CHAPTER 11

DISCUSSION

Understanding gendered dimensions of women’s access to health care has been a critical area of health research in India. Initial phase of the research on women’s health issues looked into prevalence of various morbidities among women using community based approach or facility based approach. Among the host of health problems that women face, reproductive health problems have received more attention than other health problems such as TB, malaria or leprosy. High morbidity load and low utilisation of health services among women were highlighted through these studies. Several primary as well as secondary data based studies were conducted to decipher the reasons behind these trends. The national level surveys such as NFHS and DLHS surveys helped to understand the temporal trends in access to health services for women. One can say that the research conducted in last four decades has helped to develop substantial understanding about multiple aspects of women’s access to health services including the gender and equity aspects.

At this juncture, one gets perplexed to see that amidst the milieu of overall lack of access to services, certain kind of health services are being frequently accessed in different areas. Caesarean sections and hysterectomies are two such illustrations which are being raised as a matter of concern mostly through media reports. Existing research which substantiates and explicates factors responsible for lack of access are deficient to explain these phenomenon of acceptance of tertiary level surgical interventions. In this context, this doctoral research was conceptualised to fill this critical gap in getting better understanding about women’s access to health services.

Hysterectomy was taken as an illustration to understand access to reproductive health services for women. As mentioned in the chapter on conceptualisation of research, this research has used the conceptual framework proposed by Meera Chatterjee (1988). This framework discusses access for women in the context of barriers that
women face at individual/ family and health system levels. Previous four chapters have discussed the findings of this research at length. In this concluding chapter, some of the key findings of the research have been explained in the light of existing evidence from other research studies.

From the findings of this research, it was apparent that in case of acceptance of hysterectomies, the respondents in this study did not encounter stringent barriers as such, at any stage. In fact as the study has shown, in all cases there was readiness for the hysterectomy to a variable degree in these families. The details of the various factors which led to this readiness have been enunciated in the Chapter no 8. These factors explain the particular case of acceptance of hysterectomy, however if one has to understand that in the existing social context, access to which services would be facilitated and which services may remain neglected, it would be necessary to draw linkages with the patriarchal system and the women’s roles as envisaged in this patriarchal system. Thus in the present chapter, at the outset the discussion reflects on the existing frameworks which are used to study the health care access and whether they explain this phenomenon of hysterectomies. Subsequently, the discussion attempts to explicate the acceptance of hysterectomy in this patriarchal framework.

Followed by this preliminary discussion, this chapter engages with the discussion pertaining to the following key questions about hysterectomies in young women.

These questions are-

- What is meant by unnecessary surgery in the context of hysterectomies?
- Does accessing hysterectomies indicate increased autonomy of women in the arena of health care?
- What is the role of health care providers in perpetuating gender biased attitudes?
- How do we interpret the quality of care received by the respondents in this study?

**11.1 Using Frameworks of Health Care Access for Explicating the Phenomenon of Hysterectomies among Young Women**

Review of health care systems research across various countries reveals that there are basically four different models of health care provisioning such as the Beveridge
model, the Bismarck model, the National Health Insurance or Tommy Douglas model, and the out-of-pocket model. (Wallace L, 2013)

The theoretical frameworks proposed to study health care access have originated in the industrialised countries where the health care systems are of organised nature and are of universal character. Therefore, conceptualization of access has parameters on the demand and supply sides which are governed by class, race, geographical distance and to a certain extent power related variables as determinants. These conceptual frameworks to explain access, do not seem to bring out the layers of inequities that govern each parameter in the access framework.

An attempt is made here to illustrate few of the shortcomings of the parameters of access. One of the parameters in the access framework is the availability of health care services. In India, there are multiple players in the field of health care provisioning whereas in the industrialised nations most of the provisioning happens through the UHC (Universal Health Care) system or a completely regulated private health care system. In contrast, health care systems in India exist within the Government organised, supported and managed health care systems and privately organised, supported and managed systems. The public health systems are predominantly allopathic with a small presence of ayurvedic systems of medicine. Within the private system, there are a range of providers which include large corporate hospitals, not for profit hospitals, small to medium hospitals, clinics, non-allopathic systems of health care and unqualified practitioners. The dynamics of each of these providers are very different and need to be captured to understand the health care access. The interplay of demand side factors such the environment in which the demand is made, the income of the population, the perception of the quality of health care providers, and the gendered nature of perception of illness and medical solutions for the same; and the supply side factors such as the competence of the health care providers, context in which health services are being provided, the financial or non-financial incentives and the knowledge hierarchy of doctors and patients, ultimately produce results in terms of health service utilisation.

These frameworks for studying access also do not adequately capture the systemic hierarchies in the health care system. The communications between the doctor and the patient reflect these hierarchies, where the patients are not adequately empowered to question the treatment options given by the doctor. Four basic forms of the doctor–
patient relationship such as default, paternalistic, consumerist, and mutualistic have been defined. (Roter and Hall, 1992 cited in Edwards and Elwyn, 2009) In Indian context, this relationship is mostly of paternalistic nature which is characterised by dominant doctors and passive patients, gradually this relationship is turning towards consumerism where the demand for health services like ARTs, USG for sex determination or hysterectomies are the services which are gaining acceptance as the cultural context is also favourable.

Hysterectomy as a treatment for gynaecological morbidities can be seen as an example of access where the demand is induced by the supply side. By posing hysterectomy as an innocuous and permanent solution, the private health sector has created a cultural context for acceptance of this treatment where the perceived need for treatment of gynaecological problems has been channelled into demand for hysterectomies.

11.2 Key Issues that go beyond the Access Parameters on the Demand and Supply Side

11.2.1 Understanding ‘Hysterectomy’ in the Broader Patriarchal Social Context

Access to healthcare for women in a particular society is a marker of the role of women in that society. Patriarchy is defined as a set of social institutions that deny women the opportunity to be self-supporting, thereby making them dependent on male relatives for survival, and favour men in the intra-familial allocation of resources and power. (Mason & Taj 1987 cited in Malhotra, Vanneman & Kishor, 1995) Control over women’s sexuality and appropriation of women’s reproductive and productive labour are other features of patriarchy.

In the patriarchal set up, it is seen that women maintain their position in the family through performing their gender roles, particularly their procreative role & performance of household chores and care giving. (Ramasubban and Rishyasringa 2000 cited in Ensor & Cooper, 2004) In the study, it was seen that one of the important reasons for seeking prompt care was that the gynaecological morbidities were hindering women from performing the household & care giving roles well. Links
between the value of women and their ability to work, has also been substantiated by Bonetti, Erpelding and Pathak (2004), who pointed out that being incapable of working threatens women’s place in the family structure. They may be insulted by the family members for their incapability to deliver their share of household chores.

This indicates the utilitarian approach towards women’s health in the family. Their health is prioritised in order that they can fulfil their role in the reproduction (procreative and domestic). This confirms the economic theory of health care demand which enunciates that demand for health care is derived from the demand for health. Use of health care is one of the ways to produce health. According to this economic theory of health care demand, better health is treated as a consumption good which enables individuals to be more productive. (Ensor, Cooper 2004b)

The patriarchal system obligates women to produce children preferably male children and the responsibility of taking care of children is also completely relegated to women. For understanding the ways in which familial permission operates to shape women’s access to health care, access to treatment for infertility can be taken as an illustration. Feminist research on Assisted Reproductive Technologies (ARTs) highlights that ARTs are an illustration of how technology is employed to reproduce existing power relations within a broader framework of capitalism and patriarchy. (Sama, 2010) The same argument also holds true for use of hysterectomy as a treatment for gynaecological morbidities as this option is often posed by the doctors as ultimate solution from all the reproductive morbidities so that women can fulfil their role in the domestic realm. ARTs are viewed as interventions that medicalize and commercialize concerns around infertility, without actually treating infertility. (Sama, 2010) Similarly, doctors often capitalize the reproductive health problems to amass business by performing hysterectomies to alleviate those reproductive problems which could have been treated by medicines or averted by medical interventions during delivery. (Kameswari and Vinjamuri, 2007) Another similarity between treatment for infertility and treatment for reproductive morbidities is that both these treatments are largely offered by the private health sector only. Lack of specialists and required equipment in the public health sector renders it difficult for public health facilities to provide these treatments.
Motherhood enhances women’s status in the patriarchal society (Patel 1994 cited in Sama 2010), thus there is an effort to beget biological child at any cost. For those who have children, the effectiveness of fulfilling the responsibility of raising those children is another criterion for conferring prestige. Thus acceptance of infertility treatments or accepting hysterectomy as an ultimate solution for reproductive health problems must be understood as a reflection of the socio-cultural milieu where woman’s identity is primarily linked to their reproductive capacity and role as mothers. Given the fact that both these services are only available in private health sector, access to these services is largely determined by the socio-economic status of the household.

Yet another way in which patriarchy plays role in creating acceptance of hysterectomy is through propagating biased attitudes towards women’s body parts and body processes such as menses. The gender biased attitude was not restricted to women or their families but the doctors also played an important role in endorsing these attitudes. Negative attitude towards menstruation and inability to fulfil the role of home maker, these two were important reasons for accepting hysterectomy where both these attitudes originate from the patriarchal framework which imposes specific roles on women. This also explains the trend of hysterectomy among women who are less than 40 years in age. Hysterectomy as a solution for respite from menses and permanent treatment of reproductive health problems is more attractive proposal for women who are less than forty years of age. Women in this age group have to take care of children as well as elderly in the household, in this situation reproductive health problems cause hindrance to fulfil this responsibility. Hence, women readily accept hysterectomy. Whereas, for women above forty years of age, unless the reproductive health problem is unbearable, they often wait for their menopause to set in. Also the presence of a daughter-in-law in the family also reduces their burden of taking care of all the domestic chores. So women in this age group are less likely to seek hysterectomy as a solution.

11.2.2 Does Accessing Hysterectomies Indicate Increased Autonomy of Women?

Given the increased reporting about number of hysterectomies across the country, a fallacious impression is created about improved access to services for reproductive
health morbidities. Additionally, women’s acceptance of hysterectomy can be misconstrued as increased autonomy in the realm of decision making about their health and their improved status in the family and society. As seen in the above section, one of the reasons for facilitated familial permission is that the surgery is seen as permanent solution which can enable women to perform their duties. A closer look at the decision making processes prior to surgeries reveals that these decisions are based on inadequate knowledge about various treatment options or about the short term as well as long term implications of the surgery. In a way, the decision to undergo surgery is a Hobson’s choice for women. As defined by Kabeer (2005) to be denied choice means to be disempowered. For making choices, it is essential that different alternatives are available. In case of treatment for reproductive morbidities, other alternatives to hysterectomy are not presented by the doctors as fervently as they pose hysterectomy. As Kabeer says, ‘Alternatives must not only exist, they must also be seen to exist.’(Kabeer, 2005)

It is also important to note that the relationship between the doctor and the patient is a hierarchical relationship where the authority of doctor is completely acceptable to patient and questioning doctor’s advice is not even contemplated. Like women internalise their subordination within the household and do not question the discriminatory allocation of resources, they have also internalised the power inequalities between them and the health care providers, thus the treatment suggested by doctor is accepted without uncritical scrutiny of the other options. Thus, though the acceptance of hysterectomy apparently looks like women’s choice, but actually it is denial of choice. (Kabeer, 2005)

Studies looking at women’s autonomy caution that though education and employment are considered as indicators of women’s enhanced status in the society, in reality women’s entry into the paid labour force is a consequence of impoverishment of the family and thus does not mean that there is greater autonomy. (Ravindran 1999) Similarly, we have to say that increased access to treatment for reproductive morbidities does not mean that women’s status is enhanced but it indicates that women’s labour is of immense importance to these families and thus they are willing to treat women’s illnesses promptly. In the present study, though women were involved in the decision making processes, since these decisions are based on
inadequate information and are made in the absence of other treatment choices, these decisions cannot be labelled as decisions reflecting their autonomy.

11.2.3 Are hysterectomies inappropriate?

In the entire debate around hysterectomies among young women in India, this question is recurrently asked. However, as of now there is no substantial evidence to estimate the number of inappropriate hysterectomies. To begin with it is important to know the definition of ‘appropriate’ surgery.

“ (appropriate surgery is) one in which the expected health benefits of doing a procedure (i.e. increased life expectancy, relief of pain, reduction of anxiety, improved functional capacity) exceed the expected negative consequences (i.e. mortality, morbidity, time lost from work) by a sufficiently wide margin that the procedure [is] worth doing, exclusive of cost”. (Brook et al., 1986; Park et al., 1986 cited in Fitch et al 2001 p.1)

The evidence to comment about appropriateness of surgery is scant in Indian context. The standard treatment protocols for treatment of gynaecological morbidities are mostly not followed in clinical practice. Research conducted in other countries indicates that most often the hysterectomy is recommended for indications which are inappropriate. (Broder, Kanouse, Mittman and Bernstein 2000; Al- Nuaim, Esset, Banu and Chowdhury 1997; Edozien 2005; Sharts- Hopko 2001)

To judge the appropriateness of hysterectomy, pre-operative diagnosis is correlated with the pathological findings. A study conducted by Gupta et al. (2010) had correlated the clinical indications with pathological findings. Out of 500 hysterectomy cases included in the study, 96 % of the hysterectomies were found to be done for non-cancerous that is benign conditions. Hence though the doctors create the fear of cancer among patient to convince them for surgery, in reality the proportion of hysterectomies for cancer is very low. In a news item published, it has been reported that Mumbai based second opinion services centre has found that 48 % hysterectomies were clinically unjustified. (Iyer, 2015)
To determine what proportion of surgeries is unnecessary, it is important to know the proportion of necessary surgery. (Markle and McCrea, 2008) In case of caesarean sections, WHO has estimated that out of total deliveries, up to 15% of deliveries would require surgical intervention. (WHO 1985) Since this upper limit has been set up, it is possible to decide whether in any particular group, ‘unnecessary’ caesarean sections are being conducted. However, this is not the case about hysterectomies. No such benchmark about what proportion of gynaecological morbidities would need hysterectomies has been set up. In fact, with the advent of new medical treatments, the need for surgeries is becoming low.

World Bank (2014) has also raised concern about the unnecessary surgeries. It was noted that worldwide there is an epidemic of prescribing unnecessary medical tests, procedures, hospitalizations and surgeries. Similar trend has been observed in India also. Increased affordability of people and private voluntary health insurance is found to increase this trend of overuse of medical services. Some of the factors that drive this trend have been identified, they are: more medical interventions are considered as better; techno-centric approach to health problems; culture of defensive medicine where additional tests or treatment are prescribed; failure to counsel the patients adequately about the risks and benefits of treatment and the other options available; aggressive marketing of services by hospitals, pharmaceutical firms and the medical device industry; incentives to the providers for more prescriptions; and the growing demand by patients for medical interventions. Some of the negative consequences of this medical overuse are like burden on economy, overinvestment in tertiary care and expensive medical technologies, at the expense of investments in the primary healthcare system which is a more cost-effective means of care and prevention, neglect of the social determinants of health such as safe drinking water and sanitation. (World Bank, 2014)

11.2.4 What is the role of health care providers in perpetuating gender biased attitudes?

Doctors being at the helm of the health care provisioning, mostly define what kind of services will be provided in a particular area. In the out of pocket model of health care provisioning in India, it is seen that the doctors capitalise on the regressive social
norms rather than countering them through knowledge. For example, in the social context where son preference is dominant, with the use of technology like Ultrasoundography, doctors determine sex of the foetus and further eliminate the births of daughters. Another example of how the medical system capitalises on social norms is the use of ARTs. Instead of encouraging the families to go for adoption and foster social parenting, the doctors create the aspirations for families to have biological child through use of ARTs. In case of sex selection, though the procedure of sonography has no negative effect, however subsequent MTPs may definitely cause harm especially if they are done under unsafe conditions. Implementation of PCPNDT act has led to provisioning of these services in a clandestine manner where the possibility of compromises with quality and safety cannot be denied. In case of ARTs, firstly the success rates of these procedures are very low and the procedures have harmful impact of women’s health as well. For e.g. deaths have been reported during ova retrieval procedure. (Chatterjee, 2014) Similarly, ARTs mandate high dosage of hormones which again compromise women’s health. All this is done just to achieve biological motherhood. One of the common arguments in this context is that doctors being part of the same social milieu which has created the demand for such services cannot be different. Hence, first the society should change then the changes in the health system would take place. However, I feel that doctors being the knowledgeable section have more responsibility in countering these regressive social norms.

Similarly in this study also it was seen that the doctors often propagated the gender biased attitudes. The analysis of medical text books and a narrative of a doctor confirm that the genesis of gender biased attitudes of health care provider is in the medical education. The review of the textbooks of ‘Preventive and Social Medicine’ (PSM) from gender lens done by Bhave and Acharya (2005) revealed that the textbooks instead of rebutting prevalent gender stereotyping, were consistently reinforcing them. In these PSM textbooks, women’s reproductive health needs were denigrated as a cause for the spread of sexually transmitted infections in the community. Gender, equity and social justice were mentioned cursorily without explaining their role as health determinants. High fertility, unmet needs for family planning and low acceptance of contraceptives were posed as problems arisen due to women’s ignorance, low literacy and traditional ways of life. These books upheld the state’s population policy and family planning programme.
Dr. B Subha Sri (2010) has narrated her experience of medical education and her views about how medical education shapes doctors’ attitudes. According to her, medical profession has a reductionist view of human body which reduces human body to anatomy and physiological processes. The differences in reproductive organs are considered as only difference between men and women. The reductionist view results in the impersonal way in which the doctors see their patients. Patients are labelled as cases and referred according to their disease condition. She finds that the medical education is divorced from the politics of health. Subha Sri notes that the reduction of women into bodies and further into reproductive organs leads to unnecessary hysterectomies as the underlying belief is that – “chop off something that is useless or has served its purpose”. (B Subha Sri 2010) Since the medical education has indoctrinated the gender biases in the medical professionals, hence it is no surprise that these attitudes are reflected in clinical practice where hysterectomy is suggested once a woman has achieved desired number of children.

11.2.5 How do we interpret the quality of care received by the respondents in this study?

In the present study, women had preferred to seek services from private sector as the private sector is perceived to offer better quality services than public health sector. Though the doctors had given cryptic information about the disease or various treatment options, yet the respondents had perceived the quality of health services as good and had no complaints about them. Health outcomes are one of the indicators of the quality of care received. (WHO, 2006) The present study showed that several women are still facing various health problems and some are also suffering from the same health problem for which surgery was done indicating that the health outcomes after hysterectomy may not always be positive. To understand the paradox that despite getting no information about the hysterectomy or despite negative outcomes of surgery, why do women consider the treatment to be of good quality. In this context, in the study by Gupte et al., (1999) it was seen that women’s concept of quality of health care (QHC) varied according to their social circumstances and specific health needs. Affordability of health services, distance and time involved in seeking health care, the attention of a doctor while treating a patient, round-the-clock service to deal with emergencies, easy access and conveniently located service, the doctor's respect
for the patient and readiness to listen to her problems, the doctor's empathy for the patient, and the cleanliness of the facility, availability of boarding facilities, effective treatment and quick relief were some of the criteria listed by women for assessment of health services for general health care. For treatment of gynaecological disorders, treatment by a female physician was mentioned as one of the criteria. In the present study, barring one respondent none of the respondents had insisted on female doctor.

WHO (2006) defines criteria for quality of care such as effectiveness, efficiency, accessibility, acceptability equity and safety as criteria for monitoring the quality of health service provisioning. Effective health care is defined as delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need. However, the present study reveals that hysterectomy was suggested as treatment before adequate trial of medical treatment. Secondly, though the evidence suggests that vaginal route of surgery is better than abdominal route as it is associated with lesser post surgical morbidity, in the study only those women who had prolapsed uterus were operated through vaginal route, indicating that the treatment options suggested by the doctors were not always evidence based. Rationality of care is not explicitly seen as a criterion for assessing the quality of care. It is assumed that the health care provisioning would be ethical and evidence based.

Another dimension to study the increasing numbers of hysterectomies could be through the framework of medicalisation. As defined by Conrad (1992), medicalisation is a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders. In case of hysterectomies, since all these women had health problems, though this phenomenon cannot fit strictly into the definition of medicalisation, there is definitely a trend to treat the problems with surgical interventions which could have been treated by medical interventions (Kameswari and Vinjamuri, 2007) or sometimes the menstrual problems which could be a result of premenopausal physiological changes are termed as pathology by doctors and then surgery is offered by creating fear of cancer.

In early 1980s, Pawluch (1983) argued that due to improved standard of living, public health measures, and preventive vaccinations, there were fewer sick children for paediatricians to treat. Thus to overcome the problem of decline in number of patients
(which also meant less remuneration) the paediatricians started including children's troublesome behaviour in their domain and thus treating them. She says, 'the new "behavioural paediatrics" enabled paediatricians to maintain and enhance their medical dominance by expanding their medical territory which led to the medicalization of a variety of psychosocial problems of children. A similar phenomenon cannot be denied in Indian context where declining fertility rates may have reduced the remuneration of the gynaecologists which they are trying to compensate through suggesting surgical treatments which fetch them more money. The role of improved education leading to improved utilisation of services brings women within the ambit of health system, where there are hardly any choices rather than accepting whatever the doctor suggests. At this point of time, there is little evidence to talk about the changing nature of clinical practice and what are the driving forces behind these changes. For e.g. the unethical practices employed by the private sector are being exposed through media (Satyamev Jayate, 2012; Iyer, M., 2015) as well as through research. (Gadre, A. 2015) Interviews with 78 doctors across various cities of India such as Bangalore, Chennai, Delhi, Kolkata, Mumbai, and Pune or from towns in Maharashtra revealed that the private health sector indulges in several unethical practices such as irrational drug prescribing, kickbacks for referrals, unnecessary investigations and surgical procedures. (ibid) However, this area certainly needs more exploration.

To conclude, one can say that women’s health care access is shaped by the interplay of various factors at household level, at community level and at the health system level. In case of hysterectomy, the patriarchal interests of household, health beliefs of community and commercial and gender biased attitude of health care providers collude to make uterus a redundant organ which loses its significance once women complete their responsibility of giving heirs to the family.

From this study, following areas for further research as well as suggestion for policy level modifications are emerging:

1. This study has captured the experiences of women in rural areas and has looked into the circumstances under which hysterectomy is accepted as the treatment. Similarly there is a need to understand the reasons for acceptance of hysterectomy in urban settings as well.
2. A large scale quantitative survey is necessary to find out the geographical as well as socio-demographic variations in prevalence of hysterectomy in India. Health activists and civil society groups have demanded seeking information on hysterectomies as a component in the fourth round of National Family Health Survey. Conceding to this demand, a set of questions about hysterectomy have been included in the fourth round of National Family Health Survey. (Dhar, 2013)

3. Along with understanding demand side factors which lead to acceptance of hysterectomy as a treatment, it is necessary to delve into supply side processes which promote the demand for hysterectomy. Additional research is required to find out the proportion of unjustified hysterectomies.

4. At the policy level, there is a need to develop and enforce standard treatment protocols for the treatment of reproductive health problems.

5. The RCH programme should also focus on the prevention and treatment of reproductive health problems.

6. To overcome the lack of knowledge about reproductive health problems and their rational treatments, it would be important to make the information available in vernacular languages and have a slot on television and radio where women can seek advice through a dial-up-service.

7. There is a need to institutionalise the process of auditing the surgeries conducted by private hospitals.