CHAPTER 3
CONCEPTUALISATION OF THE STUDY

Review of the literature regarding women’s access to health care highlights the issues related to lack of access to health care for women as well as draws attention to the emerging scenario where surgical interventions such as caesareans and hysterectomies are being reported from different parts of India. Existing research elucidates the factors responsible for barriers in healthcare access; however, it falls short on explaining the acceptance of irrational or unwarranted treatments such as hysterectomies. There is a need to understand that how these barriers are overcome in certain situations to seek health services. Improving access to health care is one of the important goals of any health system. Introduction of schemes like RSBY or Rajiv Arogyasri Community Health Insurance Scheme (RAS) \(^1\) is one of the ways in which Government is attempting to facilitate the access by removing financial barriers in health care access. However, in practice these schemes have promoted surgical interventions sometimes even when the surgeries were not justifiable. Hence, it is essential to explicate this phenomenon of acceptance of hysterectomies using the ‘access’ model, which can provide better understanding of the issue under investigation.

Present chapter delineates the key aspects of conceptual framework of the present study. This study investigated the concept of access to health care for women for the treatment of gynaecological morbidities. At the outset, this chapter provides the details of the concept of ‘access’ in the context of health care. It describes various models and frameworks which have been used to study health care access. Out of the various frameworks, this study uses the framework by Chatterjee Meera (1988). The chapter then elaborates the key concepts of Chatterjee’s framework.

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\(^1\) Government of Andhra Pradesh is implementing Rajiv Arogyasri Community Health Insurance Scheme (RAS) in the state to assist poor families from catastrophic health expenditure. The scheme is a PPP model in the field of Health Insurance providing end-to-end cashless services for identified diseases through a network of service providers from Government and private sector.
3.1 Theoretical Framework of the Research

In the last five decades, numerous studies have used the term ‘access’, however, there is no single accepted definition of this term. (Penchansky & Thomas, 1981; Karikari-Martin, 2010; Jacobs, Jr, Bigdeli, Annear & Damme, 2011) In an international symposium organised by United Nations Research Institute for Social Development (2006), the issues around equitable access to health care were deliberated upon. Lack of consensus on the definition and operationalisation of the concept were cited as two important barriers in engendering knowledge about the pathways between health care access and health outcomes. It was enunciated that multiple definitions of access and the variations in definition over time and across different contexts make it a complex phenomenon to study.

3.1.1 Defining Access

Following section provides various definitions used in the literature relating to health care access-

According to Donabedian (1972) the proof of access is use of service, not simply the presence of a facility, which could be measured by the level of use in relation to "need." He differentiates between the need as evaluated by the client and as evaluated by the professional. Donabedian also clearly distinguishes between the two components in use of service: "initiation of care" and "continuation of care".

Freeborn and Greenlick (1973) define access as availability of services whenever and wherever the patient needs them and the point of entry to the system is well defined.

Penchansky and Thomas (1981) relate access to consumers’ ability or willingness to enter into the health care system. They define "access" as a concept representing the degree of "fit" between the clients and the system.

According to Andersen and Aday (1983), access may be defined as those dimensions which describe the potential and actual entry of a given population group to the healthcare delivery system. Further, Andersen (1995) differentiates between potential access and realized access where he defines potential access as the presence of enabling resources and realized access as the actual use of services.
Meera Chatterjee enunciates that access requires negotiation of barriers beginning with the individual and progressively involving family, and ultimately the state/market in health care. (Chatterjee, 1988 cited in Iyer, 2005)

Julio Frenk (1992) defined access as the ability of a person to utilize health care given a need and/or desire to obtain it, while accessibility is defined as the degree to which a person needing and seeking care actually receives care.

One of the other definitions of access as given by the Institute of Medicine is that access is timely use of personal health services to achieve the best possible outcome. (Institute of Medicine, 1993)

Goddard and Smith (2001) formulated an operational concept of access, which considers access as a supply side issue, relating it to dimensions of availability, quality, costs, and information.

Peters et al. (2008) define access as ‘the timely use of service according to need’.

3.1.2 Models for Understanding Access to Health Care

Different models/ frameworks/ theories have been used by the policy makers as well as researchers to measure access to health care. Each of these models and frameworks has its own strengths and limitations in explaining the access related issues adequately. However, there has not been an attempt to explore the unity of thought behind these theories. (Ricketts & Goldsmith, 2005)

The commonalities between these different models is that they have identified various factors, which are either specific to the individual or to the health system which facilitate or impede access to health care. Different dimensions of access such as availability, affordability, acceptability of health services have been delineated.
Table 3.1- Models for Understanding Health Care Access

<table>
<thead>
<tr>
<th>Model</th>
<th>Year of proposing</th>
<th>Proposed by</th>
<th>Key aspects of access as described by this model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural Model of Health Services Use</td>
<td>1960</td>
<td>R. A. Andersen, Lu Ann Aday</td>
<td>Predisposing factors, enabling factors and need determine the use of health services</td>
</tr>
<tr>
<td></td>
<td>Subsequently revised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access as a concept of ‘fit’</td>
<td>1980</td>
<td>Roy Penchansky</td>
<td>Availability, accessibility, accommodation, affordability and acceptability of health services determine access to them</td>
</tr>
<tr>
<td>Choice making model</td>
<td>1981</td>
<td>J. C. Young</td>
<td>Four components of ‘access’</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Perceptions of gravity of illness</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Knowledge of home treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Faith in remedy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Accessibility of health care services</td>
</tr>
<tr>
<td>Institute of Medicine</td>
<td>1990</td>
<td>Institute of Medicine</td>
<td>Unidirectional linear relationship between barriers to access, use of services and mediators.</td>
</tr>
<tr>
<td>Health Belief Model</td>
<td>1994</td>
<td>Rosenstock, Strecher, &amp; Becker</td>
<td>Four central variables that determine access to preventive as well as curative services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Individual’s perceived susceptibility to disease</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>• Individual’s perception of illness severity</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Individual’s rational perception of benefits versus costs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Individual’s ‘cues’ to action</td>
</tr>
</tbody>
</table>

(Source: Rebhan, nd)

In another review of health care access models, Pauline Karikari-Martin (2010) has illustrated the strengths and lacunae of Penchansky’s Model, The Institute of Medicine (IOM) Model of Access Monitoring, and The Behavioral Model of Health Services Use. According to the author, subjective experiences with health care access are brought out by Penchansky’s model whereas the IOM model is useful for monitoring quality of health care services and the Behavioral Model presents predictive factors of health service use. Pauline argues that these definitions of access address varied issues related to health policy issues.
Pauline (2010) enunciates following strengths and limitations of each of these three models-

**Table 3.2- Strengths and Limitations of Various Health Care Access Models**

<table>
<thead>
<tr>
<th>Name of the model</th>
<th>Strengths</th>
<th>Limitations</th>
</tr>
</thead>
</table>
| Penchansky’s Model                            | Identifies the effects of health policies on specific populations  
Asserts that client satisfaction with access influences utilization of health care services                                                                                                                                                                                                                                                  | Effective use of this model requires primary data collection, and hence limits its application in the situations where time is the constraint. (Young & Ryu, 2000 cited in Pauline, 2010).  
This model measures outcome subjectively, using the recipient’s reported satisfaction with the health care services provided                                                                                                                                                               |
| Institute of Medicine Model of Access Monitoring | Aspects of access include barriers to access, use of services, and mediators that have a unidirectional linear relationship with each other  
Aspects of access are measured and correlated with two outcomes: equity of service and health status,  
Barriers to access such as personal, structural, and financial factors are defined                                                                                                                                                                                          | The limitation of this model is that it uses morbidity and mortality rates as outcome indicators.  
However, morbidity and mortality may take long time to become evident. Thus the model cannot be used for policy making where the results are needed quickly                                                                                                                                                     |
| Behavioral Model of Health Services Use       | In this model, outcome includes the sub-concepts potential access, realized access, and access outcomes  
Comprehensive and includes measures such as usual source of care, utilization rates, and efficiency                                                                                                                                                                                                                                         | Challenging to define and obtain uniform measures for some of the sub-concepts at the community level  
Differences in health care use within a subgroup can’t be explained adequately with the use of this model                                                                                                                                                                                                                                      |

Source: Pauline, 2010
3.1.3 Framework for Understanding Women’s Access to Health Care

One of the major constraints of the frameworks of access mentioned above is that these frameworks do not discuss the gender aspects of health care access implicitly. Merely availability of health services and affordability of the families to seek health care doesn’t translate into health care utilisation for women. In this context, work done by Meera Chatterjee in the decade of eighties has extensively looked into the gendered dimensions of health care access to explain why women do not reach health services. Given the focus of the present study which is trying to understand how women overcome various barriers in order to reach health facility and seek health care, the framework proposed by Chatterjee M. was found to be most relevant as this framework emphasizes on the intra-household dynamics of seeking health care.

The following section focuses on women’s access to health care using the framework proposed by Meera Chatterjee, which is useful to understand the issues in women’s access to healthcare. Chatterjee (1988) described five barriers that women have to overcome to access health care-

Need for health care. Gender which is a social construct assigns different roles and responsibilities to women and men and places women at a disadvantageous position in terms of access to resources in public as well as private domain. Due to the gendered division of labour, women face additional burden of diseases. Reproductive responsibilities coupled with poor nutritional status increase the disease proneness among women. This is evident from the fact that reported morbidity among women in the reproductive age groups is substantially higher than men, with a female to male ratio of more than 1.30 (NSSO, 2004).

Perception of need. Barrier related to perception leads to non-acknowledgement of health needs by the individual. In Indian context, women often place their needs secondary to the needs of the family members. In a study conducted in Koppal district of Karnataka, Iyer (2005) has shown that though women were aware of the illnesses, they were less likely to disclose the illnesses if there is a fear of adverse reactions from the family or the community. Acknowledging the need for treatment is the next step after the recognition of illnesses. However, in case of women, it is not just enough that the need is acknowledged by the woman, but it is essential that it is also
acknowledged by the family. After acknowledgement of the need, it depends upon the value ascribed to the family member that determines how sooner the treatment would be sought. Gendered division of labour also prevents women from taking rest during illness. (Iyer, 2005)

Permission. Permission is defined as the social factors that determine whether women can seek care beyond what is available in the household. Age and marital status are some of the important factors which decide whether a woman would be permitted by her family to seek care. Use of ultrasound for prenatal sex determination is one of the illustrations of access to health care for women when the health service has sanction from the family. In general, women lack proper antenatal care (IIPS, 2007) as there is no cultural recognition for the need of antenatal care. However, when families are interested in determining the sex of the foetus, women are taken to the health care facility for ultrasound and subsequent termination of pregnancy if the ultrasoundography indicates presence of female foetus. The prevalence of this practice is evident from the declining child-sex ratio in different regions of the country.

Ability. Chatterjee defines ability as the financial access to health services. Women’s ability to obtain health care depends on its direct costs as well as opportunity costs, and the extent to which families agree to invest in their health. (World Bank Report, nd). Iyer, Sen and George (2007) have demonstrated pure bias and rationing bias that operate in health care access. This study which included 12,328 individuals from 1920 households revealed that more women than men seem never to have treated their illness, among both the poor and the non-poor households. Gender differences among non-poor are termed as pure bias and gender differences among poor households are labelled as rationing bias. Authors define ‘rationing’ as the way in which households with limited resources distribute curative health care among sick members. Different ways identified in the study in which rationing takes place at household level are non-cognizance of illness, delay in seeking care, accessing substandard care and midway discontinuation of the treatment. In the poorest as well as non-poor group, the proportion of discontinuation of treatment was similar among men and women, whereas among the poor group more women discontinued treatment as compared to men. Gender bias in access to health care services is also evident in the NSSO 60th round survey (2004), which shows that despite higher reporting of ailments by
women, hospitalization rates per year per thousand are relatively lower for women, and untreated illnesses are higher for women compared to men. (NSSO, 2004)

**Availability of health care services.** Anderson et al. (1983) define availability of health services as the volume and distribution of medical resources in an area. Penchansky also defines availability as the volume of physician and other health care services whereas according to Julio Frenk, availability is the existence of health care resources taking into account their productivity, or ability to produce healthcare services. (Ricketts and Goldsmith, 2005) Availability of health care services is one of the important supply side barriers which affects the utilisation of health services. The rural-urban disparities in availability of health facilities are quite stark in Maharashtra which is evident from the fact that the total number of hospital beds in urban areas is almost 20 times the number of hospital beds in rural areas. (HDR, 2012)

**Figure 3.1: Diagrammatic Representation of the Factors Determining Use Of Health Services**

Source- Adapted from Sparing Lives, Better reproductive health for poor women in South Asia, World Bank Report, Pg. 53
3.2 Statement of Problem

As mentioned in the previous sections, the present study focuses on understanding the ways in which women overcome the barriers to reach health care provider, the reasons for accepting hysterectomy as ‘the’ treatment and the implications of surgery on women’s health. Review of medical literature has clearly brought out the significant health implications of hysterectomies among young women due to the premature menopause induced due to the hysterectomy. Medical literature about hysterectomies has confirmed that removal of ovaries at the time of hysterectomy is detrimental to women as ovaries are important for production of hormones. To overcome the deficiency of hormones created by removal of ovaries, external supplementation of hormones is required in the form of hormone replacement therapy (HRT). Given the financial barriers that women face in accessing health care in India, there is a remote possibility that women will have access to HRT for long duration. As mentioned in the literature review section, there is dearth of evidence which has looked into the changing paradigms of women’s health care access in cases such as hysterectomies or Caesarean sections which have implications for women’s health as well as their social life.

3.3 Rationale of the Study

It is evident from the literature review that there are very few studies which have explored the social aspects of hysterectomy in Indian context. It is emerging from different news reports as well as the survey conducted by the researcher that there is significant geographical variations in prevalence of hysterectomy with high prevalence rates in certain areas. The medical literature points towards the grave consequences of hysterectomy especially if it is accompanied with removal of ovaries. Given the omnipresence of private health sector and its unregulated nature in India (Bhate-Deosthali P., Khatri R. , Wagle S. 2011) and low educational levels among women, there is a possibility that young women may be misled by the doctors for undergoing surgery even in the situations where the illness could be treated by medicines alone.

Though there is anecdotal information about the reasons for rising numbers of hysterectomies, there is not adequate scientific evidence to explain the exact reasons
for which women undergo hysterectomy at an early age and whether these decisions are informed decisions based on information regarding the short term as well as long-term consequences of the surgery. In this context, this study was undertaken to explore these questions with in the broader framework of women’s access to health care.

3.4 Work Done By the Researcher on This Issue

Prior to taking up the doctoral research, I was part of the research team which had conducted a household survey in 10 districts of Maharashtra covering 1650 households. (Period of data collection 2006-07) This research was conducted by a SATHI where I was employed. The main objective of the household survey\(^2\) was to assess the inequities in health care access in the state of Maharashtra. Stratified random sampling method was used for selection of districts and blocks in the household survey. The districts covered were Pune, Satara, Nashik, Nandurbar, Thane, Ratnalghi, Amravati, Gadchiroli, Aurangabad and Osmanabad. In this survey, 2120 women who were ever-married and above age of 15 years were interviewed and information related to gynaecological morbidities was sought. Out of these 2120 women, 86 (4%) reported to have undergone hysterectomy. The survey revealed variation in occurrence of hysterectomy in different districts ranging from 10.1% (Satara) to 0.5% (Amravat). Region wise variations indicated that in the western region of Maharashtra, 7.4% of interviewed women having undergone hysterectomies, where as Vidarbha region reported 1.4 % women having undergone hysterectomies. Among the lowest economic class, the prevalence of hysterectomy was 1.8 per cent, whereas among the highest economic class it was 6.4 per cent. Similar differences were found on the basis of caste, where 5.6 per cent of women from privileged caste and 1.5 per cent of women from disadvantaged caste reported hysterectomy. In this study, fifty-two percent of women who reported to have undergone hysterectomy were less than 40 years of age. Youngest woman, who underwent hysterectomy, was 22 years old. None of the women, above age of 55 years, reported to have undergone hysterectomy.

\(^2\) The data from the household survey regarding women’s health care access has not been published in the form of report or paper.
Further to this household survey, FGDs were conducted with women in different age groups in the village where highest number of hysterectomies was reported. The women who participated in these FGDs categorically said that the treatment seeking has definitely increased as compared to the women from previous generations. However, still the criterion for severity of illness is that when women are not able to do their household chores, they go to the doctor. Prolapsed uterus, white discharge, pain in lower abdomen and backache during periods and scanty menses were reported as common reproductive tract morbidities faced by women. Weakness, irregular meal times, lack of hygiene during menstruation, use of intrauterine contraceptive devices and work load (especially heavy work by women on fields) were some of the causes of reproductive morbidities perceived by the respondents. During the discussions, it was observed that there was an anxiety among the women that the reproductive problems such as heavy bleeding, white discharge may become life threatening and hence they were keen to seek treatment. Respondents opined that the increase in treatment seeking may also be because of increase in educational levels. Majority of the women who participated in the FGDs believed that the treatment in private hospital is more effective than the treatment given in the public hospital.

The household survey as well the FGDs gave brief idea about the wide variation in the number of hysterectomies across villages in Maharashtra, and women’s perceptions about the increase in hysterectomy operations. Yet, there were several questions especially related to the decision making processes or the interactions with the health care providers, which needed to be explored to understand this phenomenon of increase in hysterectomies in certain pockets and the implications of these hysterectomies for women. Hence, I undertook the present study to seek answers to these questions.

3.5 Conceptual Framework of the Present Study

The conceptual framework for the present study is a combination of the framework proposed by Chatterjee (1988) and the ‘access’ as concept of fit model proposed by Penchansky (1981). The rationale for combining these two is that Chatterjee’s framework would help in understanding the demand side factors which determine women’s access to health services such as the need, acknowledgement of need and
permission for seeking care. However, in terms of understanding the supply side factors that are the characteristics of the health care system, Chatterjee’s framework includes availability of health services as the supply side indicator. In addition to the knowledge about availability of health facilities, it is important to know the physical accessibility of these services as well as the acceptability of these health services. Hence the dimensions of physical accessibility and acceptability of health services given by Penchansky have been added to the Chatterjee’s framework.

3.6 Research Questions of the Study

The doctoral research seeks to explore the following research questions which pertain to demand side as well as supply side factors responsible for the acceptance of hysterectomy and questions related to impact of hysterectomy have been added to study the outcome of this access.

1. When do women acknowledge the need for treatment for the gynaecological morbidities?
2. How do women’s perceptions about menstruation and reproductive health influence the acknowledgement of need for treatment?
3. How does health care access get prioritized within the family in these cases of hysterectomies?
4. What is the role played by the health care providers in creating acceptance for hysterectomy?
5. How informed is the decision of undergoing hysterectomy?
6. What are the factors which facilitate physical access to health services?
7. What are the consequences (short term as well as long term) of hysterectomy on the physical health as well as work capacity of women?

3.7 Objectives of the Study

Primary objective of the research is to study hysterectomy as an illustration of women’s health care access to understand the ways in which women overcome the barriers in accessing health care.
Specific objectives of this study are:

1. To understand women’s perceptions about reproductive organs and their morbidities and if these perceptions influence the acceptance of hysterectomy as a treatment for reproductive morbidities
2. To study the process of decision making within the household before undergoing hysterectomy
3. To understand women’s choices of health care facilities and the aspects of health care facilities that are considered by women at the time of hysterectomy
4. To find out women’s level of knowledge about the consequences of hysterectomy on their physical health
5. To find out the ways in which the financial barriers for accessing health care are overcome for undergoing hysterectomy
6. To understand the experiences of women regarding effects of hysterectomy on their physical health and work life

After elaborating the conceptual framework of the study, the following chapter provides the details of the methodology of the research.