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Disparity in Women's Healthcare Access across India

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ABSTRACT

Women Healthcare in India remains a critical challenge for decades. Women health care problems exist in India due to existing socio-economic inequalities, various cultural norms and structural barriers. Indian women also face health disparities due to systemic societal challenges embedded in the patriarchal social setting. Thus, women's health cannot be separated from her social and economic status. Various health programs and schemes driven by center as well as state are working towards the betterment of women's health. Consequently, there has been an overall improvement in women's health leading to reduction of various health challenges and risks among women. However, women still face various problems and difficulties in accessing healthcare facilities in India. Additionally, the problems related to healthcare and its access are not similar for women of every state of India. The study analyses the indices which highlights the disparity in women's healthcare access across various states of India. It also looks into the factors responsible for the women's health access disparity existing among the states. The study highlights the need for efforts on the part of the states on these specific areas so that the disparity in healthcare access for women gets narrowed. This paper is based on secondary data and uses analytical and descriptive research methods.

KEYWORDS: Women, Disparity, Healthcare.

MAIN THEME

Access to quick and good health care facilities is important in regulating the spread of any disease and its timely treatment. Access to healthcare facilities is also an indispensable condition for women empowerment. Despite having a privileged position provided by nature, women's access to health care is not at par with men in India. Women's health in India is significantly interconnected to her social, cultural and economic status. Factors such as socio- economic status, educational status, financial independence and cultural practices play a vital role in determining her health. Gender disparity in patriarchal contexts is also a critical issue in gaining equal access to health care facilities. Patriarchy limits the access to healthcare for women. The aim of the National Health Mission is to ensure "universal access to equitable, affordable and quality health care services, accountable and responsive to people's needs". (.) Various health programs and policies were launched by center and states in the country after independence. Today, various flagship health programs run by Centre government under National Health Mission are Ayushman Bharat -Pradhanmantri Jan Aarogya Yojana (AB- PMJAY), Ayushman Bharat Digital Mission (ABDM), Janani Shishu Suraksha Karykram (JSSK). Janani Suraksha Yojana (JSY), Pradhanmantri Surakshit Matrutva Abhiyan (PMSMA), LaQshya Programme (Labour Room Quality Improvement Initiative). However, the implementation and success rate of the health programs is not similar in every state which

has led to a gap / disparity in the healthcare access of women. This disparity across India is clearly visible in various health indices enumerated below.

Indices of Disparity in healthcare access among women of different states of India:

1- Maternal Mortality Rate-

As far as maternal mortality rate is concerned, there has been a considerable achievement over the two decades. In 1990, the National MMR per one lakh live births was 437. According to the SRS (Sample Registration System) report covering 2021-23, MMR came down to 88 per one lakh live births. India is well on its path to achieve the SDG target of below 70 MMR.(*SRS_MMR_Bulletin_2021_2023 (1)*, n.d.) However, this decline of almost 80 percent in almost over the three decades is not at par. A clear disparity lies across the states of the country. States like Kerala (30), Andhra Pradesh (30), Tamil Nadu (35), Maharashtra (36), Gujarat (51), Jharkhand (54), Telangana (59), and Karnataka (68) have already achieved the SDG target and are well below 70. Kerala and Andhra Pradesh with MMR 30, have the lowest MMR rate in the country. However, States like Odisha (153) Chhattisgarh (146), Madhya Pradesh (142) and Uttar Pradesh (141) are lagging far behind in achieving the SDG MMR target. (M, 2022) (*SRS_MMR_Bulletin_2021_2023 (1)*, n.d.) In this way, it can be said that a delivering woman of Odisha, having the highest MMR among the Indian states, faces the risk of maternal deaths as high as five times more than a delivering woman of Kerala. In this way, a sharp state wise disparity can be seen in the Maternal Mortality Rate of India.

2- Institutional Delivery Rate -

The second index is Institutional delivery rate where disparity exists between rural and urban areas of the states. A rural-urban gap is present at the national level where 89% of rural births happen in institutions compared to 95% of urban births. (*National Family Health Survey (NFHS-6) 2023-2024 Fact Sheets*, n.d.) This gap however has narrowed enormously from the situation of the early 2000s (56% in rural areas in 2005) when nearly half of all rural births happened at home. ('Maternal Care in India Reveals Gaps Between Urban and Rural, Rich and Poor', 2003)The important aspect is that this is the national picture at large. This rural-urban disparity of six percent is sharper in comparatively poorer states than richer ones. The rural population of a state like Uttar Pradesh is 75 percent. According to the National Family Health Survey- 6, the overall institutional delivery rate of Uttar Pradesh is 85.9%, which is below the national average of 98.4% for rural. So, it is evident that poorer states have a sharper rural urban disparity rate for institutional delivery than the richer ones. (*National Family Health Survey (NFHS-6) 2023-2024 Fact Sheets*, n.d.)

3- Sex ratio at birth-

The national sex ratio at birth stands at 918 as per SRS report data (2024), which is well below the biological norm of 952- 970 per 1000 boys. (May 28 et al., n.d.). There is a disparity in achieving success in improving sex ratio at birth among states. Chhattisgarh is the best performing state having the highest sex ratio of 978. Kerala with 974 sex ratio at birth and Himanchal Pradesh with 956 SRB, ranks second and third among the states. States like Andhra Pradesh (946), Assam (946) and Tamil Nadu (936) also have good sex ratio at birth. However, Uttarakhand with 872 girls per 1000 boys is the worst performing state in achieving sex ratio at birth. Then comes Delhi (876), Haryana (885) and Bihar (896).(*SRS_STAT_2024*, n.d.) The disparity further persists in rural and urban areas of the states. All this shows uneven state level success in enforcing PCPNDT Act and Beti bachao Beti padhao Yojana.

4- Disparity in effective implementation of women specific health programs-

There is a disparity in State administrative capacity in implementing the women specific health programs effectively in their respective states. Success of Programs like JSSK (Janani Shishu Suraksha Karyakram), PMSMA (Pradhanmantri Surakshit Matrutva Abhiyan), SUMAN (Surakshit Matrutva Ashvasan), Ayushman Bharat, etc depends largely on States administrative capacity and willingness.

Southern and Richer states tend to translate these schemes into on ground success with the help of better health care facilities, infrastructure and awareness among people. Poorer and Northern states lag behind in utilizing the schemes for the benefit of the larger public.(Dubey et al., 2023)

5- Disparity in Cancer screening-

Indian women suffer mostly from two types of cancer, breast cancer and cervical cancer. Overall, women are more likely to lack the knowledge and power to make informed cancer related healthcare decisions. Equitable access to detection and diagnosis of cancer is lacking in India. Various factors are responsible for the disparity in achieving fair, equitable and inclusive access to cancer diagnosis, screening and prevention among women.

Patriarchal society, lower educational status and financial dependency prove to determine the disparity related to access to cancer screening, diagnosis, treatment and care. According to the National Family Health Survey-5, nationally, only 1.9% of women (ages 30-49) have ever been screened for cervical cancer and just 0.9% for breast cancer. Among these populations of women, it is found that rural women are consistently less likely to be screened than urban women. (*NFHS*, n.d.). Majority of the Indian states showed higher urban screening rates for breast cancer than rural. This rural-urban gap, irrespective of the type of cancer, can translate into higher cancer-caused mortality rates among rural Indian women.

6- Menstrual Health and hygiene practices-

According to various studies done from time to time, it is evident that menstrual health practices are comparatively less in rural areas than urban areas. Access to sanitary products and health education to young girls and women place urban areas and institutions in a better position. According to National Family Health Survey- 6 (2023-24), 79.2 % of women aged 15 to 24, now use hygienic menstrual methods, up from 77.6 % in National Family Health Survey-5 (2019-21). (*National Family Health Survey (NFHS-6) 2023-2024 Fact Sheets*, n.d.) Rural areas saw a marginal leap from earlier 73% to 75%, where rural women aged 15 to 24 years use hygienic methods of menstrual protection. However, here also a state wise disparity in the use of hygienic products during menstruation is found. 99.1 % of women in Sikkim use hygienic products during menstruation as compared to just 63 % of women in Bihar. Sikkim being the best performing state while Bihar being the worst. Thus, there is a significant gap between the best and worst performing States as far as menstrual health and hygiene practices is concerned.

Determining factors for the Disparity-

1- Female literacy rate -

Female literacy is evidently a strong factor determining women's access to health care facilities. Education leads to financial independence, self- awareness and decision making capacity. Kerala's decades-long investment in Female literacy and primary health care facilities is now giving good results. States having high female literacy rate like Kerala (95.20 %), Mizoram (89.40), Lakshadweep (88.25%), Tripura (83.15) perform better in indices of sex ratio, maternal mortality rate, institutional deliveries, use of contraceptives and informed family planning and cancer screening. However, states having lower female literacy rate as Rajasthan (57.6%), Andhra Pradesh (59.5), Arunachal Pradesh (59.57) and Bihar (60.5) are performing

lower in these indices. (*India Literacy Rate 2022 Overview | PDF | Literacy | Reading (Process)*, n.d.) However, it is seen that education provides support but does not matter absolutely. There are other factors such as state level gaps, individual autonomy, local culture, health infrastructure and service availability which have determining consequences.

2- Health infrastructure and its access-

Health infrastructure and its access is an important factor where disparity and gap persists among the states even after 80 years of independence. Richer states and southern states have better health infrastructure than states which are comparatively poorer. States with more rural populations often lack good, accessible and reliable medical facilities. Similarly, availability of specialist doctors is still a distant dream for the rural people. Unavailability of doctors is the most common problem which is due to the failure of retention of doctors in rural areas. Rural areas hardly have an ideal doctor to patient ratio. Many resort to quacks and other sort of practices which claim to treat the ailments. All these conditions prove detrimental to the health of rural and poorer people in general and women in particular.

3- Referral and transportation network quality for emergencies and complications-

The referral and transportation network is weak in rural areas. When a case becomes complicated and needs emergency medical help and specialist mediation, there needs to be a good hierarchical and accessible referral system where the case can be transferred for saving life. Many infant and maternal mortality cases happen only because the referral and transportation system either is very weak or not accessible. In order to bring infant and maternal mortality rate below the SDG target, there needs to be a strong referral as well as a quick and accessible transportation network irrespective of each corner of the country.

4- State's wealth status, health budget and its impact on health facilities-

The economic condition of the state has a direct effect on almost each factor determining the health of women. May it be infrastructural availability, good transportation system, implementation of center's health programs and schemes effectively or investment in female literacy. All these factors in consolidation determine the health facilities access of women. States with strong financial condition invest in all these factors and provide good medical infrastructure, good and accessible transportation facilities, and implement the health scheme and programs of center in their respective states effectively. It also enables the state to allocate sufficient annual budgets dedicated towards health. National Health Policy recommends states to assign at least 8% of their annual budget to health care. However, only Delhi, Odisha and Rajasthan have allocated their annual state budget towards health above 7-8%.(*Demand for Grants 2026-27 Analysis*, n.d.)

5-State level implementation of central schemes-

Central Health schemes and programs have different success rates across the Indian states. Since health is constitutionally a state subject, therefore the implementation of the central health schemes and programs works in a federal framework. The Central government designs and co-funds the programs while the State Health agencies execute them in their respective States. The funding distribution for the implementation of the schemes is different for states. For union territories the schemes are 100% funded by the center. For Himalayan states 90: 10 ratio is adopted and for other general States 60: 40 ratio is used. (*Amalgamation of Ayushman Bharat Yojana with State Health Schemes*, n.d.) The state governments use three different operational models for implementation of Central health schemes viz trust model, insurance model or mix model.(Joseph et al., 2021) Many times the states merge the central schemes with the existing State Health programs for the ease of implementation and political leverage. These different models are based on

managing the financial responsibility and risk in the implementation of the health program or scheme. According to the National Institute of Health, states like Gujarat, Tamilnadu, and Karnataka achieved rapid success in the implementation of Pradhanmantri Aayushman Bharat scheme by merging the scheme with their existing state schemes. However, the beneficiary people of states like Bihar or Jharkhand, struggle to find proper cashless care in nearby hospitals due to low density of empaneled private hospitals or under-equipped district hospitals. According to Niti Aayog Health Index, Kerala, Tamil Nadu, Telangana are the most performing states while Uttar Pradesh, Bihar, Madhya Pradesh are the underperforming states.(*NITI-WB_Health_Index_Report_24-12-21*, n.d.)

Thus, different funding structures and implementation models, the fiscal strength of the individual state and local infrastructure, willingness / administrative efficiency of the state government in implementing the health scheme in their respective states, delivers different success rates.

6- Equity gap among the lagging states: Marginalized castes and rural poor -

It is found from various studies that the women's access to the health facilities varies across different castes and economic status of the family in almost all states. Institutional Delivery Rates are not evenly attained. General caste women were more likely to attain institutional delivery than a woman from Schedule Caste and Schedule Tribe. Similarly, in both urban and rural areas, maternal health care utilization between poor and non-poor women is uneven. In this way, it is evident that the social economic status of women largely determines her access to health care facilities.

There is an equity gap in women's healthcare access among the women in lagging states also. When gender intersects with marginalized identity, the health outcome is lowered significantly as compared to dominant caste urban women. This gap manifests in different health indicators such as life expectancy, maternity anemia and period poverty. This gap widens for women living in geographically isolated areas. Thus, tribal women experience more period poverty and lower life expectancy due to living in inaccessible and geographically isolated and remote areas. Similarly, women with poor family background, illiterate rural women, suffer from high anemia. It is higher among SC population compared to upper caste and OBC women. Women from privileged castes live longer than an average Dalit woman, while the life expectancy of a Schedule Tribe woman is lower. Apart from this, women from under- privileged caste and class barely possess private medical insurance. In this way, access to the health care facilities is not equal for all women of under-performing states. Also there is a disparity in healthcare access of women among the lagging states. States with high rural population, high tribal population, and more geographically inaccessible and remote areas have more health care accessibility disparity among their women.

CONCLUSION-

There is a sharp disparity found in the success rate of different health programs of centers in different states of India which leads to disparity in healthcare access of women. This disparity is evident in various women's health care indices such as Maternal Mortality Rate, Institutional delivery rate, sex ratio at birth, disparity in the effective implementation of women specific health programs, disparity in cancer screening and disparity in menstrual health and hygiene practices.

Various factors are responsible for the health care access disparity such as female literacy, health infrastructure and its access, referral and transportation network in emergency, state's health budget and wealth status, state's implementation of center’s health programs and schemes and equity gap among the lagging states.

Thus, although governments are working towards betterment of women's health in India through various programs and schemes, much still needs to be done and achieved. It is important on the part of the states to make sincere efforts and meaningful changes, in order to remove the factors responsible for the disparity. Greater and more coordinated plans shall lead to gender empowerment through gender equality in the healthcare area.

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