Conceptualizing Gender Equity in Indian Health Care System
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Ensuring gender equity in access to basic services has remained an enduring challenge in the political economy of social policy development in most nation states. In India, an analysis of the problem of lack of access to basic services like health care assumes significant complexity, as poverty interplays with structural inequities arising out of caste, class and gender. Gender based differences are not unique to India as they have been the fundamental characteristic of most human societies and they impact all aspects of an individual's political, socio-cultural , economic and intra-psychic life (Chafetz,1990). However, gender based discrimination has existed in the fabric of the Indian social system for a very long time and has adversely affected women's development. Gender inequity in access to basic services, stems from the way the gender roles ascribed by society impact the way resources and rights are distributed amongst men and women. Therefore, inequity in health care access is also characterized by the way resources are allocated, distributed and utilized by men and women in India (Thukral, 2002).

Since independence India has made some strides regarding its health status. Much of this development has been spearheaded by knowledge and technological development. The paradox of the development of technology and knowledge to combat degenerative diseases is that it has also led to greater polarization in access to sophisticated treatments. Women in India continue to die from child-birth related complications, pregnancy, malnutrition and common infections. In a report published by the World Bank in 1991, there were indications that in spite of persistent health risks amongst women in India, studies of health care usage show that women continue to use less health care services.

In India women's health status is not an issue of mere bio-medical analysis but it also calls for deep research and interventions on the intrinsic relationship between physical health and social status. This paper examines the socio-political, cultural and economics of women's health in India.

Context of Inequity

Equity is a broad and elastic term that has connotations to ideas of social justice. Inequity is distinctly different from inequality as it refers to those inequalities which are unjust and artificially created. Equity in health can refer to minimizing disparities in prevention, diagnosis and cure of physical and mental health amongst groups with varying degrees of social status and privilege. Discrimination against the female child starts from childhood in the family when she gets less nutrition, health care, education and other goods as compared to the male child (Thukral, 2002). Research indicates that women are considered to be both economic and social burdens for families though women contribute in many ways to the family economics. The invisibility of women's work which is mostly relegated to the household and is 'unpaid' is termed as 'unproductive'. Besides, women are primarily viewed as caregivers and nurturers even when they have sufficient presence outside their homes. The social neglect of women results in their low levels of education and access to resources and it exerts a negative impact on their health status.

In a discussion of lack of access to basic healthcare there is an imperative to introspect on the relationship between gendered poverty and how it impacts women's access to services. In India women are overrepresented amongst the poor. India holds the dubious record for the highest number of poor living in a single country (Thukral, 2002). About 26% of its rural population and 12% of its urban population live under conditions of abject poverty (Deaton & Dreze, 2002). However, given women's low status in society same social phenomenon like poverty affects women more adversely than men. Poverty is a multi-dimensional phenomenon that goes beyond hunger and malnutrition. It is characterized by incidences of high morbidity rates, higher mortality, lack of access to basic services like health and housing; it also signifies exposure to unhealthy and unsafe living environments (Ghosh, 1998). Women have less personal and institutional means of support to overcome poverty, as their assets, skills, options and education are limited by their social status.

A Framework to Analyze Gender Inequity

In analyzing the issue of gender inequity in India it is important to engage in a historical and contemporary analysis of gender relations. The colonization, decolonization and national development process in India influenced the framing of gender relations. The colonial project was a handiwork of nineteenth century sexual, racial and class based institutions (Mohanty, 1991). The colonialism process blended very well with the already existing gender discriminatory ideologies present in the fabric of the Indian social system. The post-colonial nation state was unprepared to deal with the conflict between national agendas and inegalitarian development trends. This conflict created further handicaps for women as they struggled between their traditional roles and the promise of modern freedoms (Rajan, 1993). The problem of access to health care is rooted in the ambiguities of the nation state which have perpetuated the construction and institutionalization of hypothetical gender relations in the first place.
In relation to India the problem of gender inequity and access to basic services like health care takes a new dimension given the spate of socio-economic and political changes the country has

encountered in the last decade. Economic reforms were initiated in India in 1991, following a severe balance of payment crisis (Prabhu, 2001). The reforms have brought about significant changes in the government expenditure patterns in the social services. Economic transformation alters the process of redistribution of economic and social goods. Given women's low entitlements, lack of access to credit, land, lack of information about the markets and low skills, women, particularly the poor have been virtually excluded from the gains of globalization (Murthy, 2001). In fact, in times of such economic transition women bear the extra burden as their work load increases but their consumption of even basic goods decreases.

Amongst other goods the Indian government was committed to delivering universal comprehensive health care, while the budgetary constraints resulted in this promise remaining unfulfilled. However, the issue remains that in the absence of public health services, women and other vulnerable groups with low entitlements will be left without access to critical health services. Relying on private health care alone will not be sufficient in providing equitable health care, as access to private care is associated with high costs which in turn affect health care utilization by vulnerable groups.

The shrinking role of the public sector health delivery system owing to the market reforms has exacerbated the problem of access for women. While there is a strong need for private sector health care the state cannot withdraw itself from providing basic services to groups and individuals who cannot access private goods. Ironically, however, even in states that have ensured public spending of health care services the vulnerable groups have very little access to the system and it is mostly the rich who avail the services .The development of the private sector health-care has resulted in super-specialty hospitals and diagnosis centers, however, there access is patronized only by the very affluent class.

Effects of Gender Inequity in Health-Care

Maternal mortality rates are very high in India about 453 deaths per 100,000 births (Velkoff & Adalakha, 1998). Maternal mortality rates are preventable in the presence of access to adequate health services during the pregnancy period; however, most women lack access to prenatal and other referral services (International Institute for Population Sciences, 1995). The absence of government health care facilities and rising costs of private health care can be attributed as the persistent causes for low health care utilization by women. Besides, waiting time at clinics, distance to health care facilities are also other factors associated with health care access and utilization (Borah, 2006). Indian women face considerable health risks from high levels of fertility and their childbearing age exposes them to a host of physical and mental health problems. Because of strong son-preference women undergo multiple pregnancies in most parts of India in association with closely spaced births. Given women's low status and education levels women are mostly unaware of the ill-effects of sexually transmitted diseases including HIV/AIDS. Even when they have some information given their status it is highly unlikely that they will have any say in taking precautionary steps to limit their exposure to the risks. The prevalence of female feticide and infanticide has also been cited as extreme cases of gender bias in India (Thukral, 2002).

Women in India particularly in rural agricultural areas work arduously both in the household, on family lands or other jobs to supplement their family's income. However, their poor nutritional status as compared to males puts a lot of strain on their health. Women are also exposed to hazardous working conditions like smoke from the kitchen fire which has adverse health effects. Besides, a large number of poor low-skilled Indian women work in the informal

sector economy which characterizes poor working conditions and health hazards. It is also significant that the faulty socialization process, neglect and discrimination both within and outside the family leave women very vulnerable to both physical and mental health issues. However, there is a big gap in literature on the associations between women's social status and their mental health. The second National Family Health Survey by International Institute of Population Sciences in 1998-1999 reports that only 52% of Indian women are ever consulted on issues pertaining to their health. In many cases women simply lack the freedom to access basic health care. Factors like unavailability of female health care providers, and distance to the clinic also create cultural constraints for women seeking health-care.

Discussion

The poor state of health of women in India is clearly linked to their social status. Historical and contemporary forces have reinforced the gender disadvantage pertaining to the problem of access. In order to improve women's health status and create opportunities for access to health services, institutional changes have to be incorporated. Policy makers should take into account that institutions both public and private have to be transformed to ensure gender equity. Merely instituting policies can never address a problem that has taken such deep roots. The role of the state vis-à-vis the market has to be analyzed from the gender perspective. Health is intrinsically linked to other indicators like education, income, social mobility etc and therefore any intervention to improve women's health status calls for a holistic intervention amongst various stakeholders namely the family, state and civil society. As India emerges from the shadows of a reticent developing economy into a global leader it needs to address the issues of gender inequity. The socio-political and economic development of India is still a mere rhetoric in the face of such persistent inequity. The challenge of the development dialogues is to address this inconsistency.

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