

Gender Discrimination in Healthcare in India

R. N. Pandey* and S. K. Mukhopadhyay†

Introduction

Providing good health care to all the citizens of India is one of the important policy decisions of the Government of India. A number of programmes have been initiated by the Government in the recent past also. National Rural Health Mission is one of the ambitious programmes of the Government in this field. Provision of health infrastructure by the Government is only one component responsible for the health status of the people. Adequacy of the health infrastructure in the country is itself a subject matter of research. The National Family Health Survey (NFHS) 2 data clearly brings out inadequacy of pre-natal and post natal maternal care facilities, coverage of immunisation of mother and children, etc. However, the use of the available health infrastructure also depends upon the level of education, income, social taboos, etc.

Even in the same household, particularly in rural areas, all the members of the households do not get equal medical attention during the illness. Earning capacity of the household member is an important factor for deciding the urgency and type of medical attention. Social taboos, particularly in some rural areas, do force uneven medical attention to the women as compared to men, particularly to female children.

In this paper, with the use of data from National Sample Survey Organization (NSSO), an attempt has been made to examine the gender discrimination in the household in terms of hospitalisation, medical expenditure, type of medical facilities used, etc. It may be mentioned that the National Health Policy was formulated and enacted in 1983. Since then, NSSO has conducted three nationwide surveys on utilisation of medical services by the various sections of the population during 1986-87 (NSS 42nd round), 1995-96 (NSS 52nd round) and 2004(NSS 60th Round). In this paper mainly the data of NSS 60th round (January - June 2004) survey on morbidity and health care have been used. Changes observed in some of the health indicators during 1995-96 and 2004 have been also presented in this paper.

Source of Data

The important objectives of the survey on morbidity and health care conducted by the NSSO in its 60th round was essentially to study the utilisation of **public and**

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private health services by various sections of the population as well as to measure the role of the private institutions vis-à-vis government institutions in providing health care services. This survey, conducted within a duration of 6 months (January – December, 2004), covered 47,302 households in rural areas and 26,566 households in urban areas. The NSS 52nd Round covered 71,284 households in rural areas and 49,658 households in urban areas during July 1995 and June 1996. The main objectives of this survey was essentially to study the benefits derived by various sections of the population from investments made by the Government as well as by the private sector in the fields of health and education. In the Schedule for morbidity and health in this survey, information was collected on maternity and child health care, morbidity and utilisation of medical services, problems of the aged persons, etc. The NFHS-2 was conducted during 1998-99 covering 91,196 households in 25 States and 89,199 ever married women of age 15-49 in these households. Information on fertility, mortality, family planning, and important aspects of nutrition, health & health care and several other information were collected in NFHS-2.

In this paper, the values of various indicators have been presented at all India level only. As is evident, the values of the indicators used for the analysis in this paper are the findings of the sample survey and the robustness of the indicators may depend on the presence non-sampling errors as well as the magnitude of sampling error measured in terms of the relative standard errors (RSEs) of the estimates. However, the magnitude of the RSEs of the various indicators has not been studied. Thus, it is quite possible that in respect of certain indicators, the values of the indicators may be subject to high RSEs while for others the RSEs may be within the acceptable range. It may be noted that in this paper, a few variables have been selected for the purpose of studying gender discrimination in healthcare in India and as such the findings of have to be interpreted with respect to the indicators chosen.

Discussion of Results

Rate of hospitalisation

Serious ailments warrant the hospitalization of persons. It will be interesting to study the gender differentials in the hospitalization cases. In Table 1 above, the rate of hospitalisation per 1,00,000 of persons is presented. It is seen that in the urban areas, the rate is well above the rate observed in the rural areas. Moreover, in both the rural and urban areas, the rates for males are higher than that for females. The difference is higher in rural areas as compared to urban areas. This clearly shows the greater attention to males as compared to females. The higher hospitalization in urban areas may be due to the better accessibility and affordability of the costs of medical services as compared to rural areas.

age-group	rate of hospitalisation during last 365 days		
	males	females	persons
(1)	(2)	(3)	(4)
Rural	2715	2479	2599
Urban	3505	3456	3482
Rural+ Urban	2919	2722	2823

Since a person may be hospitalised more than once during the reference period, the rate of hospitalised cases may be a bit higher than the rate of hospitalised persons, in which case a person is counted only once. Using these two information, one useful indicator, namely the average number of times hospitalised -defined as the ratio of persons hospitalised to that of number of times hospitalised- can be derived. It is seen from Table 2 that on an average an ailing male was hospitalised 1.15 times whereas an ailing female was hospitalised only 1.13 times. Therefore, the rate of hospitalisation was also found to be lesser for females in both the rural and urban areas. Ass in the case of hospitalisation rate, discrimination was more in rural areas.

age-group	average number of hospitalisation during last 365 days		
	males	females	persons
(1)	(2)	(3)	(4)
rural	1.16	1.12	1.14
urban	1.14	1.13	1.13
rural+ urban	1.15	1.13	1.14

Changes in the magnitude of hospitalised treatment over time

In Table 3 a comparison of the rate of hospitalisation during two survey periods viz., NSS 60th round and NSS 52nd round has been made. It has been observed that the overall rate of hospitalisation has increased during 2004 compared to the situation prevailed during 1995-96. This increase was observed to be true for both the males and females in rural as well as urban areas. This may be due to better availability of hospital facilities and increase in perception among the people about the utility of hospital services.

Table 3: Rate of hospitalisation (in per cent) during NSS 60th round (January – December, 2004) and NSS 52nd round (1995-96) during last 365 days

sector	male	female	person
(1)	(2)	(3)	(4)
NSS 60 th round			
rural	27.2	24.8	26.0
urban	35.1	34.6	34.8
NSS 52 nd round			
rural	14.0	13.0	13.0
urban	20.0	20.0	20.0

Type of hospitals

Information about the type of hospitals and type of wards for hospitalisation for males and females in the rural and urban areas were also collected in the survey. It is seen from Table 4 that, in the rural and urban areas combined, nearly 41 percent of hospitalisation cases were in the public hospitals and the remaining 59 percent was in the private hospitals. In the rural areas, also 42 percent of the hospitalisations were in the public hospital and nearly 58 percent were in the private hospitals. However, in the urban areas, preference for the private hospitals was prominently visible – nearly 62 percent of the hospitalisation cases were in the private hospitals.

Table 4: Percentage distribution of hospitalisation cases by type of hospital and type of ward

category of persons	type of hospital								total (incl. n.r.)	
	public hospital+ public dispensary				private hospital					
	type of ward				type of ward					
	free ward	paying general ward	paying special ward	all (incl. n.r.)	free ward	paying general ward	paying special ward	all (incl. n.r.)		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	
Rural										
male	35.0	6.4	0.7	42.0	2.4	45.4	10.1	57.9	100.0	
female	35.0	5.7	0.4	41.3	2.7	45.1	10.7	58.5	100.0	
person	35.0	6.0	0.6	41.7	2.6	45.3	10.4	58.2	100.0	
Urban										
male	30.8	6.7	1.2	38.6	1.1	43.0	17.2	61.4	100.0	
female	30.0	6.7	1.1	37.8	2.1	43.6	16.5	62.2	100.0	
person	30.4	6.7	1.1	38.2	1.6	43.3	16.9	61.7	100.0	
Rural +Urban										
male	33.7	6.4	0.8	40.9	2.0	44.7	12.3	59.0	100.0	
female	33.4	6.0	0.6	40.2	2.5	44.6	12.5	59.7	100.0	
person	33.5	6.2	0.7	40.6	2.3	44.6	12.4	59.3	100.0	

It is heartening to see that no significant gender differential was observed in the case of preference for type of hospitals for hospitalisation. It may also be noted that in the public hospitals the use of the free ward was in the majority of

hospitalisation cases whereas in the private hospitals the paying wards was used in majority of the cases. In rural areas, marginal discrimination was observed for females in paying wards in public hospitals.

Changes in the pattern of type of hospitals over time

In Table 5 the percentage distribution of the cases of hospitalised treatment by type of hospital during 2004 and 1995-96 are presented. The declining role of the government hospitals in providing the treatment is visible in both rural and urban areas. It may be seen that the percentage of hospitalised cases treated in government hospital declined from about 44 percent in 1995-96 to about 42 in 2004. In urban areas, the rate of decline was even faster: 43 percent in 1995-96 to 38 percent in 2004.

Table 5: Percentage distribution of cases of hospitalised treatment by type of hospital during 2004, 1995-96 and 1986-87

type of hospital	2004 (60 th)	1995-96 (52 nd)	1986-87 (42 nd)
(1)	(2)	(3)	(4)
rural			
government	41.7	43.8	59.7
non- government	58.3	56.2	40.3
all hospitals	100.0	100.0	100.0
urban			
government	38.2	43.1	60.3
non- government	61.8	56.9	39.7
all hospitals	100.0	100.0	100.0

Treatment before hospitalisation

Treatment in some of the diseases, except for the emergency cases generally commence before hospitalisation. In Table 6, proportion of hospitalisation cases receiving treatment is presented along with average duration of treatment before hospitalisation.

Table 6: Percentage of hospitalisation cases receiving treatment before hospitalisation and average duration of treatment before hospitalisation

category of persons	percentage of hospitalisation cases that received treatment before hospitalisation	average duration of treatment before hospitalisation (in 0.0 days)
(1)	(2)	(3)
rural		
male	52.3	92.4
female	56.3	99.3
person	54.2	95.7
urban		
male	55.7	99.0
female	58.4	105.2
person	56.9	102.0
rural + urban		
male	53.4	94.6
female	57.0	101.2
person	55.1	97.8

It may be noted that in the case of females, in the rural areas, nearly 56 percent of the hospitalisation cases received treatment before hospitalisation and average duration of such treatment was nearly 99 days. On the contrary, for the males in the rural areas, nearly 52 percent of hospitalisation cases received treatment before hospitalisation and average duration of such treatment was nearly 92 days. This trend is also visible for the urban areas, where nearly 58 percent of the urban females received treatment before hospitalisation with average duration of such treatment being 105 days which were considerably higher than the males for whom nearly 56 percent of those hospitalised received treatment and on an average they received treatment for 99 days. These shows, that the males have been hospitalised with lesser waiting time, in the sense that the household admitted them relatively promptly, whereas in the case of the females, households had waited for a considerably longer time before actually hospitalising them

Ailments treated on medical advice:

Previous discussions were confined to the treatment of illness in hospitals. However, all the ailments are not treated. The reasons could be varied and the decision of the individual or the household to treat or not to treat an ailment will be guided by a variety of reasons prominent among them is the seriousness of the ailments as perceived by the members of the household. Besides, important members such as a child, and earning member etc are to be treated early. In Table 7 the proportion of the spells of ailments treated during the last 15 days and percentage distribution of those which were not treated by reason for no treatment have been presented.

It can be seen from this table that as far as the treatment of the ailments are concerned the households do not discriminate between the illness of a male and female members. However, the tendency to treat the ailments from private sources was higher in case of male illness than in the case of female illness. In the rural areas, nearly 82 percent of the spells of ailments were treated for both males and females. In the urban areas also the figures for males and females were almost same- 90 percent for males and 89 percent for females. However, it can be observed that in both the rural and urban areas, higher proportions of ailments were treated in private for males than for females. A study of the reasons for untreated ailments reveal the attitudinal bias against females. Due to financial constraints a higher proportion of female ailments were not treated in both rural and urban areas. In the rural areas nearly 29 percent of the female ailments were not treated for financial reasons, while it was nearly 27 percent in the case of males. The urban areas also exhibited similar

It features, where nearly 23 percent of the ailments were not treated for financial reasons compared to only 18 percent of the male ailments not treated due to financial reasons. Another reason for not treating the ailments was that the ailments were not considered serious. In the rural areas, nearly 33 percent of non-treated female ailments were not considered serious but the corresponding figures for the males were 31 percent. Urban areas, however, displayed different pictures where nearly 54 percent of the ailments of males were not treated because these were not

Table (7): Proportion (in percent) of spells of ailment during last 15 days treated on medical advice and percentage distribution of untreated spells of ailments not given medical treatment by reason for not taking treatment

category of persons	proportion (in percent) of spells ailments treated on medical advice during last 15 days from			spells of ailments not given medical treatment by reason						total (incl. n.r.)
	government	private	all	no medical facilities available in the neighbourhood	facilities available but no treatment sought owing to				others	
					lack of faith	long waiting	Financial reason	Ailment not considered serious		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Rural										
male	17.9	64.5	82.4	12.5	3.4	1.1	27.2	30.7	14.4	100.0
female	18.8	63.4	82.2	10.6	2.6	0.7	29.0	33.3	15.3	100.0
person	18.4	63.9	82.3	11.5	3.0	0.9	28.1	32.1	14.8	100.0
Urban										
male	17.2	72.5	89.7	0.9	1.7	0.6	17.6	53.8	12.0	100.0
female	17.0	71.8	88.9	1.4	2.1	2.5	22.7	46.9	13.0	100.0
person	17.1	72.1	89.3	1.2	1.9	1.6	20.4	50.0	12.5	100.0
Rural + Urban										
male	17.7	66.7	84.4	10.3	3.1	1.0	25.4	35.0	14.0	100.0
female	18.3	65.8	84.1	8.7	2.5	1.0	27.7	36.0	14.8	100.0
person	18.0	66.3	84.3	9.5	2.8	1.0	26.6	35.5	14.4	100.0

considered serious whereas nearly 47 percent of the ailments of the females were not treated because these were not considered serious.

Cost of treatment

Cost of treatment will depend upon the type of disease and its seriousness. Except a few sex specific diseases (such as gynaecological and breast cancer in women and prostate cancer in men), prevalence of other diseases are more or less same in men and women. A study of expenditure incurred on treatment for male and female will also give an indication of gender discrimination in health care.

Cost of treatment as inpatient

In Table 8, average total medical expenditure for treatment per hospitalisation cases during the stay at hospital during the last 365 is presented. It may be seen that medical expenditure for women was less in both rural (Rs.5406) and urban areas (Rs.8112) as compared to males- rural (Rs.5946) and urban (Rs.9535). It can also be observed that irrespective of whether treatment was availed in the government hospital or in the private hospital, the average total medical expenditure was much lower in the cases of females in both the rural and urban areas than the corresponding expenditure incurred for the males. In fact, female medical expenditure was nearly 90 percent of the corresponding male medical expenditure during the stay at hospital.

Table 8: Average total medical expenditure (Rs.) for treatment per hospitalisation case during the stay at hospital (as inpatient) for last 365 days

category of persons	Govern-ment hospital	private hospital	all hospitals (incl. n.r. cases)
(1)	(2)	(3)	(4)
rural			
male	3550	7640	5946
female	2874	7145	5406
person	3238	7408	5695
urban			
male	4135	12448	9535
female	3600	10580	8112
person	3877	11553	8851
rural + urban			
male	3703	9163	7004
female	3076	8264	6237
person	3410	8738	6643

Changes in the pattern of average medical expenditure over time

Comparison of the average medical expenditure over two survey periods, viz, during 2004 and during 1995-96 is given in Table 9. However, expenditures are at current prices and adjustment has not been made for inflation. To take care of this

constraint, it will be better to study the changes in the ratio of medical expenditure for males to females for rural and urban areas during these two periods. It may be seen from Table 9 that medical expenditure on males was 1.5 times to that of females in the rural areas during 1995-96. This ratio reduced to 1.1 times during 2004 indicating better medical attention for females as compared to that in 1995-96. In the urban areas, medical expenditure on males was 1.2 times of that for the females in 1995-96. This ratio remained the same during 2004 also. Therefore,

Table 9: Average medical expenditure (Rs.) per hospitalisation during 2004 and 1995-96

gender	rural		urban	
	60 th round (2004)	52 nd round (1995-96)	60 th round (2004)	52 nd round (1995-96)
male	5946	3778	9535	4,185
female	5406	2510	8112	3625
person	5695	3202	8851	3921

Average total expenditure in hospitalisation & non-hospitalisation cases and average loss of household income

Every illness in the household is accompanied by basically two types of costs. On the one hand there is the direct cost of treatment of the diseases in terms of medical expenditure and other than medical expenditure such as food, transportation, lodging, etc. Therefore, the total expenditure in such cases will include both components. In non-hospitalisation cases, total expenditure will basically be for medical expenditure.

Besides these two costs, there are other hidden costs of illness and it may arise due to non-participation in economic activities by the household members. Often ailment of a working member of the household causes loss of household income. Ailment of a non-working member too causes disruption of usual activity of the working member of the household, which in turn results in loss of household income. While for persons getting pay, either as regular salaried employee or casual labour, the amount of loss in income during the period of treatment was derived on the basis of pay that he/she was drawing before the hospitalisation/ailment; for the self-employed persons, it was imputed based on the proportionate average income (lost) during those days. For non-ailing members of the household who could not carry out their 'work' (economic activity) in order to attend to the ailing member, the loss of income for them, if any, was derived in the same manner and was also included in the loss of income of the household. Amount of such a loss incurred by the household during the reference period was collected in the survey.

Table 10 presents the data on average total expenditure per hospitalisation and non-hospitalisation ailments cases as well as the average loss of household income in both the cases. It may be seen that average total expenditure in both the cases were higher for males in both rural and urban areas. The average expenditure for females

was in the range of 85 to 90% of the average expenditure for males in two types of cases in both rural and urban areas.

The loss of household income due to hospitalisation was Rs. 760 during the reference period for males and it was nearly 493 for females. In the urban areas, due to hospitalisation of a male member a household lost an average Rs. 1073 during the reference period, while when a female member was hospitalised the loss was to the tune of Rs. 391. Thus, on an average the loss of household due to hospitalisation of a male member of a household, was nearly 1.5 times than that the loss it had incurred due to hospitalisation of a female member in the rural areas. In the urban areas, the loss due to hospitalisation of a male member was nearly 2.7 times to the loss that it had incurred due to hospitalisation of a female member. In the non-hospitalisation cases, though the average loss to the households was less as compared to hospitalisation cases, the gender differential was much more prominent in such cases. In rural areas, the loss due to male' ailments was 3.3 times of the loss due to females. However, in urban areas this was about 5 times. The higher loss of income to the

Table 10: Average expenditure (Rs.) as in-patient per hospitalisation case, average expenditure (Rs) for treatment (other than hospitalisation) and average loss of household income due to ailments per ailing person treated during last 15 days in both the cases

category of persons	In-patient hospitalisation cases		Other than hospitalisation cases	
	Average expenditure (Rs.) per hospitalisation	Average loss of household income (Rs.) due to hospitalisation	Average medical expenditure (Rs.) for treatment	Average loss of household income due to ailments
(1)	(2)	(3)	(4)	(5)
rural				
male	6496	760	304	211
female	5914	493	267	64
person	6225	636	285	135
urban				
male	10080	1073	343	163
female	8596	391	311	33
person	9367	745	326	96
rural + urban				
male	7553	852	315	197
female	6737	462	279	55
person	7169	669	297	124

households due to male's ailments than the female's ailments may be the genesis for giving preference to male member of the households in medical attention over female members.

Conclusions:

Analysis attempted in this paper clearly brings out the gender discrimination in medical attention among the household members. On an average a male member of a household was hospitalised for higher number of times than females during the reference period. If the need for hospitalisation is purely dictated by the gravity of the illness without the influence of any extraneous factors, one may like to encounter a situation where the rate of hospitalisation for males and females are likely to be very close, if not equal in the long run. But the results prove the contrary.

As far as the duration of treatment before hospitalisation is concerned the females received higher days of treatment before hospitalisation compared to their male counterparts, indicating that the households waited for longer duration, may be with the hope that immediate hospitalisation is not necessary, where as the male members were admitted relatively early.

The analysis also found that due to financial reasons a higher proportion of female ailments were not treated in both rural and urban areas. Further, in the rural areas, a higher percentage of non-treated female ailments were not treated since the ailments were not considered serious.

The expenditure incurred on the treatment is an important indicator to study the gender discrimination. Data used in the survey clearly show that expenditure in the hospitalization as well as non-hospitalisation cases was much higher for males as compared to females. In fact, female medical expenditure was nearly 90 percent of the corresponding male medical expenditure during the stay at hospital.

The comparison of the situation between 1995-96 and 2004 reveals that though the rate of hospitalisation increased, the percentage of persons availing the government services decreased in both rural and urban areas during this period. Further, the gender discrimination in health expenditure, measured in terms of ratio of health expenditure for males as compared to that for females observed a decline in rural areas but remained the same in urban areas during this period.

The gender discrimination in medical attention appears to be driven by economic consideration. As the participation of males in economic activities is much higher as compared to females, the loss of income due to ailment was much higher for males and hence affecting the household income. To reduce this loss and its consequences on the welfare of the households, male members were given preference in treatment of ailments.

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ABSTRACT

Providing good health care to all the citizens of India is one of the important policy decisions of the Government of India. A number of programmes have been initiated by the Government in the recent past also. National Rural Health Mission is one of the ambitious programmes of the Government in this field. Provision of health infrastructure by the Government is only one component responsible for the health status of the people. Adequacy of the health infrastructure in the country is itself a subject matter of research. The National Family Health Survey (NFHS) 2 data clearly brings out inadequacy of pre-natal and post natal maternal care facilities, coverage of immunisation of mother and children, etc. However, the use of the available health infrastructure also depends upon the level of education, income, social taboos, etc.

Even in the same household, particularly in rural areas, all the members of the households do not get equal medical attention during the illness. Earning capacity of the household member is an important factor for deciding the urgency and type of medical attention. Social taboos, particularly in some rural areas, do force uneven medical attention to the women as compared to men, particularly to female children.

In this paper, with the use of data from 60th round (January - June 2004) survey on morbidity and health care conducted by National Sample Survey Organization (NSSO), an attempt has been made to examine the gender discrimination in the household in terms of hospitalisation, medical expenditure, type of medical facilities used, etc.

Analysis attempted in this paper clearly brings out the gender discrimination in medical attention among the household members. On an average a male member of a household was hospitalised for higher number of times than females during the reference period. If the need for hospitalisation is purely dictated by the gravity of the illness without the influence of any extraneous factors, one may like to encounter a situation where the rate of hospitalisation for males and females are likely to be very close, if not equal in the long run. But the results prove the contrary.

The analysis also found that due to financial reasons a higher proportion of female ailments were not treated in both rural and urban areas. Further, in the rural

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areas, a higher percentage of non-treated female ailments were not treated since the ailments were not considered serious.

The expenditure incurred on the treatment is an important indicator to study the gender discrimination. Data used in the survey clearly show that expenditure in the hospitalization as well as non-hospitalisation cases was much higher for males as compared to females. In fact, female medical expenditure was nearly 90 percent of the corresponding male medical expenditure during the stay at hospital.

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