CHAPTER 9

SUMMARY AND CONCLUSION

In this concluding chapter an attempt has been made to draw an outline of the research background, the stated objectives as well as to summarise the major findings of the research work done so far and to draw the final conclusions. Moreover, a few suggestions have been put forward here, so that the concerned administrators as well as the common mass can re-think over it and can take measures to do away with the practice of gender discrimination in access to health care facilities in West Bengal and the country at large.

9.1 MAJOR FINDINGS

Studies related to health issues are generally analysed through its biological dimension. But, several other aspects related to social, cultural, economic, political and environmental dimensions are equally important in the promotion and maintenance of health. Thus, health is to be understood as ‘a socially produced natural reality’ (Kopparty, 1994).

Therefore, the present study makes an earnest attempt to examine the sociological dimensions of health and health care issues. This assumes greater significance in the context of our national commitment to achieve ‘Health for All by 2000 A.D.’, where access to health care services ought to be universal. Hence, the major aim of this research work is to identify the health needs of both male and female population of the selected wards of three towns of Kolkata Metropolitan Area, namely, Baruipur, Kamarhati and Uttarpara-Kotrung and to explore the position of present urban West Bengal, with respect to the ‘utilisation of’ and ‘access to’ health
care facilities, through gender perspective. The entire work has been done in this direction and the findings have been summarised in the following manner.

The study shows that, though women are biologically more robust than men, yet, in terms of health status, females have recorded higher rates of morbidity incidence as compared to males. This implies that women’s health and morbidity issues are quite being neglected over the study area. Furthermore, the study has shown that, though the proportion of persons resorting to ‘no health action’ is very less, yet it is more common among female ill persons than that of the males. This is probably because the mobility of women is far more restricted than that of men. Since, the health system in India is generally institution based rather than domiciliary; women are more often deprived of utilisation facilities rendered by the health system (Mathur, 1995). In addition, the inherited knowledge about males’ neglectful response towards the sufferings of women as well as the fear of expenses for treatment probably results in subsequent denial of resorting to any sort of health action by the women (Rana, K. et al, 2005). In general, women are mostly over-burdened with different household chores and child care responsibilities. As a result, they have paucity of time and are often reluctant enough to take care of their health issues.

Moreover, it has been observed that both private and government health institutions are the most common type of health care facilities accessed by most of the sick people, of either gender, as compared to home remedy, homeopathy and self treatment measures in all the selected wards of the three towns. However, it is worth mentioning that, female patients are generally more provided with cheaper health care services which include home remedy, homeopathy, government hospitals and self treatment measures, if taken together, as compared to their male counterparts, especially in the wards of medium and low category in the selected three towns. In
fact, it is quite interesting to note that, higher proportion of females often seek treatment from home remedy, homeopathy and self treatment measures, rather than their male counterparts, mainly for the ailments like fever, respiratory, bone-related and other diseases. However, on the contrary, for serious illnesses like alimentary and circulatory diseases both male and female ill persons have resorted to private or public health institutions mainly, depending upon their economic viability as well as their personal preferences or choices.

In fact, the statistical analysis confirms, that though the type of health care facilities availed is dependent upon the type of diseases for male patients in the wards at all levels of development, but, in case of female patients, the access to health care facilities is not always disease specific, especially in the wards with low level of development. In such cases, certain other exogenous determinants like demographic or socio-economic variables might act as much more dominant factors in determining the access to health care services to be availed by female members of the society.

Furthermore, the study signifies that the people, of either gender, are mostly satisfied with the quality of health care services available within the locality, except for a few exceptional cases, when the health care services within the locality have failed to produce fruitful results or during some serious hospitalisation or operative incidents, when the ill persons of either gender, are compelled to move to Kolkata or some other towns in search of better medical assistance. However, the study ensures that situation becomes more compulsive in case of women than men, as the former have a tendency to neglect their health and show reluctance to visit doctors unless the diseases have been aggravated. This confirms the poorer conditions of female patients in the study area.
It has been observed that access to health care services does not always depend on any one factor like the type of diseases, rather different demographic, socio-economic variables interact with one another and again they individually act on the community to create different utilisation pattern of health care services. The study shows that access to type of health care services, for both the gender, is determined by the educational qualification of the head of the household and the income level of the household in the wards with different levels of development. However, access to type of health care services, for both the gender, does not seem to be determined by the age of the patient in the wards with high and medium level of development. But, in the wards with low level of development, the situation is somewhat different. Here, the access to health care services does not depend upon the age of the male patients, but, in case of female patients, their access to health care services is influenced by their age groups. The study shows the prevalence of neglectful response of this patriarchal society towards the health conditions of the adult females especially in the areas of low level of development.

Furthermore, a gender-wise analysis of the mean medical expenditure pattern of the study area shows that, the amount of money spent for the treatment of female members of the society is generally less than that of the male patients in the wards with different levels of development. In fact, the gender gap in the mean medical expenditure increases with the severity and continuity of the treatment process. This is probably because females have a tendency to avoid seeking treatment for chronic illnesses for the sake of prolonged treatment procedures which could end up with huge economic burden of the medical expenditure on the household budgets. Moreover, the analysis confirms that the differences in the mean medical expenditure between male and female patients is found to be quite nominal especially when the
patients, of either gender, have resorted to public health care services, homeopathy and self treatment measures. But, in case of private health care facilities, though the highest amount of money is spent by both male and female ill persons, yet, there is a huge disparity in the average health care expenditure, between both the gender, in most of the selected wards of the study area.

Furthermore, the analysis shows that, though the maximum share of the medical expenditure incurred for the treatment, for both male and female patients, is met by the household savings followed by other financial sources like free treatment, financial assistance from others, medical insurance and indebtedness, in all the selected wards of three towns, yet females, here, are less provided with medical insurance facilities than their male counterparts. This point to the sheer neglectful attitude of the patriarchal society towards the women’s health conditions, even in the 21st century.

In a nutshell, the present research work, therefore, depicts that the health status of the women as well as their opportunity to access to health care services is not in favour of female members of the society, especially in the wards with medium and low level of development. In fact, the study reveals that, the gender discrimination in this regard is least in the wards with high level of development whereas in the wards with medium and low level of development, such gender differences are quite notable. This in fact, brings out the darker side of this patriarchal society, where the culturally deep-rooted practice of gender discrimination in the allocation of health care facilities is still in vogue, even in the urban areas, where access to health care services is ought to be universal.
9.2 POLICIES AND PROGRAMMES

Therefore, in spite of impressive achievements in demographic and health indicators, West Bengal’s health status is chiefly characterised by intolerable shortcomings with abnormally high risks of morbidity, little knowledge about other psychological and cultural dimensions of health including serious social disparities in access to health care services etc. In fact, gender differences in health have not only perpetuated but have been possibly accentuated (Mathur, 1995). Furthermore, the problem of health hazards is very widespread as the masses are deeply steeped into the culture of silence and poverty. The common people especially the women, poor and the socially-downtrodden mass are not only ignorant but they have also accepted their pathetic situation, very meekly, in the name of divine providence, ‘karmphal’ and socially and culturally sanctioned taboos, precepts and traditions. In reality, socio-economic inequality results in excessive exploitation and oppression against the weaker sections of the society, which have consequently developed into a cultural trait where the depiction of health hazards can be tolerated easily by them (Srivastava and North, 1995).

So, the study reveals that the patriarchal attitude of this present urban society neglects women and their medical needs and hence there is an urgent need for a gender-focused understanding of health and health care issues.

In general, a gender approach to health moves beyond describing women and women’s health in isolation but rather brings into the analysis how the different social roles, decision making power and access to resources between women and men affect their health status and their access to health care. It examines how these differences determine, for example, differential exposure to risk, access to the benefits of
technology, information and services and the ability to protect oneself from disease and ill-health (World Health Report, 1997).

Hence, in order to do away with these gender differences, the integration of women and women’s health into the mainstream of the development process is urgently required. The policy-makers must recognise the primacy of good health as an essential component of human development in India. It is also important to view health more holistically, and understand how social, cultural, political, economic and other factors interact to constrain people’s access to health care services and contribute to human deprivation. It is expected that much of the gender gap in health and access to health care services is preventable and proper policy, programmes and interventions can reduce these differences (Mathur, 1995). Moreover, the state must address the protection and advancement of women’s health interests through gender planning, so as to achieve the abstract value of justice and to conform to legally binding international human rights obligations as well (Cook, 1999).

In fact, the women’s health has been receiving special attention throughout the world since the inception of the United Nations’ Charter foundation (24th October, 1945). Several policies, programmes, agenda, meetings and conferences on gender equality and women’s health have been taken up from time to time. One of the three objectives of the First World Conference on Women, held at Mexico City (19th June to 2nd July, 1975), was to attain full gender equality and promote the elimination of gender discrimination.

In 1979, the United Nations adopted the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which is often described as an International Bill of Rights for Women. The Committee on the Elimination of Discrimination against Women is the United Nations’ treaty body that oversees the
Convention on the Elimination of All Forms of Discrimination against Women. Fifty three sessions have been held to date, with the most recent being held from 1st to 19th October, 2012 (http://un.org/womenwatch/daw/cedaw).

Five years after the Mexico City Conference, a Second World Conference on Women was held in Copenhagen (14th to 30th July, 1980). This Conference recognised that ‘equal access to adequate health care services’ is one of the three spheres in which measures for equality, development and peace was essential. Then from the United Nations Third World Conference on Women (15th to 26th June, 1985) at Nairobi, through the Cairo International Conference on Population and Development (5th to 13th September, 1994), till the latest women’s summit i.e. the Beijing Conference (4th to 15th September, 1995), women’s health and access to health care has been an important agenda item which has taken a growing share of attention (http://www.un.org/en/development/devagenda/gender.shtml).

Besides, many other summits, conferences and their follow-ups on the gender dimensions have been organised world-wide till date, at regular intervals, so as to review and appraise the achievements, gaps and challenges of the gender-related commitments undertaken during the cycle of UN’s World Conferences on Women (http://www.un.org/womenwatch/directory/UNconferences_meetings_special_days_40.htm).

In order to meet the special needs of women and to remove inequities, the WHO has also set forth certain norms and standards for developing the guidelines and policies (WHO, 1997). The WHO’s activities and increased efforts to improve women’s health is directed towards:

a) Advocacy for women’s health and gender sensitive approaches to health care delivery and development of practical tools to achieve this.
b) Promotion of women’s health and prevention of ill-health.

c) Making health systems more responsive to women’s needs.

d) Policies for improving gender equality.

e) Ensuring the participation of women in the design, implementation and monitoring of health policies and programmes in WHO and in countries.

The Global Symposium on Health Systems Research organised by the WHO in November 2010, with 25 other partners at Switzerland, was focussed on the theme “Science to Accelerate Universal Coverage” (Gupta, A. et al, 2011). Moreover, in order to accelerate the progress on gender equality and the empowerment of the women, ‘UN Women’ was created by the United Nations General Assembly on 2nd July’ 2010, which became operational since 1st January’ 2011 (http://www.un.org/en/global_issues/women/). The United Nations believe that the establishment of ‘UN Women’ in 2011 can be meaningfully substantiated with a global programme focusing on women and thus has proposed to convene the Fifth Global Conference on Women in 2015, twenty years after the last women’s summit in Beijing, in order to assess the achievements and shortcomings of the ‘Fourth World Conference on Women: Action for Equality, Development and Peace’ and to set forth the goals to achieve gender equality in near future (http://www.un.org/News/Press/docs/2012/sgsm14148.doc.htm).

In lieu of the global health programmes focusing on women’s health, the Government of India has also formulated, reconstructed and re-oriented the National Health Policy, accordingly, from time to time. The policy admitted that access to, and benefits from, the public health system have been very uneven between the better-endowed and the more vulnerable sections of society. This is particularly true for women, children and the socially disadvantaged sections of the society. In fact, it has
realised that social, cultural and economic factors continue to inhibit women from gaining adequate access even to the existing public health facilities. This in turn does not merely affect women as individuals; rather, it also has an adverse impact on the health, general well being and development of the entire family, particularly children. This policy recognizes the catalytic role of empowered women in improving the overall health standards of the community.

Hence, the NHP-2002 has envisaged the identification of specific programmes targeted to improve women’s health and their access to health care. The Policy of NHP-2002, has made various recommendations in regard to the expansion of primary health sector infrastructure, which will probably facilitate the increased access of women to basic health care. The Policy has further committed the highest priority of the Central Government towards the funding of the identified programmes related to woman’s health issues. Moreover, the policy has recognized the need to review the staffing norms of the public health administration to meet the specific requirements of women in a more comprehensive manner.

In the past few years, international debates on universal healthcare have found echoes in academic and policy circles in India. The issue was followed in late 2010 by the Planning Commission setting up a High Level Expert Group (HLEG) on Universal Health Coverage (UHC) by 2020 (Gupta, A. et al, 2011). The report of the HLEG on UHC for India has recommended for putting ‘gender’ firmly on the agenda of healthcare. According to this report, gender along with income level, social status, caste and religion are considered as important attributes that could individually and in combination constitute barriers to equitable access to health care (Ravindran and Nair, 2012). As per the HLEG Report, gender is recognized as a social determinant of health, but also receives special emphasis because “gender discrimination and gender
insensitivity, if left unaddressed, will threaten the very framework and guiding principles of UHC for India” (HLEG, 2011).

This evidently widespread concern regarding the need for universal access to health services is not only critical in view of the Draft National Health Bill (2009), but is also an opportunity to deal with the inadequacies and inequalities in conceptualising, provisioning and financing as well as with the irrationalities in practice of healthcare. The serious implications for the majority of India’s citizens of these adverse conditions prevailing in the healthcare system call for urgent action with a long term vision. However, the complexity of issues also demands carefully thought-out approaches and strategies (Gupta, A. et al, 2011).

9.3 CONCLUSION

Although brilliant in parts, gender issues in the HLEG report on UHC have been addressed in an ad hoc and uneven fashion. In most instances, the recommendations do not provide specific and clear guidelines for correcting gender-based inequalities in access to healthcare (Ravindran and Nair, 2012). This is quite unfortunate and as a result, gender discrimination in access to health care services is still a burning issue in the urban society of the developing countries like India, even in the 21st century.

This research work has revealed that the gender gap in this regard varies with the levels of development over the sample study area. This is quite obvious because the literacy rate, educational status, work participation rate, level of income, standard of living of the individuals are very much inter-related with each other and they together help to construct and frame the social outlook and cultural perception of the common mass towards ‘practising gender’ within the society itself.
Since, this age-old practice of gender discrimination is deeply rooted within the cultural set up of our patriarchal society, certain exogenous forces alone can never do away with this, until and unless the urge evolves spontaneously from within the society itself. Hence, gender equality can be achieved through a strong political will and commitment, which can in turn be generated only through a strong people’s movement. The first step in this direction is to set forth a massive and active literacy drive so as to enlighten the society by raising mass awareness and the widest possible dissemination of information on health issues. It is practically feasible only through vigorous debate on ‘gender’ and ‘health’ issues- in the Parliament, in the State Legislatures, in the media and at various public forums- which will eventually grow and get into broader people’s movement at large.

To conclude, it is noteworthy to mention that at various moments of our lives, we have actively questioned the routine practices of gender, but we rarely question the fundamental premises on which these practices are based. So, what we need today is to awaken our inner conscience and open up our mind, so that we can treat both men and women through the eyes of equality, in every spheres of life, so as to set our society free from the trap of culturally deep-rooted malpractice of gender discrimination of any sort, whatsoever.

REFERENCES


