet these requirements a formal health delivery system is must with supporting medical personnel, economic resources along with requisite institutional build up. Health care services are thus one of the necessary components which constitute welfare functions of the state. Hence the state willingness to make a commitment and make efforts to resolve health issues is the most important aspect (World Health Organisation, 2008:5-6).

The delivery of health care services is based on overall conditioning of social institutions. The functioning of social institution’s further depends upon financial, administrative and planning outlays as determined by the State. Thus the decision making process along with political ideology do determine the nature of health care system. The present structure of the health care system in India has evolved over the past 200 years under the British influence where the biomedical system based on western medicine was given preference over the indigenous health system (Chauhan et al., 1997:40).

Health care services include prevention and curative services along with rehabilitative aspects to treat illness and offer cure for diseases. The preventive care services includes immunisation schedules which are administered to children and individuals against various diseases which are infectious in nature. The curative services are largely offered by hospitals and dispensaries after the onset of illness. However it is curative orientation which dominates the existing health scenario both in public and private sector. The working of health care facilities is managed by health professionals.
of varying hierarchies having appropriate qualifications which are mostly concentrated in urban areas. Thus there is a need for well-established and functional health system to serve the health needs of the society.

The individual usage of these health services is based on preference and trust in the health system. The issue of efficiency, transparency and availability of health services is determined by the political economy of health care. Thus the provision of health care services can be measured along utilisation pattern by keeping above mentioned factors into account (Ibid.:40-44). Cities as base provides individuals with necessary goods and services, in sufficient quantities so that material deprivation should not be faced by those who are underprivileged and forced to live in slums.

1.3 URBANISATION AND HEALTH SCENARIO IN INDIA

In case of India urbanisation needs to be understood in specific context and historicity. (Sharma, 2007:123). A large number of people that is 377 million which is 31.16 percent of the total population of India lives in urban areas. There are about 468 class I towns in comparison to 394 in 2001. The level of urbanisation has increased from 27.81 percent in 2001 to 31.16 percent in 2011 as per census figures. About 160.7 million Persons (42.6 percent of the urban population) lives in Million Plus UAs/Cities. In all 18 new UAs/Towns have been added since 2001 Census (Government of India, 2011: NP). The decadal growth of population has been 13.73 million persons. The increase in case of urbanisation has been to the tune of 25.72 million from a previous decade of 2001 (Government of India, 2012:35-59).

As per the National Urban Housing and Habitat Policy 2007 about 23 per cent of the urban population is living in slums which may be as high as 55 per cent in big metropolitan cities like Mumbai (GOI., 2007:7). The latest slum statistics released by Government of India on September 3, 2010, projected that slum population to rise to 93.06 million by 2011 (Zee news.: NP). It has been observed that slum population varies across states this being 41 per cent in Meghalaya to about 2 per cent in Kerala the national average is around 23 per cent. The percentage of slum population in Punjab is 20.38 per cent (Toor et al., 2013:50-54).
In order to overcome these problems we have to devise proper social development initiatives in real sense (Sandhu et al., 2001:91). Therefore, human development emerges as an important concept which needs to be put into practice within the planning discourse, both at the national level and the international levels. Human Development has been defined by UNDP “as enlarging people’s choices so that they could lead healthier life and thereby enjoy respectable standard of living. This also encompasses political freedom, guaranteed human rights and self-respect” (Human Development Report India, 2002). Amartya Sen has advocated the capabilities approach which underlies freedom of choices which the individual can enjoy and not merely wealth. For this reason Amartya Sen stresses upon three aspects of human existence: health, food and education. This approach has been part and parcel of Development literature since 90’s (Bajpai, 2003:3-10).

The Indian State just spends 0.25 per cent of GDP on urban infrastructure. As a result of it overall scenario is dismissal as 40 per cent of the households do not have piped water connections. The water is supplied on an average for three hours only. Other facilities which are available are also of questionable nature as 55 per cent of households have accessibility to electricity. To that matter sanitation facilities fall between 50-70 per cent and shelter is available to 80 per cent households (Samuel, 2010:3). Similar findings are observed in a study undertaken by centennial group in 2009 which states that physical infrastructure in terms of road paved is 47 per cent, access to sanitation is around 28 per cent whereas improved water source is available to 89 per cent of the households (Kohli, 2010:135). Similar scenario is depicted with regard to slums as it has been pinpointed in NSSO 2010 which states that 78 per cent of the notified slums are having roads within the slum which are *Pucca* whereas 92 per cent of the notified slums are having an approach road which leads to their respective slums. The proportion of slums having underground drainage or covered drainage system constructed with *Pucca* materials is 39 per cent in notified slums. The share of slums having open drainage facility is 50 per cent and those without any drainage are merely 10 per cent in the year 2008-09. Similarly the proportion of slums not having any latrine facility is 10 per cent in 2008-09 in notified slums and whereas about 20 per cent lack latrine facility in non-notified slums. At all India level 16 percent of the slums have no
system of garbage disposal in 2008-09 out of this 10 per cent are notified and rest 90 per cent of them are non-notified slums. In about 75 per cent of the notified slum garbage is being collected by government agencies. Almost 92 to 93 per cent of slums dwellers states that one in seven days collection of garbage takes place (NSSO, 2010:19-25). This are often reflected in growing differences between rich and poorer sections of the urban population. The increasing pollution levels have an adverse effect on the health of individuals. Urbanisation has made the life of individual comfortable but has been compromised at the altar of health (Challa, 2013:77).

The poor people are thus forced to live in slum like conditions which are permanent features of any growing city in the world (UN Habitat, 2012:9). We need to ponder over how conventional sanitation and environmental health agenda are affected by the processes of urbanisation. The unsanitary conditions, accumulation of solid waste affect the immediate environment especially of low income groups as in case of slum dwellers. The slum dwellers are at receiving end in terms of unsanitary conditions and crowded environment.

But in addition to that they are likely to suffer accessibility issues with regard to urban services which range from solid waste removal, water supply, sanitation etc. One of the remarkable issues which often lie dormant in field studies is that of tenure rights with regard to property on which they are living. According to the NSSO 2010 report reveals that 24 per cent of all slums were located along nallahs and drains and 12 percent along railway lines. Twenty two per cent of slums were located on the fringe or border area of towns and 78 per cent in other areas (Sharma et al., 2012:62). Hence the poor slum dwellers remain vulnerable when any crisis affects their lives especially related to their overall well-being. This is due to the fact as they have low human capital formation along with lack of supporting mechanisms. Thus, slum dwellers are likely to fall in the trap of poverty as debt rises due to frequent episodes of illness (Chauhan et al., 1997:40).

The picture of the health and population performance in India has been dismal one. At present juncture Infant Mortality Rate (IMR) has declined by three points from 47 to 44 infant deaths per 1000 live births during 2011. IMR for rural areas has
followed a similar trend that of dropping by 3 points from 51 to 48 infant deaths per 1000 live births. In fact the urban rate stood at 29 in comparison to that of 31/1000 earlier. The states like Goa and Manipur have recorded IMR of 11 infant deaths whereas in Kerala it was 12 infant deaths per 1000 live births (Government of India, 2011: NP). Hence, one has to agree with Amartya Sen approach which opines that three issues really affect poor, one of survival, the other being daily living and third one sense of dignity. These insecurities of the poor emerge because of facing deprivation while interacting with social and economic institutions like hospitals. All these issues get translated further at helm of political level in the form of basic political and civil rights (Nayyar, 2007:121).Therefore, it is important to inquire as, how these figure translates into ground reality which need to be examined in relation to urban basic services which are not in tune with the pace of urbanisation as gross regional differences can be observed with regard to India.

1.4 URBANISATION AND HEALTH SCENARIO IN PUNJAB

While, moving from macro to the meso level we can visualize the case of Punjab, both at urbanisation front and basic health care. This State has been at the forefront of Green Revolution, its populace has linkage with national and international level because of migrations abroad and outside state. Its development has been largely Agro- based or commercial and is one of the most urbanized. As per 2011 census the total state population is 27.7 million out of which 17.3 million is rural whereas 10.3 million is urban population. The rural population is 62.51 percent of the total population and urban population is about 37.49 per cent of the total population. The density of population is about 550 person’s per. sq. km. (Government of Punjab, 2011:3).

The analysis of the trends with regard to urbanisation in 2001 reveals that an upward trend is witnessed with regard to level of urbanisation in cities like Ludhiana (55.80), Jalandhar (47.45), Amritsar (40.00), and Patiala (34.98) respectively. Whereas in 2011 (59.14) of urban residents live in Ludhiana, followed by SAS Nagar (55.17) Amritsar (53.64), Jalandhar (53.18) Tarn Taran (15.7) is least urbanised thus every fifth urban dweller in Punjab is living in Ludhiana. (Business Standard India, 2011: NP).
However As per 2011 census, the growth rate of urban population in Punjab is 25.9 for state as a whole higher growth rate in urban population was witnessed in SAS Nagar (90.2), Bhatinda (41.9), Patiala (31.7), Sri Muktsar Sahib (27.0) Tarn Taran (26.1), Firozpur (22.6), Ludhiana (22.2) and Amritsar (20.1). Thus two million plus cities of Punjab witnessed less than state average growth rate of urban population in 2011 (Anonymous, 2013:NP).

As per statistical abstract of Punjab 2011 the number of medical institutions in the State are as follows: hospitals 91, CHCs 130, PHCs 444 Dispensaries 1412, Unani 529 Homeopathic 111. The number of beds installed in allopathic institutions are 21504 (Government of Punjab, 2011:7). The number of health institutions serving the urban population of Amritsar city is 20 in numbers. Out of which 6 are hospitals, 1 CHC, 6 PHC and 7 dispensaries. There are 3 specialist hospital and 3 specialist dispensaries this totals to 6. Amritsar city is serving not only Amritsar population but also population from nearby hinterland (Government of Punjab, 2011:402-403).

The percent of institutionalised deliveries in urban Punjab have been 72.3 whereas deliveries carried at home have been 27.4 out of which 11.2 per cent were done by skilled birth attendants (SBA). Thus safe deliveries have been 83.5 per cent. The women who received post natal care within two weeks of delivery numbered 84.4 per cent. About 1.9 per cent of women received financial assistance under Jannani Suraksha Yojana (JSY) (DLHS 2007-2008). As per Punjab Human Development Report 2004 the patients seeking treatment for health care prefer private facilities rather than government be it in urban or rural. The system has been there but only one out of twenty patients seeking out -patient care visits the governmental institutions. The reasons for this dismissal scenario have been poor referral system and lack of monitoring by health authorities in the overall functioning of PHCs (Government of Punjab 2004:77).

The state government on its part accepts that there is a serious shortage of health infrastructure. It is pertinent to mention that as per 11th plan document more than 50 per cent of sub centers, 74 percent of SHCs 51 per cent of PHCs and 11 per cent CHCs lack proper buildings. The population served per sub center is 5632 and per PHC it is 33257.
which is higher in comparison to the National average. Whereas in case of CHC level it is 138763 which is lesser than National average. In case of Amritsar district there are 170 sub centers 88 Subsidiary health centers 26 primary health centers 4 community health centers 2 rural hospitals 2 sub-divisional hospitals 1 district hospital. (Sood & Sharma, 2011:5)

The state of Punjab in terms of basic household amenities is better off than all India average with respect to availability of drinking water and toilet facilities as 99 per cent of the population is served by improved drinking water facilities (GOP., 2011:78). As far as basic infrastructure is concerned according to DLHS 2007-2008 Almost all households (98 Percent) in Punjab have access to electricity connection, only 35 percent of the households have access to tap water for drinking, whereas 60 percent of households have provision for a flush toilet.36 per cent of households use LPG for cooking, almost 64 per cent were living in Pucca houses out of which 68 per cent households have at least three rooms. However the health system does not correspond to levels of urbanisation which the state has witnessed during last two decades. The nature of health care delivered to the public either by public or private institutions is an appropriate point of contention for different stakeholders mainly comprising of government officials, academicians, professionals and citizens.

The city of Amritsar which is geographically situated at trade junction between India and Pakistan approaching west Asia has been suffering from physical constraints which affect the larger community. It is still rooted in traditional business set up without any technological progress witnessed in recent decades among other million plus cities of India like Bangalore and Hyderabad. The state on its part failed to streamline the procedures for the creative and innovative activities being undertaken in the city. Even Amritsar which has rich historic legacy being spiritual and temporal seat of Sikhism has failed to exploit its tangible and intangible heritage which may ensure it unique cultural identity. This could have played a pivotal role in social as well as economic transformation of the city (UN Habitat, 2012b, 42:44). As per habitat report there seems to be a positive influence of level of urbanisation upon the infrastructure as most urbanized countries ensure better services for their citizens on account of readily
available infrastructure. However the Amritsar scenario is indifferent to that linkage (Ibid., 2012:69).

The physical infrastructure is lacking in Amritsar city. The number of households having access to water supply is 71.0 per cent. The water supply is of irregular nature and contaminated which is more pronounced among slum dwellers. Similarly the number of households which have sewerage connections is 62.0 percent. The overall health infrastructure is also not according to requisite standards as number of doctors which are available at primary level of health care at city level is 0.185 per 10,000 populations. The slums in Amritsar city cover 5.8 sq. kms which constitute 4.26 percent of area of the city. The data regarding basic services in slums is neither up to mark nor authentic. (Sandhu and Teotia, 2013:152:154). Hence in light of above mentioned facts the scenario which emerges is not at all rosy. However the state governments on its part promoting technological led infrastructure in a big way by following the Post liberal logic of investment is half baked approach of creating smart cities to attract investors. However this is not happening in case of Amritsar, the city’s healthy environment is out of place as there is a lack of equitable distribution of resources. The slums are the places where euphoria regarding prosperity is all together missing and only a few are getting benefits. Thus we trace issue of urbanisation and health from macro to meso to micro level with reference to Amritsar city.

In order to examine above mentioned issues in an appropriate manner one have to understand the approaches which can be employed in this study to offer suitable framework for analysis in a collective manner to articulate health based issues faced by slum dwellers in Amritsar city.

1.5 APPROACHES USED IN STUDY

1.5.1 Approaches to Study Slums

Slums have been first defined in a published manner in 1812 by James Hardy Vauxs in the vocabulary of a flash language where they have been synonymous with crime racket. It is poor who are often found living in these slums. The Victorian middle classes looked upon these slums as they have been characterized by wearing out housing structures which are overcrowded, diseased prone and poverty is rampant
Slums have been largely conceptualized by physical, economic and social attributes. Therefore, slums are defined as congested areas having substandard housing insanitary conditions and people living in slums work in low end jobs or are unemployed and lead a life of immorality. Hence, income poverty is often associated with slum like conditions. The housing conditions are such that it affects the health, safety, morality and welfare of residents. Thus, housing is an important issue which has bearing on other social conditions. However, providing housing for the poor by the state has not yielded any better results. Slum dwellers are not a homogenous category their stay in a city is characterized by availability of opportunities.

Slums have been considered as unwanted areas within the city by sociologist like Oscar Lewis who propounded the concept of ‘Culture of Poverty’ which states that poverty in general and slum life in particular have number of associated traits in relation to family, interpersonal relationships, time-orientation, value system and spending patterns which are passed on from generations to generations in family set up (D’Souza, 2012:33-36). However, social scientists like Whyte in 1943 argued that there has an overt attempt to highlight disorganization aspects of slums. To support his viewpoint that slum also has an organizational element he put this argument in *The Street Corner Society*.

Charles valentine in 1968 argued that Oscar Lewis model of poverty has been middle class construction by blaming the poor for poverty thus avoiding any radical improvement in their lives (Sandhu, 1989:6). Lewis thesis has been rejected by South American scholars Mangin (1968) and Schwartz (1975) all of them have given their own interpretation. Mangin argues that Peruvian slum dwellers have been involved in community level exercises covering wider issues from public health to local transportation etc. Schwartz analysed Venezuela slum dwellers who also doesn’t exhibit any peculiar subculture (Dahiwale, 1997:36-37).

Scholars like Charles J. Stokes point out that slums perform permanent functions of the city as it provide both goods and services. In slums those people who reside who do not contribute directly to the social and economic life of a city. There are two variables which are determinants of slums. One a social psychological attribute which
refers to mobility through the class system either through assimilation or acculturation. The other refers to barriers which hinder these movements. Charles J. Stokes refers to type of slums: slums of hope and the slums of despair. Hope implies that slum residents have an ability to better their lives. Its importance lies in the fact that they are home to strangers or the recent immigrant’s or arrivals. These categories of individuals are attracted to the city because of economic political and social reasons. The strangers come to the city to improve upon their abilities. Whereas, despair is a negative undertone referring to lack of change in the status by virtue of their inability to meet minimum requirements of employability or integrate into city life as they lack social and economic resources. Stokes went on to examine this theory by describing two classes of people one escalators who have the capacity to undergo change for better prospects and non -escalators who are denied the opportunity to escalate (Stokes, 1970:58-59).

With reference to Indian studies on slums, similar position has been articulated by Victor D’ souza, (1979) Social Cultural Marginality: A theory of Urban Slums and Poverty in India. He points out that poor people who are socially as well as culturally marginal live at the crossroads in abject poverty and they lack will to get integrated into society (D’ Souza, 2012:32:42). Paul Wiebe forwarded dependence perspective which underlines economic reasons for the pity condition of slum dweller’s cited in the work of Victor D’ Souza, he argues that slum dwellers of Madras are poor but are not living in Culture of Poverty.

Similarly Sandhu, (1989) in his study refutes the notion of social cultural marginality propounded by Victor D’ Souza. The study highlights that slums are not places of despair but of hope for the future of slum dwellers whose lives can be improved upon. The slum dwellers are not culturally marginal but structurally marginal due to the fact that majority hailed from the Scheduled caste community. At the same time they are very well aware about their past and present problems. At all levels whether it is religious, political, social or economic level they are well organized. Thus all three studies refute Oscar Lewis thesis in the real sense with substantive data supported by theoretical perspective having been analysed in a sociological manner (Stokes, 1970:58-59, Sandhu, 1989:168-170 and Dahiwale, 1997:36-37).
1.5.2 Approaches to Study Health

Sociology of health is an important field within sociology. It tries to study the way society works. Largely sickness and disease are an outcome of the way society is organized and the way resources are distributed. Under the framework of sociology of health, we study the health system, its organization structure and how health policies are framed. The Parsonian approach of health studies doctor patient relationship. In his work *Social System* Parsons defines Illness as a form of deviance where the role of physician assumes importance to cure the disease. Social factors do have influence over disease and sickness (Timmermans, 2008:659, White, 2002:5-35).

The concept of illness has been studied by adopting functionalist framework. This approach tries to understand illness as irrelevant aberration that needs to be rectified by a professional having requisite knowledge. Thus, an individual adopts the sick role for which he needs to be treated so as to assume normal position within the social system. Illness refers to any account of failure in day today observations of the role which rests on subjectivity. Hence, it is more of a social-cultural construct because this experience emerges not only from shared understanding but from individual experience also (Mehta, 1992:33-34). Somehow the sick role of parsons has some curbs especially in case of poor people who forego a visit to health facility when they suffer from any illness in spite of the fact that they insist upon getting health care at their doorstep.

There is another perspective whose essence lies in pursuing preventive medicine. This is based on idea that individual considers himself or herself susceptible to disease as a result of which he goes for prevention rather than going for larger course of curative care once he falls sick. This approach is termed as health belief model as given by Irwin Rosenstock. However, people generally seek health care when they are in dire need. Some slum dwellers often state that the need never arises to visit the nearby health facility.

Illness as a social construct having deviance orientation has been further examined by a Howard Beckers. He propounded the labeling theory which insists upon how different individuals with similar symptoms behave differently in a medical setting.
Thus this has its genesis in shared meanings and consequences. However, again this has limitations as it is confined to the differential behavior exhibited by patients in a medical setting (Mehta, 1992: 47-49). The concept of illness and sick role assumes importance within above mentioned approaches.

Within medical setting it is important to understand the nuances of role which often refers to attitudes, values and behaviour given by society and as performed by the individual in question. Thus it implies appropriateness in behaviour. Robert Merton advocated the concept of Role set which imbibles role relationships due to social status occupied by an individual. Similarly George Herbert Mead advocated the role taking whereby individuals respond to their personal gestures and anticipate the behaviour of others as their own. Even, Erving Goffman examines role in terms of both distance as well as performances by reiterating that one’s role does influence other person’s behavior. Over a period of time this repetitive behaviour to same audience results in establishment of social relationships. He also discussed the issue of role distance which implies how there lies the difference between individuals, normative rule and its actual enactments (Ibid:1992:74-75). These approaches could possibly help in understanding role commitments of an individual which may have conflicting performances with different actors within the Health system. Thus, within health institutional set up role performance of doctors, nurses, paramedical staff assumes importance with in institutional set up.

Apart from these approaches materialist approaches take into account large number of social, political and economic factors which affect health over which individuals don’t have any control. The main studies focus on occupational position and its relation to illness as in case of miners suffering from respiratory infections over a period of time. Housing conditions and diet within this Marxist assertion can be studied with regard to health. Doctors enforce the main tenants of capitalism by having control over issuance of sickness certificates; diagnose availability, access to drugs etc. Hence it becomes necessary to control sickness among workers for stable production of goods and not losing any work hours (White,2002:101). The practice of commodification to gain better health status has assumed glaring proportions among upper class, or even corporate medicine in relation to health e.g. key players in India like FORTIS group.
Foucauldian approach to study Health has been very important as his two seminal works *The Birth of a Clinic* (1973) and *The Discipline and Punishment* (1977) aptly reflects his engagement with medicine and how the human body is being studied. How the notion of sovereign power and disciplinary power has been reflected within the field of medicine. Even his work the *History of Sexuality Vol.1* (1979) discusses the issue of surveillance over bodies especially the issues of population control and fertility which have been adopted by the state in the disguise of family welfare programs. This approach has been adopted by feminists who assert that women have no control over their bodies in accessing health and taking decisions as patriarchal structures have surveillance over them just like the state (Scambler, 1987:6-71). The debate is endless the problem is how to come at single point to assess role played by the state in producing and distributing collectively consumed social services related to health (Smith, 1988:64).

For Anthony Giddens a post modernist, to some extent individuals are responsible for the design of their own bodies. In order to understand the health care apparatus we can use methodological interactions to understand concrete social situations in terms of the actor's strategies and contextual constraints The Anthony gidden’s concept of Agency may be interpreted as capacity for action performed by social actors. In order to understand the Health Care System we need to classify the structure into Macro-level (Stake holders) and Micro: -level (social strategies). At the same time there is a need to identify constraints imposed by economic, political, social and symbolic systems. In order to overcome these, there is a need for adaptation and innovations wherever it is necessary (Sardan, 2005:53).

Indeed above mention arguments becomes important in the present context of the liberal agenda pursued by various nations, where the mantra lies in that the State should withdraw from welfare services and it should be borne by the individual. This is based on the assertion that we are living in a postmodern society whose basic feature is consumption rather than production. At the same time one must keep in mind the cleavages of age, gender, social status which determine economic but also social and political logics within a social group.
The other important element which is generally missing in health care analysis is interaction at various stages between different groups which is overshadowed by enthusiastic approach of achieving targets (Sardan, 2005:54). In society these are reflected in terms of inequality. This inequality is the reflection of the prevalence of diseases especially linked to poor people which could have been easily prevented (White, 2002:1).

Accessibility, equity, and efficiency are evidently linked the way institutions related to medicine are organized. According to Erving Goffman, Science and Technology are used as a tool by bureaucratic structures to enforce norms which help in running society smoothly. For sociologists set of structures within society are important criteria to understand how life chances are produced for individuals who belong to some group or the other. Hence class, gender, race or other forms of stratification are important attributes which help us in understanding status of individuals who want to access medical care. Further on, it is the gamut of power relations which decide who can access health and who is denied health care (Ibid: 39).

Health inequalities may be referred to in relation to differences at the levels of access. At times it refers to lack of participation in decision making or further variations related to levels of social respect and stigmatization about health conditions, settings or identities(Crrib,2005:86). In fact in order to understand social inequality we have to explore the intricate web of hierarchies as stated by Graham comprising of education, income, occupation, social status, housing, and locality etc. (Ibid.:92). With the passage of time the new terms are being employed in policy discourse like social capital which reflect the need for community participation to deliver Health in relation to the State.Welfare is perceived in terms of minimum well-being. Parson stated health as an individual capacity to fulfill the role and tasks for which he has been socialised. As per WHO health is defined as a resource for everyday living (Ibid.:24). When health is defined in context of well-being, this denotes positive connotation as one stated in WHO parlance “Health is a state of complete mental, physical and social being and not merely absence of disease”.
Thus these two approaches in combination need to be employed in the study in such a manner so as to arrive at inter disciplinary analysis. Thus health care delivery among slum dwellers becomes important issue to be reviewed and analysed.

1.6 REVIEW OF LITERATURE

There have been large numbers of studies which have been generated in the past on various thematic issues related to health. The review provides us with an analytical approach to study these issues in critical manner and bring about relevant concepts, concerns in a concise way. The literature on the problem have been presented, researched and reviewed under following segments:

- Health Care services available in Public and Private Sector
- Inequalities in Health Care
- Inter sectoral Approach on Health care
- Stakeholders in Health Care
- Perspectives to Study Health
- Ageing, Gender and Health Concerns
- Cities Neighborhood influences on Health

1.6.1 Health Care Services Available in Public and Private Sector

Deodhar and Mutatkar (1993) in their study insist that Urban medical care has evolved into its present form due to cultural influences, socio-economic situations, the role played by colonial system and India state in meeting the aspirations of the people ever since independence. The study reveals that health care utilisation is hampered by problems of awareness, cost, time factor inaccessibility at the meso-level. At macro-level factors such as urbanisation along with emergence of slums has affected ease of use of basic health care services which are lacking and people are not aware of preventive methods to be used to protect them from diseases. Common ailments which affect poor people include respiratory ailments, communicable diseases, alcoholism, and injuries at work place, suffer violence at homes and in neighborhood due to various personal and social reasons. Urban poor look for quick and cheapest solutions to sickness. Hence they fall prey to the quacks in their slums. Being poor affordability is a major factor which hinders their access to food and medicines.
Bhat (1996) highlights, how the lack of any regulatory mechanism affects the working of the private sector which is providing the majority of health care. The study indicates that according to legislative interpretations private medical services fall in the rubric of contract for services and the relationship which they established is based on the principal-agent where patient corresponds to the principal and doctor correspond to agent type. Various cases have been discussed to understand mistaken diagnosis/negligent diagnosis, uncertainties/imperfections of medicine. Thus within the judiciary the person who makes forceful assertions with ample support of evidence wins. At the policy level the issue of quality of care has resurfaced. It mentions improved health within limitations of medical technology. The quality of care works on three pillars competence of provider, accessibility of care and acceptability of care.

Bhat (1999) identifies the basic characteristics of private medical care in Ahmedabad. In this study it is reflected that physicians generally see 25 patients physically in a day minus emergency cases, in fact they spend 15 minutes per patient. They are doing less of clinical diagnose and more of referral and diagnostic tests. The study highlights that for treatment to be provided to the patient the doctors do not have requisite para-medical staff available. If it is there, it is not abreast with latest technology. Doctor fraternity indulges in malpractices such as over prescription of both drugs and costly diagnostic tests, dividing fees among doctors, no-proper disposal of medical waste etc. The study recommends that creation of regulatory framework is important to oversee private sector working. There is a need for strengthening institutional mechanisms to protect patients from unruly problems faced at the hands of private doctors.

Ray (2002) focuses on how public social services such as health are being utilized by slum and non-slum population. This study was carried out in Ahmedabad city in Gujarat the study indicates that allopathic system of medicine is popular; however the slum people use public health facilities whereas non slum people went to private doctors. Slum dwellers changed their preferences of health care facility due to less time and better services. These slum dwellers access this system for immunisation which is termed as good and efficient. Thus slum people use municipal hospital for indoor services. For special cases the private health care system is used which is
The issue of per capita availability of services is important for people residing in slums and non-slums. The state role is very important in delivering these services. The affordability to access these services puts pressure on the poor people’s cost of living denying them basic amenities of life.

Schneider and Palmer (2002) in this study try to ascertain the viewpoint of users of primary health care. This study relates to South Africa. The results indicate that sometimes account of satisfaction may vary from one section of the society to the other. The patients are satisfied only when doctors provide proper explanation of their illness and quality of medicine are given to them. Some reported inequalities in kind of provision to which they had access, whether they accessed health services as first timers or were referred by earlier practitioners. The study highlights class positions, age and gender profile do have important bearing on the way the problem is perceived and defined and the treatment is given to them.

Zamir (2002) studies quality of care provided in FPAI clinics using the client perspective in semi urban areas of Bhopal, Sagar, Vidisha in Madhya Pradesh. The study reveals that majority being poor and illiterate used 17 different names for describing the hospital on the basis of their observation. For them healthcare largely translate into easy and free availability of drugs, proper packaging having shinning cover reflects costly medicines. The issues of over prescribed medicines as given in government hospitals irritate them. The patients state that doctors must listen to them in an effective manner, explain them health problems in a proper manner, give proper advice, and provides emotional backing. Doctors must take proper case history and advising them in a rational manner, for clients traveling time and consultation time are other important attributes of cure and care. This study highlights that for clients care is a multi-component concept, in which doctor and drug assume great importance.

Banerjee et al. (2004) has tried to study the health delivery system and its impact on the health status of poor in Rajasthan. According to this study rich frequently visit public health facility. The poor visits traditional healers (Bhoopas). The rich are accessing both private and public health care facilities in greater numbers. On an average 7 percent of the budget is spent on health by the households. It has been
observed that the issue of absenteeism is around 45 percent in sub centre level, at PHC level it is 37 percent. The absenteeism is not because of outreach programs but for other personal reasons which could be only know when investigated. The results indicate that people avoid visiting PHC as they are frequently closed a visit cost both waste of time and resources. The cost of seeking treatment at PHC is high as medicines are bought from outside as there is shortage of these at the facility. The private care being unregulated has its bearing on health professionals running these facilities. Forty one per cent of doctors do not possess medical degrees 17 per cent are not graduates and 18 per cent do not have any training what so ever.

It has been noticed that those visiting private health care 68 percent preferred getting an injection whereas 12 per cent were the ones who are given a drip. However in PHC just 32 per cent were administered injections 6 per cent got a drip. Thus approach towards health care was different in these two settings. In spite of accessing health care facilities health is found to be poor among old persons and women respectively.

Bhatia (2004) in his work tries to do comparison between components of quality of care among female outpatients provided by private and public sector practitioners in Karnataka state in India. The results reveals that women visit doctors for various medical services. The maximum number went for Obstetric, followed by Gynecological, followed by those having problems associated with circulatory, and respiratory systems. The distribution of cases is found to be uneven between private and public health care.

Thirty per cent of the cases related to obstetric and gynecological issues and consulted public health care system whereas 53 percent went to private hospitals. It is observed that communication factor is higher in private care as health professionals spend 6.68 minutes per patient whereas in public health care the time on patients is 2.81 minutes. Even, in clinical procedures it has been found that private practitioners are more often using instruments like Barometer, Thermometer etc.

However the tendency to measure pulse is higher in public than in private. The physical examination assumes high percentage of 70 per cent owing to obstetric, gynecological and circulatory problems in comparison to 58 percent in public health
care system. Therapeutic approaches correspond to vaccination are high as 67 per cent in private and just 34 percent in public. Costly medicines are prescribed in case of private sector in comparison to public, visiting specialist is preferred at private health care facility rather than in public health care facility. Thus the overall result portrays that doctor patient communication and thoroughness is better in private rather in the public health care system.

Ensor and Cooper (2004) highlights the barriers which the poor and vulnerable face with regard to health care services The study points out that demand side barriers emerge at three level nature of illness, cost constraints and choice of provider. The nature of ailment i.e. defining illness as acute or chronic does determine whether visiting local pharmacy shop or visiting the doctor. The health care choices are second barrier point as not many know whom to approach during illness and kind of treatment to be followed.

The choice of medical provider is also based on cost factor which includes traveling and sustaining the cost of treatment. The nature of illness determines stay in the hospital which also enhances money constraints faced by the individual and the household.

Ager and Pepper (2005) explores how far the state provided public services are utilized within Orissa, how people perceive the availability as well as quality of services. The perception of health care services are based on reputation of doctors, and faith healers for which they can travel the extra mile for this reason. Primary health care services are the last option by the very fact of absence of health professionals. The ANMs who are managing these health centres lack professional competence .They are overburdened by meeting the targets of national health programmes. People who access public health care system state that the medicines which are prescribed by doctors are made available at the local pharmacy, which increases the cost of treatment along with traveling time. Thus the preferential place of treatment is private health care providers. The study does discuss the role of social networks in guiding the people to access service providers.
Paul et al. (2006) conducted the study in 24 states to access the effectiveness and efficiency of public services delivered by the government. The government spends a large sum of money but it fails to fulfill primary needs covering both urban and rural areas. The study adopts the user perspective by underlining four basic indicators access, usage, reliability and satisfactions which are measured in relation to five basic services namely health-care, drinking water, public transport, primary education, and public distribution system. The results show that the public health facilities are available to 40 per cent of the households; rest gap is filled by private service providers. Access to reliable drinking water is a problem whereas accessibility to public distribution is as high as 80 per cent but only one fourth of it gets a regular supply. Further PDS rates are displayed in 50 per cent of cases only. Primary education usage is more in rural areas. People are aware of the midday meal scheme. However, only 3 per cent of the households in the survey used anganwadis under ICDS. Government transportation is rated low in terms of punctuality and frequency. The study reflects that the poor are not satisfied with services like health care, public transport and public distribution system. Policy implications suggest that overall governance levels need to be improvised up to the desired level for effectiveness of public delivery of basic services.

Sunil et al. (2006) examines the utilisation of maternal care services by using data from NFHS-2 by adopting system approach. In this study focus is on components of the programme rather than individual characteristics. It is found that level of education, living standards and exposure to media does have an effect on utilisation of services. The inbuilt program factors such as active IEC, involvement of Mahilamandals and participation of anganwadis have a positive relationship with maternal care utilisation. The distance of the health facility as well visit of health workers during pregnancy do influence maternal care utilisation.

Amrith (2007) focuses on the way the state examines the issue of public health. The study reveals that modernist follow latest models of public health as used in the west. The social reformers still holds the village as a prime site for advocating public health issues. The elites ruling the country in order to maintain racial purity and avoid degeneration emphasized public health. Public health remains relatively unessential in comparison to military or industrialization pursuits. India’s development policy has
been a story of instruments becoming an end in itself and often sidelining values of public health care.

Andaleeb et al. (2007) demonstrates how certain sections of society who are not satisfied with public health facilities seek healthcare in hospitals of neighbouring countries especially in India, for this study two state run hospitals in Dhaka and private care hospital in Dhaka are identified. WHO have brought in performance system criteria which have been adopted by focusing on certain composite areas. The doctors have played a prominent role in shaping this criterion, hence it is more oriented towards clinical side rather than emphasizing upon delivery of service which is patient oriented.

The study analyses service factors such as reliability (medical test, non-availability of specialist, irregular supply of drugs, the kind of care provided to patients), functionality of the system is identified in terms of tangible products in relation to hospital infrastructure, beds, toilet facility, clean environment.

Accessibility depends upon the communication of staff and provision personalised ear to the problems of the patients. The results reflect that variations are there at the level of satisfaction depending upon above the stated factors. The results indicate that the patients rank the credentials of doctors, followed by facilities available at the hospitals along with the nurse’s behaviour and technical qualifications as important indicators for accessing health care.

Hammer et al. (2007) attempts to highlight government failure in Public Health Services. In order to explore this issue the researcher define the terms health, healthcare and health policy within India. Further in understanding the problem in a holistic manner distinction is drawn between the terms like health status and health services.

The study highlights that primary healthcare is based on the assertion that money must follow the patient. The people expressed their displeasure by saying that ambulances are largely meant for upper class strata and they don’t seek treatment because of the cost factor as they are not covered by any public health insurance schemes. The patients who access public health care facilities pinpointed the reasons for not seeking care at these places due to following reasons: high rate of absenteeism, working hours timings, followed by the lack of competence to diagnose disease, unruly
behaviors and lastly the issue of illegal payments which are as high as 27 per cent made to doctors to facilitate treatment process as quickly as possible.

Baru and Nundy (2008) in their study explore the linkage between private and public sector in the field of healthcare during the past 60 years. How these linkages have led to an evolution of a number of actors performing multiple roles within newer institutional mechanism. Over a period of time, the notion of neo-liberal agenda advocated by WHO and other supra national institutions have been coaxing the state to build partnership with market players, for financing, provisioning, research in health services.

The study highlights the social contracting of primary health care services which includes non-clinical care laundry, diet, drugs, diagnosis, and transportation for obstetric services, within private hospitals at secondary and tertiary levels. However, no mechanism has been created to ensure accountability for proper implementation of these programmes.

Singh (2008) explores how the public services are performing within the broader context of decentralization, how the institutional changes affects its performance and certain policy guidelines keeping in mind the pace of decentralization. The work throws light on how actually the money meant for the health sector is being spent and then we can suggest whether to enhance it or not. Thus finding the pilferage of finances from their actual allocation to their utilisation is very important.

It is important to know how the money is spent on curative services, the cost of administrating large hospitals is quite high in urban areas as it eats major component of health spending. In relation to the state the local level governance structure having been decentralized but they don’t have legislative freedom or the revenue authority to spend resources on health. There have been a plethora of schemes which have been consolidated into different programs but the results are not conducive enough. The study identifies that for decentralization to be successful following three factors funds, functions, and functionaries are important.

Jayaprakash (2010) tries to draw a comparison of reproductive child health within the two Indian States of Uttar Pradesh and Kerala. The problem arises at
implementation level that includes the funding issues, lack of quality and social cultural factors which inhibit poor access to RCH services. The study states that the reasons attributed could be male dominance in decision making and need for a male child to carry on the legacy that contraception is avoided by women. However the level of education does affect decision making among women as in the case of Kerala where female literacy is as high as about 87.66 percent. The state politics played a pivotal role in ensuring equitable and effective contraception through the RCH program. In spite of the decline in public spending on health care state has envisaged methods of community based insurance and risk pooling which has lessened the burden of out of pocket expenditure on poor thus making access to health care possible. Thus women’s education and political will of the state has been enabling factor in RCH success in Kerala in comparison to Uttar Pradesh.

Jose and Navaneetham (2010) states that social infrastructure has an important bearing over the women's nutrition. They have analysed unit level data from NFHS-3 (2005-2006). It has been observed that environmental and personal hygiene plays crucial role in enhancing the nutritional outcomes among children and adults. More than 53 percent of women falling within the age group of (15-49) lack access to toilet facilities thus making them prone to infections. They also face embarrassment due to open defecation. The urban women have greater access to toilet facility in comparison to rural counterparts. These figures are 84.2 percent for urban women and 72 percent for rural women. It is interesting to note that in Punjab accessibility to the toilet is 72 per cent, water 89 per cent, fuels 42 per cent Almost 18.9 per cent of women in Punjab suffer from chronic energy deprivation in comparison to 18 percent in Kerala.

Rajiv Lochan and Meeta (2010) in there study found out that in case of illness 45 percent of them consulted private providers 13 percent used both private and public facilities ,where as 8 percent did not seek medical care. They are of the opinion that absence of health care facilities, Health service providers in the health system, the cost of treatment and the limited working hours during day time adversely affect the primary level of health care which is available to poor living in urban areas. Thus absence of above mentioned factors along with distance travelled and transportation cost make them uninterested in accessing government health care system.
Thus forces poor people to look for alternatives in terms of private health care which is readily available yet costly. For routine illness they seek out-patient care for which they have to seek debt. The episode of chronic illness requires an average spending of Rs.6636/- It has been observed that about 21 percent of urban residents do not seek treatment because of money and facility constrains as per 2004 NSS round. A study undertaken in Karnataka highlighted the fact that diagnosis and better communication are two reasons for women accessing private providers in spite of high user fee.

Chandrashekar and Mukhopadhyay (2012) carried out a study based on NSSO 2002 data set where they identified 6138 slum households 35,703 households from non-slam areas. They tried to compare well-being of slum residents. The findings of the study indicate that the livelihood programmes must also take into account the poor who are living in non-slam areas. Further it is noticed that the slums having the notification status have better drainage and rights of water thereby improving slum dwellers lives in comparison to non-notified areas.

Rao and Sundararaman (2013), in their study "which doctor for primary health care? Quality of care and non-physician clinicians in India” focuses on issue of scarcity of physicians in the rural areas which are serving the Primary Health Centre’s. The study tries to measure the competence level of four types of physicians which comprised of Medical officers, Rural medical assistants, Ayush Medical Officers and Paramedical officers who were working in various PHC located in the State of Chhattisgarh.

It is found that when they were given similar standardised cases with regard to six types of illness among different age groups. They provided best levels of treatment. Among them medical officers and RMA provided appropriate prescriptions (61%). Ayush providers are lesser competent than the medical officers, paramedical is the last. The reason for paramedical administering medicines was that certain PHC did not have trained physicians. So when patients visit PHC paramedicals have to treat them. The results of the study found serious lapses on the part of medical officers who failed to treat basic ailments like pneumonia and diahorrea among children. This questions the legitimacy of their training and skills which they have acquired to enter the Medical
profession. The study emphasised that in order to provide universal health care to all requisite health professionals are needed more urgent in rural areas where medical officers fail to turn up.

Therefore the above mention studies examine the role and performance of public and private health care sector. The studies do mention the occupational strains of doctors and paramedical staffs which are working at primary level of health care has also been analysed. The issues related to the nature of health delivery system and its functioning has been especially discussed in relation to slum dwellers and urban poor. The studies also highlight the barriers which poor face with regard to health care in terms of distance, finances, awareness, behavior all are given equal importance in studies reviewed. The findings of the studies also raise appropriate research questions as which are the factors that promote accessibility to health care among poor and non-poor. Does lack of rapport between poor patients and health personnel is one of the indicators of dissatisfaction among poor patients? Which factors prompt people to utilize private health care facilities whether is it related to medicines, vaccinations and other diagnostic facilities offered by these providers? Whether state can be blamed for the decline of public sector as it gave unruly concessions to the corporate hospitals which led to change in the orientation of health care system.

But somehow studies fail to provide any comprehensive strategy to overcome problems mentioned above. In order to understand dynamics of delivery system within both public health care and private health care reasons need to be ascertained from patients for preferential place of treatment and why.

1.6.2 Inequalities in Health Care

Banerji (1982) study relates to health culture of rural population. How they access the public institutions related to health care which have been created in their areas for their needs and comfort. To what extent social cultural parameters influence their decision making process. Within village setting the study explores how far power structure, religion, caste kinship, level of social interaction facilitates health care or act as hindrance among the village inhabitants. The findings of the study reveal that poverty as observed and perceived have an effect on social existence of the poor. Harijans do
face social discrimination while accessing health care facilities as they come in direct contact with health professional and other auxiliary staff who practice the concept of purity and pollution. The study pin point that lack of educational awareness among poor does have impact on the family planning and other government interventions which are being carried out from time to time.

Bolaria (1994) study explores various paradigms which can be employed to understand health policy and health care issues at the individual level and at the societal level. Clinical paradigm is concerned with individual predisposition rather than taking into account societal factors. This generates mechanical induced individual centric notion of illness subjected to medical treatment. There is another perspective which is related to the lifestyle of an individual which has bearing on the sickness one suffers from. This approach has been adopted in promoting preventive health care and used in health promotion programmes undertaken by the state over a period of time.

Hay (1994) studies how access to health care is determined by social status. The basic indicators which have been used in this study are education, social class, occupation supported by explanatory variables such as gender, age, marital status and social support mechanism. This work analyses various reports which have been produced with regard to these variables. For instance, Black report generated by a British research group and U.S based report have generated common findings such as higher disability days are encountered by families having lower social class. The poor socio-economic status do influence mortality rate, poor health, malnutrition. Both these reports do mention that mental sickness increases with deprived conditions.

Velden and Wildt. (1995a) work tries to deconstruct the slogan Health for all. It is important to understand how the state finances contribute to inequitable distribution of health care. The study highlights the need for employing perspectives to place public health along right dimension. Thus all the stakeholders are important which includes policy makers, scientific community, health workers, or consumers. Government policies should have mix of political will, level of education awareness, growth of resources to ensure standard nutrition levels and meeting health needs of the community.
The study raises the issue that we have to overcome the strategies based on Eurocentric viewpoint which may not be amenable according to the needs of the developing countries. Within developing countries political elites are corrupt and they siphoned of money coming from international aid organizations which is meant for medical aid. The study insists upon that public health has emerged an important component of health care programmes in developing countries. These are meant to overcome diseases which are emerging due to ever increasing urbanisation. The study also looks into inequality with regard to accessibility to health care services.

Yesudian (1998) work tends to explore how existing inequalities in society deprive large sections of society from utilisation of health care. The study is placed within an urban setting where class differentials play a decisive role in accessing health care. This is a study of Azad Nagar locality within Madras city exploring factors which determine the nature of care and facilities utilized by people from different sections of society. The response of the persons is elicited in form of satisfaction of services, how different factors such as demographic, socioeconomic and cultural factors have a bearing on health access. The study points out that in order to measure utilisation there is a need to understand perception of health needs of people.

Blackburn (1999) study, analyse how poor are excluded from accessing good health. The poor face issues related to affordability to food or unhealthy diets which led to sickness and disabilities. There is a paucity of basic necessities and the deteriorating financial conditions make them stress prone. The study reveals that poor housing conditions, crowded and damp conditions largely affects the children and women as they spend larger time at home it led to sickness. The poor also face social barriers while getting treated for illness which further enlarges these inequalities. Hence, they are excluded from enjoying healthy life styles.

The findings of the study indicate that perceptions of medical professionals, geographical location of services act as a barrier to medical care. Further introduction of user charges under the influence of neoliberal agenda pursued by countries actively as strong impact over utilisation and access to health care in the United States as indicate by some studies.
White (2002) work highlights how social factors are key variables which have affect health. At the same time outlines various approaches to study health and illness. The study illustrates that health should be understood as a byproduct of social forces which shape individual and communities at large. The issue of Medicalization of society has been discussed with reference to chronic illness. The study addresses the issue of policy making in changing political times supported by relevant ideologies under which various actors play determining role. The study explores how social determinants like race; ethnicity has a bearing on differential access to health care.

Ray (2003) in his work mentions the problems which urban poor face in terms of low income, insecure neighborhoods, unmet basic needs, problems related to physical environment which includes housing shortage, inadequate water supply, and proper sanitation all these factors lead to an unhealthy life. This further aggravates the health of urban poor who face onslaught of urban diseases in form of epidemics and infectious diseases, poor personal hygiene. The study reveals that on average in a month children from lower socio economic class are ill for 21 days in comparison to children of higher economic background who suffer illness for approximately 10 days only. The study thus recommends that strengthening of PHC as well as referral system is appropriate solution to providing health care to the urban poor.

Young (2005) study explores how health is closely linked to social factors. The biomedical definition emphasizes on the role of pathogens, contaminations and deficiencies which led to weakening of immune system hence illness emerges. Behaviour and lifestyle such as lack of sleeping, not doing exercise does contribute in creating unhealthy bodies. Thus certain patterns are socially visible like maintaining bodily functions, aware of threats and monitoring social environment whereas medical issues are identified through diagnostic techniques. Thus typology of defensive and maintenance behaviours help us in understanding social factors which influence our health.

Baru (2004) in his work underlines the issue of deprivation which social groups like scheduled castes, scheduled tribes and others face with access to basic needs like nutrition, security, shelter and water. They are termed deprived due to their
vulnerability to communicable diseases such as gastro entities, malaria which they face because of poor living and environmental conditions. The role of public health care institutions become important for providing health care services. There is plethora’s of problems which poor face in accessing health care from lack of resources, with opportunity cost, to insensitive treatment in public hospitals. The study indicates that for minor ailments people prefer private practitioners and for surgical issues visit public health care services. The study highlights how we perceive commercialization and consumerism in terms of money and resources to compare standards of health care delivered by public and private hospitals. The study point out that Indian middle class is both provider and consumer of private health care sector.

Young study focuses (2004) on the issue related to illness, basic life indicators and medical access thus providing multiple platforms to analyse sickness. The study mentions that we need to employ sociological analysis to examine public health issues. In order to ascertain individual health needs we need to follow biomedical approach. The study establishes a chain of events which defines health in larger sociological perspective which includes biomedical, environmental, behavioural and psycho social aspects of health.

Health seeking behaviour is explained by referring to resources (social support system, knowledge, money) and secondly by focusing upon health socialization (whether you are well, fine or imitating your surroundings). The study indicates that these models are complementary to each other while biomedical model relates to wellness, sociological one relates to positive public health and vitality.

Kishan and Sanjay (2006) study focuses upon how access to basic services in capital city of Delhi is over shadowed by complexity of rights advocated on paper by bureaucratic structures to make it available to the people.

The study reveals that the poor cannot access health care because they lack residential proofs or identification cards. They also lack of any viable health insurance scheme which can act as safety net for poor to save them from hidden cost of illness whether it is acute or chronic. The principle of the political allegiance works in
providing health care to slum people by mobile health care vans which decide their fate in accessing health care.

Bansal (2007) his study pinpoints how basic services are important to meet the needs of the poor. The poor live in neighbourhoods devoid of clean water and quality air which is cause of many infectious and communicable diseases. The nature of risk experienced by poor people gets compounded by the fact that they are vulnerable to nature as well as man-made circumstances. The way infrastructure is distributed describes the linkages between poverty and health disparities. In order to ensure that needs of the poor are met it is important to evaluate the performance of existing programs. At the same time one has to understand the planning process and its viability by examining terms like quality, adequacy, accessibility and equity. Thus integrated approach has to evolve to look into poverty induced health related disparities.

Starfield (2007) study provides a brief outline of how inequalities related to health are generated. Inequities are in terms of accessibility to the delivery system, severity of illness, inequities also emerge due to policy interventions reaching the rich first and denied to the poor.

Jacob elucidates (2009b) that caste system as a social construct has its bearing on inequalities related to health. The study underlines that a large number of poor who migrate from their native habitat to greener pastures somehow get excluded from the state health delivery system as they come to rely on quacks for medication. This is related to their citizenry status such as proof of residence and other issues.

Caste is linked to social determinants of health as power, income, goods and services have direct bearing on issues of sanitation, clean water, shelter and nutrition. The social cultural context has adverse impact on issues confronting lower castes, they are marginalised, excluded, and unfair policies are practiced by officials who are at the helm of affairs who are biased towards them thus denying viable life chances to them for survival.

that how far social cultural parameters does influence decision making process in relation to seeking health care. To what extent factors like power structure, religion, caste, class, level of social interaction are supported by explanatory variables such as occupation, gender, age marital status and social support mechanism are crucial for accessing health care facilitates. The studies point out that Inequities are in terms of accessibility to delivery system, severity of illness and also emerge due to policy interventions reaching the rich first and denied to the poor. Thus health is an outcome of social forces which shape individual and communities at large.

1.6.3 Inter Sectoral Approach on Health Care

Pannerborg (1995) study focuses on how ill health can have a bearing on different sections of the society. In case of workers' illness affect workers’ performance, illness leads to absenteeism in school children thus affecting their studies, certain health risks make living space denied to a large number of inhabitants. The study explores how demographic and epidemiological factors are important to define the health transition. Thus the issues of ill-health can be resolved through able man power, institutionalized system of delivery and priority setting within health.

Velden et al. (1995b) in this study highlights how medico industrial nexus has pushed the primary health care to the margins and undue emphasis is upon tertiary level of healthcare. Primary health care was conceived as a strategy to promote a people centric approach at the same time taking into account social and political considerations. However lately there is need to understand organizational structure, financial outlays, and inputs from medical education are important to stream line the working of the Health care system.

Chaterjee (2001) in her study try to relate three problems in one go that of population, poverty and health. It is pertinent to mention here that child mortality and morbidity are rampant among the poor as the readily accessibility to health care is missing. The child survival depends upon the health of mothers, In India 60 per cent of women is anemic and 53 percent children are malnourished. There is need to redefine health sector beyond money, cases and technology and must focus upon community participation where both formal and informal practices work together.
Kutty (2000) study relates to the State of Kerala, whose health indices are closely related to advancements in other sectors such as education, transportation, and the awareness generated by social movements. People identify three reasons for not accessing the public health care system that includes issue of drug availability, no proper response from health professionals and better care available in private institutions. The demand for health care in Kerala society corresponds to the longevity and problem of chronic illness related to ageing. The other reason that people seek health care is attributed to the availability of higher incomes and education i.e. being aware of facilities and treatment available.

Ramachandran’s work (2005) highlights the concerns and problems related to implementation of the Integrated Child Development Program which was initiated by Government of India in 1975. The main objective was to solve the problem of hunger and malnutrition among children of poor parents belonging to the marginalized sections of the society. The field work for this study has been carried out in villages of Rajasthan and Uttar Pradesh to know the ground realities. Since its inception 25 years ago there have been serious lapses with regard to its working and objectives not being met. The problems are multidimensional such as universal access to nutrition is lacking, mismanagement, high handedness, rations are siphoned from Anganwadi centers, quality of food unfit for human consumption, accessibility rest upon caste and community profile of users as well as the provider. The target groups are not adhered to, only age groups of 3-6 are catered whereas pregnant mothers, infants, are enrolled but don’t get any support. The health centers don’t have any proper weighing machines to see infants progress nor did they maintain any grading system to categorize children as malnourished. The nature of the activities carried out vary from one state to the other, some had preschools other lack basic facilities for children. The study recommends that social auditing by village people is must to check malpractices so as to ensure its proper implementation.

Qadeer (2002) study concerns about the nature and working of the health system. The present day health system is based on Techno centric paradigm based on three icons drugs, equipment and vaccines. This is promoted as part of biomedical approach in collusion with international agencies. The introduction of user charges in
public sector has led to preference for seeking health care towards private sector. His viewpoint is that family planning programs have taken the major share of health budgets which could have been very well used for other health interventions. He states that family planning programs have been influenced by the larger discourse initiated at International level by various funding agencies.

Thus presently emphasis is upon female education, sex ratio, gender bias, son preference, changing orientation of family planning program by focusing upon target approach. He underlines that population policy is concerned with numbers and target principle thus it fails to look at women's health needs and their perception. Policy document over look inter sectoral dimensions as it remains silent on issue of food, education and transportation which are part of wider social coverage. Similarly, National health policy undermines the role of welfare state and goal of selective health care has been abandoned.

Saxsena (2004) opines that for ensuring any success of governmental interventions or programs for the masses there is need to understand the problems of governance level. There are a plethora of problems at the governance level, issues of accountability, transparency, effective role performance and absenteeism. The ability to create professionalism among young civil servants within the bureaucratic structure is important for system to be run successfully. The budgetary practices are also perquisite for effectiveness of government programs.

Gill (2006) study focuses upon the crisis which state of Punjab is facing in terms of economic growth, changing the orientation of its work related activities from agrarian to industrial society. With regard to basic human development indicators Punjab is having sufficient ground to move ahead, however issues like declining sex ratio and female foeticide are issues which need to be dealt in a proper manner. The role of the diaspora has to be channelized which sends remittances to Punjab. It is estimated to be around 2 to 3 billion per year which can be a big contributor in the state development. However the problem of governance is immense and the state finances are negligible. This can be resolved by improving administration, enhancing taxes and
creating political will. The picture of health scenario is bleak, accessibility to primary health care is lacking, and even problem of drug menace is alarming.

Jhabvala (2003) in her work highlights the need for combining multiple health schemes to deliver to the workers who are working in the unorganised sector. Being poor, they lack access to health care they are vulnerable to occupational risks, sickness which leads to loss of income opportunities. The problems of older workers are more intense as they don’t have any social protection thus they are dependent upon family members. The problems of women workers are of different nature related to their family responsibilities. These workers don’t enjoy any benefits for maternal and child care. These women many times land themselves in poverty by borrowing money from money lenders at a higher rate of interest. For them no facilities of day care centers are available thus depriving their children of social security. In liberalisation era slogans like work flexibility are used by employers to run away from any social security obligations. Thus workers are at the mercy of market forces.

Bardhan (2008) in his study insists that the structural features of the economy have a major role to play to understand the problems of the health sector in India. The political economy of development led by elitists discourse focus on anti-biotics availability than overall personal hygiene. The geographical location of country near to equator results in larger incidence of tropical diseases such as malaria or dengue etc. In India health services are confined to curative services only. The Indian health system suffers from issue of absenteeism and poor-quality of services which are enough reasons for people to seek health care from private health care providers.

Berman and Ahuja (2008) analyses the economics of health. The government spending on health is 2-3 per cent of GDP as the states spending has declined over a period of time it is reflected in total spending (GOI.,2005a). All family welfare schemes have come under NRHM and it’s the state job to implement this new initiative. The center has routed its funds through NRHM 60 per cent in total. However problems of funds utilisation have been seen at the state level. In various sub heads due to initial higher budgeting by center and what is given to a concerned state in subsequent allocations which largely depends upon State contribution. The natures of funds are less
flexible which are meant to be used over certain categories only. So there is over spending where it is not needed. Thus institutional mechanisms are needed for health spending to achieve targets meant for eleventh five-year plan.

Guruswamy et al. (2008) tries to understand the intricacies of public financing of health in the case of the Centre and States so as to ensure equity and social welfare for masses concerned. The secondary level and tertiary level health care are located in urban places which are utilized by affluent sections of the society. Larger finances are spent on family welfare programs. Some researchers argue that expenditure on public health, sanitation and water supply can be combined with healthcare to arrive at total health expenditure. These expenditures can be classified as revenue expenditure through which money is spent on salaries, provision of drugs, public health programs, general operational expense and medical training. On the other hand capital expenditure is used for creating infrastructure. That is why better of states spend more on revenue side providing better salaries to doctors spending money on their training etc. On the other hand those states which are engaged in creating infrastructure presently spend more in capital terms. Other findings which emerge from the above study reveals that poorer states tend to spend more on health out of their total GDP. Various alternatives are discussed for financing health especially insurance policies but very few have been successful. The public expenditure on health largely remains one percent of GDP which is stagnant over the years. There is biased approach against rural and relatively poorest states.

Kurian (2008) work highlights that there have been remarkable shift in ideas of multilateral agencies from following a policy at comprehensive level to narrowing down to selective care whether in terms of clinical or curative care. What is the rationale behind the state spending on health, when structural inequalities largely remain? During past few years utilitarian perspective has emerged in terms of collective health indicators for society, maximizing the reach without taking into account provision of basic services? This has happened in case of polio campaign where virus resurfaced in U.P as a result of which new parameters are being defined as disease profile has changed. The study quotes that at least minimal packages should be provided
by the states as a part of their health policy agenda. Thus both at National and International level health have been confined to utilitarian criteria.

Mehrotra (2008) study question the seriousness of Uttar Pradesh government in meeting the health needs of its citizens. In order to achieve desirable results public health system need to be reformed. There is sorry state of affairs in relation to basic health indicators and physical infrastructure available to residents of Uttar Pradesh. Twenty three percent of children below two years have received immunisation, deliveries in institutionalized setting were 22 percent, accessed to safe drinking piped water is available to 35 percent of urban residents, toilet facility available only in 16 percent of the households in rural Uttar Pradesh. The health related infrastructure in all 20,153 sub centers is not up to the mark, there is a lack of availability of paramedical staff and 32 per cent of sub centers provide housing facilities to ANM. In Uttar Pradesh 92 per cent money is spent on accessing private health care which is higher than the national level of 80 per cent. Thus it emerges from above study that the public health system has failed to deliver. The study recommends that there is a need to move from clinical and curative to primary health services.

Mukherjee and Karamkar (2008) in their study does the interpretation of 60th round of the National Sample survey so as to understand the reasons why majority of the masses in India are not accessing public health care system. The survey reports reveal that 85.2 per cent of ailing accessed medical care and 14.8 percent didn’t. Fever is the most common ailment reported, followed by respiratory and bone related problems for which medical care is not termed necessary.

The reasons are multidimensional for not accessing health care system. Twelve percent reported that infrastructural problems, financial reasons and perception of illness. Thus different strategies are needed to address the concerns of different groups who seek health care from public health care system.

Nath (2008) study analysis national family health survey which shows that health care is curative in its goals rather than preventive or promotive, Just 0.5 per cent is spent on these by the public sector. Health allocation is just 1.2 percent of gross domestic product. There are specialists being produced by our medical colleges but very
few public health specialists. There is no equitable distribution of doctors in primary health care centers. NFHS 2005-2006 shows glaring shortcomings with regard to utilisation of health care services. Immunisation covers only 44 percent of the children in the age group of (0-5), only 37 per cent of women went for a post natal check-up. Thus it means basic preventive services are not available. Disease profile is rapidly changing but public health care system is not attuned to these dramatic changes.

Bhargava's work (2009) takes into account the issue of security into wider perspective related to food security, agricultural security, to health security. New technologies should be placed to test the efficacy of genetically modified seeds or crops before being used by farmers. There is a need for critical evaluation of health infrastructure. The study highlights how a lack of effective coordination between different government agencies and bodies affects the health system in general. There is lack of holistic planning as less than three percent of gross domestic product is spend on health. The approach towards medicalization of health is also affecting the poor as greater amount of money is being spent by them on diagnostic tests to ascertain the cause of illness. A cross reference to China has been given as it has earmarked 124 Billion U.S dollars for health sector within stipulated period of three years that portrays its political commitment and prioritization which Indian government is lacking.

Shah (2009b) has tried to critically evaluate the NREGA scheme initiated by UPA government. How it has brought dignity to work and labour, providing food security, creating viable assets and women empowerment. For its success the delivery mode and market mode need to be strengthened. This in turn promotes health as social good. However the record of the UPA government has been a dismal one as public expenditure on health falls below 3 percent of GDP which was enshrined in common minimum programme in contrast to it was 1.39 percent in 2007-2008. Thus the questions remain whether this endeavor remains on paper only or another handout for poor.

Education was taken as a reference point. It was observed that as education level decreases the trend of reporting morbidities increased in both data sets. In fact 72 per cent of the respondents with no formal education reported poor health.

Sule work (2009) mentions two P’s planning and policy must for achieving millennium development goals. The ground situation is alarming as 230 million population has purchasing power parity of 1$ only as it is mentioned in national sample survey data. India ranking in human development reports generated in the past ten years has been insignificant, within a health system only marginal increase has occurred in health indicators through various vertical programmes. There has been no systematic change noticed in the health system. The problem in health system gets further compounded due to lack of infrastructure, shortage and quality of supporting staff, lack of timely intervention to save life’s. Thus quality of life for the average citizen in country remain in shambles and what to talk about poor slum dwellers living in Indian cities.

Das Gupta and Bhist (2010) opines that national urban health mission with its focus on urban poor and other disadvantages groups inhabiting growing cities will cater to their health needs. In all 429 cities will be covered up in its initial phase benefiting 22 crore population including. This includes five crores slum dwellers. An amount of Rs. 9159/- crore would be spent under this mission. It is being estimated that by 2041 half of the Indian population will be urban. The process of urbanisation is facilitated by natural population growth in urban settings along with migration from rural to urban areas. The urban health system has not been reorganized in spite of Krishna committee recommendations and the Pattanayak recommendation committee formed to look into a dengue epidemic which affected New Delhi in 1996. The pace of urbanisation has not been at par with the growth of urban services and infrastructure. The eleventh plan mentions that in spite of a large number of public and private health providers in urban areas the poor are left out. Thus urban health agenda has been fragmented one.

Dasgupta et al. (2010) study analyses how India public health system need to be strengthened. The study suggests that lessons can be drawn from Tamil Nadu where public health has been prioritized for creating health infrastructure. This aspect has been
ignored by the central government since 1950's onwards. The government has adopted issue based approach rather than taking the holistic effort. Public health departments ensure safety of water supply, proper management of solid waste and sewage, setting public health standards etc. The department also focuses on disease vulnerability, vector control and disinfection. It was felt that bureaucratic decisions over a period of time have eroded the public health system as public health services were combined with medical services as per recommendations of Bhore committee report. The government initiated disease based programmes such as malaria eradication that were started in 1950s as per directive of World health organization which led to transformation in the orientation of health policies. The change of male health workers into multipurpose health workers to assist in implementation of national health programs also eroded the very essence of public health.

The study reveals that the Centre government spends 8.9 percent of the health budget on public health component in comparison to 40 per cent being spent on curative aspects. The steps initiated by the states like Tamil Nadu could be adopted by other states for managing public health. Tamil Nadu has separate directorate of Public Health whose health budget is 38.8 percent in comparison to medical services and education. They have public health act on the basis of which they draw plans to overcome threats of annual floods. The public health system is run by a cadre of public health officers working along with sanitary officers and inspector cadre.

Hence, there is no dearth of studies that provide appraisal of the government led programmes such as carried out by Banerji (1978), Pannerborg (1995), Velden et al. (1995), Chaterjee (2000), Kutty (2000), Ramachandran (2005), Kulkarni (2002), Qadeer (2002), Saxsena (2004), Gill (2006), Jhabvala (2003), Bardhan (2008), Berman and Ahuja (2008), Guruswamy et al. (2008), Kurian (2008), Mehrotra (2008), Mukherjee and karamkar (2008), Nath (2008), Bhargava (2009), Shah (2009a), Shah (2009b), Sule (2009), etc. These studies discuss hits and misses or pros and cons of existing health programmes. It has been examined, how health has been prioritized within the realm of public health, analyzing financial outlays meant for health sector, questioning the over prioritizing of some programmes over basic delivery of health care. All researchers were of opinion that all levels of health care system need to be strengthened by
concerned governments, by identifying the gaps between them, there is need for placing multiple and social security approaches to bring health care to poor.

1.6.4 Stakeholders in Health Care

Kirkham (1999) work raises the issue of occupational stratification within the medical field. Women played a decisive role in child bearing practices. Their role has been important traditionally as knowledge has been shared between women and midwife’s relating to hygiene and overall health practices. Midwifery as profession has been not given its due it has been relegated to a semi-professional or subordinate status. They have been excluded by power holders (Doctors) within clinical practice. The role have been defined in the strict narrow sense as that of support and care giver rather being interventionist. They are termed as helpers to male who exercise their authority in the medical occupation. They are treated as a group on marginal of professional competence and autonomy etc. The professional setting has changed as technical language is over used hence ignoring the social cultural practices prevalent at community level. As a result of which humanistic touch has been missing during child birth thus becoming more clinically based.

Baru (2000) study analyses the shift in the health care sector due to privatization, where market forces come to play significant role in the fields of pharmaceutical, medical equipment, health insurance and computer software etc. The corporations of pharmaceutical companies have been there in the field for long but they have become active players in promoting specialist care. The private sector comprises of practitioners trained as well as untrained. These have an expanded referral system which links these practitioners in chain with chemists, nursing homes and hospitals. The hospitals have become a profitable venture with the coming of new medical equipment’s since the late eighties.

Sethi (2001) study examines doctor perspective to understand medical profession. Social values shape the profession humanistic touch has paved the way towards commercial endeavor. While practicing earlier doctors would talk, hold hands, stand and show caring attitude towards patient which provided support to the family. However at present times the art of listening to the patient has been replaced by
objectivity and medical diagnostic techniques. The study points out that there should be balanced between what is taught to medical graduates at college and what is expected from them in a medical setting. The regulatory bodies such as the medical council of India and medical association have failed to promote the work done by doctors in rural India with little resources. Over emphasis on western medicine has taken away the power to heal oneself. The continuous medication creates new health problems. Modern medicine symbolizes impersonal attributes rather than personal health care. At research levels those activities are carried out which has approval from advanced countries.

Kundu (2002) in his study describes the role played by various state actors within the government machinery from top to bottom. How system has been institutionalized to cater to the needs of citizens at all levels. Various health system levels signify the kind of health care delivered to individuals based on the nature and severity of sickness. This includes common ailments to higher end surgeries which require a specialist approach and medical treatment supported by diagnostic tools. The work also highlights the roles allocated to center, state and local authorities in providing logistical support to run the system in an appropriate manner. The urban poor use government dispensaries and hospitals at local level, however certain factors discourage poor to go for these public health services such as low quality services being provided, non-availability of medicines, no testing facilities, devoid of referral system and most significant attitude of doctors towards these poor patients.

Pinto (2007) raises the issue of the role of Midwives or Dai in changing the context of providing prenatal, postnatal and maternal care in Indian homes. Role of Dai is related to assisting child birth to performing symbolically critical tasks, to carry out healing and cleansing tasks. All these tasks are related to pollution taboo. The dais has been trained as midwives within the health care system thus providing institutional support to meet birth related indicators. The state surveillance over family planning programs, immunisations and inducing abortions in critical cases is often related to medical progress as a result of which Dais traditional role has been affected.

Baqui et al. (2008) work tries to explore whether the participation of NGO’s in delivery services has any positive impact over a community, the study discusses the
implementation of Neo Natal health programs in rural setting in two districts of Uttar Pradesh. The results yield that women from the intervention district were illiterate with respect to comparison district, home visits increased in the intervention district for antenatal and post natal care, equity was also reflected with regard to care, childcare of immediate born focused on breast feeding, clean cord care and delaying bath for six hours in intervention district, whereas breast feeding was only practice found in comparison district. However certain constraints were noticed in infrastructure facility and coverage of programme. The multiple health workers were overloaded with work related targets thus failed to provide necessary health care services. Thus basic manpower is required to set off linkage between government and private health sector.

Ramachandran (2009) brings into limelight how the premier institute in the field of health care AIIMS has to be dependent on outsourcing for providing medical treatment to the elites. This question the recruitment carried out of less qualified doctors which have led to decline of medical standards. Apart from doctors that are overburdened by number of patients seeking treatment at this institute. The doctors confine themselves to general treatment as the number of they fail to specialize at higher end surgeries. The processes of adhocism at level of appointments affect the overall research environment in the institute. At same time politicization of the campus and nepotism where skills and brilliance take the back seat has lower the standards of health care in India’s premier institute.

Zachariah (2009) underlies that present focus of medical fraternity is on the tertiary sector at the cost of other sectors. It is where medical personnel specialization along with advanced technology combines together to deliver to miniscule of urban population at higher end of the social stratification ladder. However the masses are ignored as their problems are related to mundane issues of ENT problems, viral sickness, child delivery or accidental incidents. Thus they are forced to rely on multi component physicians in their neighborhoods whom they refer to as family physicians. The medical education system has to be blamed for this imbalance as curriculum taught in medical colleges creates a cadre of specialists in tertiary care and no one studies family medicine which is the last resort for medical graduates.
Mavalankar (2011) examines the reason for the decline of midwifery. There are multiple reasons for this phenomena to occur administrative reasons accompanied by lack of political will and change in the orientation of health programmes over a period of time are ones which have been highlighted in the study. The result indicates that certain steps such as changing the time duration of the course of midwifery integrating midwifery training in nursing, laying emphasis on preventive care rather than hand on training eroded the essence of midwifery profession. It has been regarded as profession meant for women of lower classes thus stigmatizing it further. The funding mechanism has been lopsided one which favoured opening up of medical colleges’ vis-à-vis nursing colleges. Moreover the state undue emphasis on national level health programmes has led to ignoring basic natural health care. The study recommended that Indian state should take measures to build midwifery as a profession along with focusing on strategies of Skilled Birth Attendants (SBA) and emergency obstetric care as key features of its health system.

Thus we can conclude that studies of Kirkham (1999), Sethi (2001), Kundu (2002), Pinto (2007), Baqui et al. (2008), Ramachandran. (2009), Zachariah (2009) Mavlankar (2011) argue that the roles of all health personnel are important in delivering health services. The need for realignment of health system is must. New mechanisms need to be placed for efficient delivery of health care services. There is need for reorienting occupational hierarchy and changing contours of medical education to make doctors more adaptable to societal conditions and not remain aloof from existing realities.

1.6.5 Perspectives to Study Health

Baneerji (1986) work elucidates the point that contribution of social sciences within the Health field has not received much attention Hence it becomes pertinent to evolve inter disciplinary approach to understand facets within wider health system such as patient illness, their adjustment to clinical environment, sick role etc. At community level it is important to understand how cultural and social factors contribute in understanding health practices and how basic necessities of life affect well-being status of a individual. All three approaches sociological, epidemiological and biomedical can
be employed to study health in right perspective. The development and expansion of health institutions and its services depends upon the political will of the state. It provides logistical support by creating infrastructure, recruiting human resources and fixing financial outlays for various programmes. The output of health delivery system rest upon structuring of health institutions and its governance pattern. This feature ensures that health facilities reach the desirable sections of society.

Davies (1999) study highlights how the issue of social exclusion has been associated with deprivations which people face in meeting their social concerns. Thus different approaches have been underlined to overcome social exclusion which majority of poor face. The community approach emphasizes upon equitable distribution of health related indices. Empowerment approach lays down emphasis on choices that can be made available to individuals and community. The basic essence of this approach is to tackle inequality, inter-linking of different problems, prioritizing how resources can be made available to different groups by identifying deprivation levels. There are other approaches that identify how the system can be politically or socially restructured. The study states that for overall sustenance of any development program initiated by the state it is important to involve people for whom it is designed.

Blane (2000) in his study relates how life course perspective helps in understanding life chances which an individual enjoys in relation to accessing health care. The class is one of the determining factors in accessing health opportunities as it may affect the disease pattern, certain biological problems get aggravated due to poverty. Thus Social mobility has its bearing on consequences which affect individual health.

Pappas et al. (2003) view the various theoretical approaches of globalization how they could be fruitful in analyzing health. The study conceptualizes institutionalization of modernity along with globalization to discuss the nature of economy, the process of industrialization, emergence global military power and social control. Globalization brings in its fold risk pattern such as the emergence of infectious diseases, epidemics, and contaminated foodstuffs, circulation of legal or banned stuff and changing of occupational roles leading to new stress levels. The study points out
that for whom this globalization is actually working and in which way. Sociologically speaking consequences of globalization may be intended or unintended as stated by Robert Merton as especially in case of public health.

Fidler (2003) work put into perspective how public health over a period of time has assumed centric position in the realm of international relations. Its emergence lies in new epidemics emerging such as HIV/AIDS. There are other facilitating factors such as the dimension of pricing, patenting and the role of aid agencies. Utilitarianism defines public health as an instrument to achieve social good. The health of workers and diseases affect larger society, Disease act as a hindrance towards economic development which is pursued through public health policy of the government. Beyond the state, at global level this model is largely advocated by multiple agencies that come together on a single platform. Liberalism rest upon vertical non state actor's role for example how lobbying for beverages as commercial endeavor and issue of pesticides and sugar contents in beverages as a public health issue. Constructivism explores relationship between structure and agents, explore when, How, Why constructs are important to understand the health issues.

Williams (2005) work elucidates Parson’s contribution to the field of Health sociology by elaborating concepts related to health and illness. How they could be correlated with the present debate relating to patient response to clinical environment where issues of emotion, trust, uncertainty are highlighted. Two kinds of reactions are manifested by the patient when illness is known to him one of emotional shock followed by anxieties related to future course of life. These issues are explained by parson using pattern variables i.e. the dilemmas which correspond to position doctor must adopt towards his patient. Thus the issue of privacy, effective rapport, objectivity, affective neutrality is maintained by doctor. Further on two models of illness are underlined in the study one of incapacity model where individual fails to perform his or her role due to illness, other refers to deviance model related injury or accident were need for therapy is highlighted to understand the issue of illness.

Timmeramans (2008) work explores the emergence of sociology of health within the discipline of medical sociology. Talcott parsons’ contribution has been
immense. He stated that health and illness can be analyse sociologically as social factors have motivational as well therapeutic influence. Parson emphasized that social scientist along with medical professionals should confront health issues together. The nomenclature has changed from medical sociology to the sociology of health to give wider play ground to health professionals who have been ignored in the clinical setting. The study underlined the issue of preventive care which is related to individuals social environment.

Jacob (2009a) states that public health perspective is important for defining development in right context. It overlooks issues related to sanitation, housing and nutrition. It is the biomedical approach which guides public health in India. There is collusion of interest between biomedical, capitalist and social perspective. The political leadership focus on short term ends rather than conceiving solutions in larger context. Health can be ensured if minimum standards of living are provided to people and not just focusing on specific diseases or following vertical strategies. The state funding for sanitation and clean water programme is appropriated by spending on vaccines meant for particular diseases. However interventions should be directed towards creating a viable environment for living rather than being defensive of introducing vaccines. Health should be defined as right within the legal framework and on humanitarian grounds. It is because hunger, nutrition, unsafe drinking water physical environment, and shelter all attributes are associated with poor health status. The scope of public health can be expanded through the state commitment. The inter sectoral approach needs to be pursued by placing social factors in the right manner.

Reddy (2009d) studies the model of medical education provided in India. He suggests that an interdisciplinary approach is important to explore the relationship between health and disease. He advocates that medical graduates must expand their knowledge using inter disciplinary perspective rather than confining themselves to technology led medical care. Doctors must familiarize themselves with health system in total, should go in the field and identifying constraints which affect their work. Five “E” factors are important epidemiology, economics, ethics, empathy and engagement which are lacking in modern medical education system.
Akram (2014) studies the evolution of sociology of health as a discipline in India. He dwells on the issue of both social and community health both sub disciplines of sociology of health. He traces the contribution of scholars like Anita Minocha and S.R Mehta whose work has given due importance to this field. The study brings into notion of health by adopting theoretical approach and factors which determine health care. The study looks into health indicators and evaluates health policies of the Government of India. This work has been placed in the context of environmental health, public health and medicalization of human bodies two debates which are of recent emergence.

Nagla (2014) work explore the issue of health and illness in a larger perspective by providing essence of studies which have been carried out in past decades which have institutionised the discipline of sociology of health. This work touches each aspect of health by looking at cultural aspect of food in relation to health diet and its significance, he work examines nature of delivery system and traces the role of state in providing health care within Indian the state of Uttar Pradesh. The study highlights how recent advancements in technology along with social cultural factors have led to practice of foeticide ,further the study identifies issue of infertility, emergence of mental illness along with disease related to HIV proneness among marginalized especially Devadasi and other sections of women due to promiscuous relationships and women being the suffers because of patriarchal and changing value system and how prison mates because of appalling living and health conditions along with violation of sexual rights by facing rape ,sexual assault etc. The works unfolds different layers of health and its attributes by focusing upon system, institutions actors both service providers and users, diseases, reproductive health its manifestation along with illness and accounts of suffering.

These studies by Baneerji (1986), Davies (1999), Blane (2000), Pappas et al. (2003), Fidler (2003), Williams (2005), Timmermans (2008), Jacob (2009b), Reddy (2009d), Akram (2014), Nagla (2014), have greater relevance as it brings into picture how inter disciplinary approaches between sociology and health disciplines need to be adopted for arriving at reliable identification of factors which promote health care. How perspectives like utilitarianism, constructivism can be used to understand how health is part of globalise debate. How different approaches can be used to examine different
health issues, for example individual illness can be studied by using life cycle approach and community approach can be used to handle public health issues. The works examine new currents within sociology of health.

1.6.6 Ageing, Gender and Health Concerns

Ramalingaswami (1987) studied women access to health care. This study has been undertaken in Visakhapatnam district covering two blocks of Paderu and SabbaVaran. The results reveal that 23.37 per cent rural women deliveries are carried out by ANM. However 74 per cent of rural wanted ANM assisted deliveries. In case of tribal families members assisted deliveries are preferred which are as high as 50.54 percent. It is dais who has carried out most of the deliveries i.e. 57.11 percent. Family planning program's utilisation has been as high as 72 percent among rural and 67 among tribal women. At the level of awareness almost 99 percent women are aware about Malaria and treatment to be sought in both rural and tribal women. PHC facility is being utilized in case of accidents or acute illness 78 rural and 67 tribal used it. The awareness levels have been high in relation to all health related programs in spite of not receiving them.

Ravindaran work (2000) explores gender perspective on health. This is not confined to child bearing and pregnancy related information but goes beyond it. This analyses differences in health care needs and need to evaluate factors which promote risk behaviors. The study looks at gender dimension of health as how women perceive illness, its nature (severity and duration), accessibility to health care and its outcome. The study highlights that by birth girls are denied proper feeding and health care hence increases chances of mortality. Women have high rate mortality due to pregnancy related complications, vulnerable to sexually transmitted diseases because of unhealthy behavior of partners. India being a patriarchal society women access to health care is restricted under the mask of social cultural traditions. Sometimes women do not access health care due to lack of time, money or sometimes the stigma associated with a disease. Thus health policies need to be gender sensitive so as to take into account gender differentials in health risks, health information and healthcare accessibility.
Joshi and Sengupta (2001) suggest that health of aged assumes importance due to demographic profile of the population i.e. the percentage of old aged people to total population may cross 21 percent by year 2050 which was merely 5.1 percent in 1901 in case of India. The issues which effect elderly are multi layered: - illness, economic dependence on children, living in isolation. The diseases affecting them may be degenerative or communicable due to less immunity because of old age, problem of hearing and vision are also reported. Respiratory disease like pneumonia, septic arthritis’s, tuberculosis and urinary tract infections all get compounded by lack of proper care, nutritional deprivation and abject poverty. The old people also suffer from mental illness due to ageing of brain, emotional attitude and lack of family support. Hence a wholesome approach should be taken into account while dealing with elderly in society.

Vishwanath (2001) work highlights philosophical underpinnings of the state led programmes from family planning to stage of population control to stage of reproductive health. The various methods advocated from time to time are mere biomedical in nature which does not take into account social cultural factors that may promote or hinder them. The methods used for family planning may have adverse affects which are in fact not known to users, whereas its efficacy is only highlighted by government in their policy documents.

Bhatt (2006) in her study of SEWA explored various dimensions which affect life of women folk in direct or indirect manner. She addresses the issue of healthcare related to expectant women dying during child births, women from deprived backgrounds are vulnerable to sickness during their Life cycle largely due to their living conditions where basic access to all kinds of services is of poor quality. Women are prone to occupational related health hazards common ones such as respiratory diseases found among bidi makers. There lie a contrast between doctor’s world and the world in which women work thus emerges collision between doctor’s recommendations and a woman's response to take care of them. The Sewa organisation on their own tried to educate women through health camps and seminars the topics covered include knowing your body and issues related to occupational diseases, reproductive issues and women's
rights etc. *Sewa* started health cooperatives selling generic drugs rather than selling branded medicines so as to increase affordability of medicines among poor women.

Jacob (2009d) in his observation states that in spite of vocal concern shown by government with regard to women and girls issue it has not been translated in real term of their social achievements or health related indicators. There are marked gender differentials with regard infant mortality rate, adult literacy rate, school enrollment and attendance. Within any development program women are treated as targets rather than equal partners in implementing them. The public health perspective needs to be adopted to analyse the issue of health among women and girls and not just be dependent on biomedical approach.

Nagla (2013) examines health in relation to gender by describing inbuilt social cultural hindrances which women face while defining notion of illness and to the time of seeking health care. It follows a life cycle approach by looking at health of girl child, issues of expectant ladies, overemphasizing of women as target groups under the umbrella of family planning programmes run by the state, looks at ethical issues in relation to women’s health problems, newer mechanism of giving birth based on surrogacy and abortion that points to individualistic orientation which is emerging in conflict with collective sentiments of family as an institution and its role in birth of a child.

Hence Studies on Ageing, Gender and Health Concerns by Ravindaran (2000), Joshi and Sengupta (2001), Vishwanath (2001), Sen (2004), Bhatt (2006), Jacob (2009c), Nagla (2013) do reveal that women and ageing issues are have been marginalised within health care setting. The state adopts international agendas without understanding social cultural constructs thus harming both these groups. The health professionals are routinized to follow health programmes in practice by following target approach.

### 1.6.7 Cities, Neighbourhood Influences on Health

Gupta (1993) in his work discusses the integrities of the urban health system. The study provides a profile of illness to which urban slum people are subjected to starting from infectious diseases, malnourishment, and chronic diseases to the level of
social diseases. This study highlights how health services function in an urban environment, the problem of duplication of services, lack of coordination between different units which provide health care in terms of preventive and curative services. The study points out that cost factor as well as mal-distribution of services affect their utilisation. They are largely concentrated in posh areas of the city.

Barten & Naerseen (1995) raise issues of urbanisation which may vary with regard to ground realities available in different countries. As there is a close relationship between health and environment there is a need to define health in terms of social, cultural, physical, economic and political variables. For devising health strategies for urban areas the issue of slum people associated with poverty and violence should be kept as consideration for framing overall health policies. The issue of urban management and planning assumes importance in relation to problems generated by sprawling cities.

Bernard et al. (2007) in their study defines the notion of place in terms of neighborhood. How it influences the health of an individual, place in relation perspective is studied where one live, work, and play. It is important to understand compositional (similar in socio-economic status) from the contextual (ecological attributes) definitions of a place. While studying neighbourhood and its role in catering to health five aspects are important physical features, environment supporting home, quality of services available, socio-cultural features and area reputation. However in order to access resources four rules are important proximity, rights, price, informal reciprocity all corresponding to social, economic, physical institutional domain. Thus holistic perspective to access to health services is an important element to be employed in studying ever expanding neighborhoods.

Jeremiah (2008) in her study explores the issue of health within domain of ever expanding cities especially in the west. The nature of the city has impression upon the individual as well as the larger community. Urban health issues can provide impetus to study not only in the field of medicine, public health, social and environmental sciences but also within the rubric of health policy. The issues such as segregation, differential accessibility to health, crime and violence, drug abuse are major concerns covered within the ambit of urban health.
All these issues emerge from inequalities with access to better opportunities and livelihood. The physical decay of urban structure aggravates problems further leading to alienation and rise in crime. The population and community approach is can be employed to understand the life chances and life styles which are available to the poor people who are largely dependent upon state led policies for their survival. The problems they face vary, from poverty to homelessness, illicit drug use, problem of sexual minorities and aged. Hence, there is a need for different avenues to rectify their illness through various methods and therapies.

Ergler et al. (2011) reports from field based study carried among the poor residents of Chennai, that mentions the reasons for preference for private health care among poor in spite of nearest public health facility available. It has been observed that the public health care system suffer from out dated equipment and over burden health professionals which get associated with the tag of low quality services. From the study it comes out that distance is not the crucial factor for seeking treatment for illness. It is a social entitlement (money) which is the crucial factor. For some if money is available people go to private doctors for injections, if they have lesser money they go to the pharmacy for medicines. If none they follow home remedies and if nothing better happens the last resort is government polyclinic. “It is only for family planning and pregnancy related issues that public health facilities are consulted. This suitability depends on the type of care to be administered”. In order to save time, money people preferred private as they get cured within three days which is a 10 day time period in public health facility. The poor feel out of place as no proper diagnosis is done, sense of carelessness prevails and doctors don’t listen to them. Hence it becomes obvious from the study that style of functioning and emotions do play a prominent role along with access factors while utilizing health Care. There has been flight of doctors from public health care system due to high bureaucratization and large work load of patients hence they seek employment within the private sector as they get high pays thus further eroding the legitimacy of public health care system.

Goli et al. (2011) study of living and health conditions of selected cities in India setting priorities for national urban health mission examines that for creating healthy cities one has to focus on physical, mental, social and environmental well-being of
citizens who live in urban areas. The study reveals that in all eight cities majority of scheduled castes and scheduled tribes are found to be living in slums. In case of Meerut 70 per cent of them live in slums whereas in Chennai percentage is lowest i.e. 32.90 SC and ST living in slums. On the whole there are variations as per physical infrastructure in slums was concerned. In Meerut there is 100 percent availability of an improved source of drinking water; in relation to toilet facility maximum access has been found in Hyderabad 57.8 percent. The provision of electricity is higher in Mumbai 99.3 percent. In terms of health care more than 65.9 percent children does not avail immunisation facility in Meerut thus influencing the infant mortality rate which is 62.8 percent. Meerut scores badly on maternal care indicators as institutionalized led delivery is 46.1 percent in any sector where as at government facility it is quite low 5.6 per cent.

It has been observed that 92 percent do not use government facilities at all who reside in slums of Meerut city. Almost 60 percent of slum residents state that reason being poor quality services. Thus Meerut stands last on public health performance index. Thus lots of health based interventions are required to overcome health differences among slum dwellers of different cities.

Jaiswal and Gupta (2014) study is placed among the slum dweller of Mumbai city. The study traces the factor which facilitates usage of health care facilities. Religious belief systems along with low level of awareness about hygiene practices do determine their notion of illness. Further study points out that system enabling factors like behavior of staff(48 percent ) lack of drugs (60 percent) and staff shortage (40 percent) does determine their health utilization. Whereas, working timings play a prominent role in not availing public healthcare system as 88 percent reported as a main factor. The migratory nature of the population along with their poverty of habitat in the slums does affect the emergence of diseases especially tuberculosis.

Thus studies mentioned above undertaken by Gupta (1993), Barten and Naerseen (1995), Montgomery and Hewett (2005), Bernard et al. (2007), Jermiah (2008), Ergler et al.(2011),Goli et al.(2011), Jaiswal and Gupta(2014) have provided insight into how health as gradient is affected by changing conception of ‘place’ within urban sociology and planning studies, which individual in habits and what
consequences follow from it. There are other studies which looked into issue of health indices, legal framework, and nature of diseases which have been dealt below.

Armstrong and Caldwell (2004) and Advani and Akram (2007) have examined how various health indices are to be drawn so as to arrive at reliable results while undertaking any field studies? Some limitations of above mentioned studies were that very few adopt inter disciplinary approach while framing and analyzing results.

Whereas scholars like Bloom et al. (2008), Desai (2007), Anand (2009), Hassan (2009) opines that all these studies are important within changing orientation of health delivery system and need for user to beware of intricacies related to health care. Somehow no study brings to focus the role of regulatory bodies in relation to medical profession. It is only from client perspective that legal issues have been discussed. Reddy (2009a, 2009b) both these studies highlight the issue of chronic lifestyle diseases and need for integrated mechanism to understand diseases occurrence by taking into account biotic and abiotic factors together along with role of human interference. Hence, we are summarising in light of above observations.

From the review its clear that the deprivation levels and infrastructure concern, economic inequalities have widened which have profound impact on health indicators which have remained unchanged thus adversely affecting those who are poor (Deaton & Dreze, 2002:3742-3745). At the same time the contribution of sociologists has been minimal to examine the issue of marginalization and inequality in urban areas. Further the reviewed materials lack a clear theoretical basis of interpreting the nature of health care system utilisation among slum dwellers. There are inadequate references to inter sectoral linkages necessary for delivery of health care. The majority of the studies take one aspect or the other rather than providing a comprehensive view of health care system. Mostly scholars have highlighted health care within biomedical model as an independent variable ignoring its relationship to public health, its efficacy and factors which determine its usage by slum dwellers.

In light of the above mentioned concerns there is a need to focus on urban health as with the rapid pace of urbanisation the slum dwellers are further marginalised and get little access to basic services (Aggarwal, 2011: 27). Thus over a period of time multiple
level of disparities have increased. This existing literature raises enormous number of
issues which can be critically identified with regard to health care in slums and role
played by public health care system in its delivery. Thus various linkages need to be
examined from issue of initial conceptualization of problem and planning exercises to
delivery of health care in slums in a holistic manner.

Keeping in mind the above gaps in the literature reviewed the study has been
conducted with the objective of:

1.7 OBJECTIVES

1. Analyzing the utilisation of health care services among the slum dwellers;
2. To know the user perception of public health delivery system among the slum
dwellers;
3. To examine the socio demographic and economic profile of the slum dwellers of
Amritsar.
4. To study the role of State for creating health care facilities in Punjab with focus
on slums of Amritsar in comparison to India.
5. To bring out the policy implications of the study.

With such objectives the study makes an attempt to answer the following
research questions and addresses research gaps identified above.

1. How and why slum dwellers are vulnerable to diseases typical to slums?
2. How far socio demographic factors play a role in health care services for Slum
dwellers?
3. How far such vulnerability is related to housing, water, sanitation, education and
income inequity?
4. How far professionals share people perception about the health care delivery
system?
5. Which factors are decisive in determining levels of satisfaction with regard to
health care among the slum dwellers?
The usage of *Slum dwellers* in the study refers to those who live in notified slums of Amritsar city. The study is placed within the sub discipline of *sociology of health* as sociologists interact with health personnel in a medical situation to judge the possible social factors which have a bearing on the health behavior of slum dwellers. The present study attempts to study utilisation of health care services among slum dwellers in Amritsar city. Keeping in mind the nature of the study descriptive research design has been used to look into the structural impediments which hinder health care utilisation among slum dwellers. To achieve the set objective of the study, utilisation has been measured in terms of degree, extent of usage, trust and the nature of services rendered. The term ‘degree’ refers to differences between the members of homogenous groups living in slum areas. The term extent means how many people have access to health care system. Which factors promote or become obstacle in accessibility. What are the alternative systems of health care available to slum dwellers in case of inaccessibility of public care health services. The people’s perception of health care has been examined by looking into the trust factor among the user of health care services and health professionals/healthcare institutions which play an important role in delivering health care services. Several studies indicate how trust ensures patient willingness to seek health care and its utilisation (Meyer *et al.* 2008:177-179). The trust has been examined by analyzing following terms:

a) **Accessibility** in terms of unequal distribution of medical care among different social, strata, lack of awareness, parental illiteracy, and economic compulsions;

b) **Quality of health care** in terms of buildings, hygiene, and availability of medicines, doctors and medical facilities;

c) **Doctor’s skills** in relation to their training and achievement levels;

d) **Efficiency** in terms of health interventions work.

### 1.8 RESEARCH METHODOLOGY

#### 1.8.1 Area of Study

The universe of the present study is the ‘notified slums’ of Amritsar city. The number of notified slums is 63, which are within the limits of the municipal
boundary. The city lies between 31°7’ and 32°3’ north latitudes and 74°29’ and 78° 23’ longitudes on the national highway No.1. Amritsar city is having an area of 11500 hectares with a population of 1,132761 (in 2011). The health system has been analysed on the basis of allopathic medicine. The health facilities has been classified into government and private sector and within hierarchy of services health care offered at city level covering slum area dispensaries and the satellite hospitals which are comparable to primary health centers existing in rural areas. The out-patient information has also been collected from these health care facilities.

From these ‘notified slums’ five slums are chosen on the basis of urban services (water, sewerage and drainage facilities) available in these slums using the lottery method. Every tenth household was included in the sample and one adult member of each household was interviewed. In all 321 adult respondents from each household was interviewed. Data was collected initially by observation later on using interview scheduled to get reliable and authentic information.

The unit of investigation is household. A household for this study is defined as a person or group of persons related or unrelated, living and eating under same roof in above mentioned slums. Moreover to make the sample as representative as possible these slums are identified from three separate locations that is Western, Southern and Northern part of the city. Focused group discussions have been carried out to elicit response from the stakeholders with regard to quality of health care provided at satellite hospitals.

The first three areas include slums of Fatehpur, Bhrariwal and Angarh located in the Southern part of the city. Fatehpur and Bhrariwal are the two areas dotted by agriculture fields, where vegetable cultivation for the city of Amritsar is carried out. Whereas, Anagarh has more of concrete structures narrow lanes and does not have open spaces as is the case of other two slums. In Fatehpur large number of diaries which have been shifted from the interior of the city are situated. This area has also been identified by improvement trust to house the new modern jail to be constructed by the government. This area is dotted with public health care facility in the form of the
satellite hospital apart from having numerous private health care providers ranging from pharmacy shops to clinics to unqualified practitioners.

The second area is Kala Ghanupur which came under the municipal limit in 1981. It is in South West part of the city, having public health care facility i.e. the satellite hospital.

The last area in North of the city is Ganda Singh Wala a slum having narrow street crisis crossed by lanes. The Slum houses predominately scheduled caste population. (Map 1, Municipal Corporation depicting sample slums which have been identified for the study).

1.8.2 Techniques of Data Collection

The data was collected in the period from October 2011 to March 2012 through Quantitative and Qualitative methods. The quantitative method has been applied through interview schedule which was constructed after conducting pilot study. The researcher visited the slums of Fatehpur a number of times to know about their living circumstances and hardships they face at day today level. Informal interviews were conducted with people residing in the slum. The researcher also paid occasional visit to the satellite hospital to understand the working and interacted with the patients and their immediate family members. These visits have been of immense help in formulating the research problem. Interview schedule once prepared was pre-tested to overcome systematic error and also to add or delete certain questions. The interview schedule is divided into following sections: socio demographic profile; health status; disease profile and utilisation pattern along with perception of health system. To overcome the language problem the interview schedule was translated into Punjabi so that it could be administered to the respondents in each household in all five slums under study.

The interview schedule had both open ended and close ended questions. Data collection was not an easy task as often people would come to ask for medicines or brought prescriptions to describe about their illness. However once they were convinced that it is an academic exercise they were forthcoming in their answers sought by the researcher. The questions which dealt with MCH required the help of women who were present in the house (for further reference see annexure no. 6).
The secondary sources of data such as books, articles, developmental reports, policy documents, committee reports, working papers, conference and seminar proceedings, newspapers records of census and official websites of various ministries were also consulted.

1.8.3 Code Design

A code design was prepared for dealing with large volume of data to be properly classified. After completing the field work, the immediate task was to separate structure and unstructured questions in the interview schedule so as to allot appropriate code. Every interview schedule is coded according to the code number given to different questions, as to convert the qualitative data into the quantifiable data.

1.8.4 Tabulation

Tabulation of unstructured questions has been done manually whereas the structured data have been processed on computer by using the Statistical Package for Social Sciences (SPSS) software.

1.8.5 Data Analysis

Inferences have been drawn using percentage analysis and chi square. The most pertinent quantitative technique of factor analysis has been carried out to construct health utilisation index which helped in understanding health utilisation pattern in a better way and to arrange household on the basis of better or worst health status. On the basis of the data collected from the field relevant case studies have been constructed. The case studies are drawn taking into account health perception and their day today life. It also looked into their health seeking behavior and constraints they face from the family and within the health system. These case studies are helpful in drawing more appropriate inferences and sharp generalizations.

1.8.6 Significance of the Study

The studies focusing upon the issue of health care services in slums are very few. Many of the studies undertaken on health care are based on secondary data but very few based on field studies. Majority of the studies dealing with personal health and public health issues have been carried out at the State level in the Southern states only and some have been carried out in slums of metropolitan cities like Mumbai, Delhi,
Chennai and Bangalore etc. Some of the questions remained unanswered as these studies have not examined health within a larger frame of reference. These studies ignore living environment and its relationship to illness pattern and treatment. Moreover, no comprehensive study has discussed health care with respect to Punjab. There is no study on health care among slum dwellers living in Amritsar city, although substantial inputs about social, cultural and political organisational aspects have been highlighted in the study undertaken by Sandhu (1989). This study seems to contribute on health problems faced by people living in slums.

1.9 ORGANISATION OF THE STUDY

The present study is divided into six chapters. The first chapter provides the general introduction to the work. The second chapter traces the role of the State in provision of the health care system in Punjab vis-a-vis India. The third chapter gives a detail description about socio-economic and demographic profile of slum dwellers in sample slums. The fourth chapter looks into health profile of slum dwellers by examining utilisation pattern of health care services by slum dwellers where morbidity pattern, health care system accessed and how various national level health programmes are utilised within public health care system have been studied. The fifth chapter looks into Utilisation pattern of health care services by slum dwellers where empirical data from the field has been collected and analysed by using factor analysis and constructing health index. The chapter also studies the user perception of the existing health care system by analyzing data from the field study along with case studies drawn from the experiences of slum dwellers to arrive at better analysis. The sixth chapter is the last chapter of the study which is concerned with findings of the study and conclusions drawn from it.

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