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THE ROLE OF FEMALE HEALTH IN ECONOMIC DEVELOPMENT

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ABSTRACT
India is on the verge of becoming an economic superpower, but its performance in the health component of human development, particularly for women, is disappointing. The traditional female advantage in life expectancy does not exist in India. It is necessary to understand whether women will benefit from the economic take-off in the context of the new economics of liberalisation and the challenges to work, human security, and development. As a result, this paper attempts to examine women's health issues in India in relation to their work environment, productivity, and welfare. It focuses on two broad categories of gender differences and inequalities: the relationship between gender and economic productivity, and women's development. Women's health worldwide falls short of its potential. This deficit's negative economic impact may be consequential, in addition to the potential consequences of negative moral and civil rights. We intend to conduct a systematic investigation into the broader economic benefits of investing in women's health, building on previous research that has identified health as a driver of economic growth and poverty alleviation.

Keywords:

INTRODUCTION
When we say that India is a developing country, we include in “development” the progress that is witnessed among women too. In fact development is gender neutral. The new and non-income indices of development viz. Physical Quality of Life Index (PQLI), Minimum Needs Approach, Human Development Index etc have in them the vital component of ‘health’, couched specifically in life span or life expectancy and infant mortality rate. In the Human Development Report (HDR) of 1990 there was a clear emphasis on the health aspect of human development. HDR 1994 underlined the importance of health security.

Contextually HDR 1995 introduced the Gender-related Development Index (GDI) and Gender Empowerment Measure (GEM). Women seemed to have come to the centre from the periphery. With Clifford Cobb, Ted Hallstead and Jonathan Row suggesting the Genuine Progress Index, the stage was set for a genuine concern for women in sustainable development (Hans, 2000). However, the causes of the persistent inequality between men and women are only partially understood, be it in education or in health sectors.

This paper evaluates a plethora of research confirming that women's health is linked to long-term

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productivity: how each country protects and promotes women's health influences nations' development and economic performance. Opportunities for deliberate family planning, healthy mothers before, during, and after childbearing, and the well-being and efficiency of future generations can all help to kickstart a positive social and economic development cycle.

Women's Health: Definitional Aspect

Recent approaches encompass a broad spectrum of issues concerning women's health. They acknowledge all diseases and disorders affecting women, include an understanding of the impact of social, cultural, economic, and political influences, and emphasize both prevention and treatment (Shaw, 2008; Goldman and Maureen, 2000).

According to the National Academy on Women's Health Medical Education, women's health is concerned with the preservation of wellness and the prevention of illness in women; it includes empowering women to be educated participants of their own health care; and it recognizes the significance of gender differences. The American College of Women's Health Physicians defines the practice of women's health care as,"A sex-and gender-informed practice centered on the whole woman in the diverse contexts of her life, grounded in an interdisciplinary sex-and gender-informed bio-psycho-social science".

The modern view of women's health is comprehensive in reference and analysis to include besides epidemiologic perspective, the social, environmental, occupational determinants of health, diseases and disorders. The concept beings with the birth of a girl child, goes through woman's entry into reproductive years to midlife, and to her aging.

However, these are emerging and evolving definitions and cannot be called as entirely new or final. For instance, the aspect of "reproductory health" which has surfaced prominently in recent times has been in the roots of women's health, its knowledge and practice. Today it has acquired a distinct feminist touch and policy orientation.

Gender Perspective of Health – the New found Importance

Women's lives have evolved over time. Historically, most women had it especially tough. According to the World Health Organization, 500,000 women die each year as a result of pregnancy-related complications. In developing countries, approximately half of all women of reproductive age and two-thirds of pregnant women are anaemic. Historically, most women did not live long enough to be concerned about menopause or old age. A woman's life expectancy in 1900 was around 50 years. American women have a life expectancy of 82 years, which is steadily increasing. Women are not only living longer lives, but they may also have a higher quality of life throughout their lives. While women continue to be in a state of marginalization, there are also positive developments as in the case of gender sensitization, women empowerment and even emphasizing the role of homemakers. Today the overall quality of life in a country is amply measured with several of the indicators of women's status

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Table 1. Female Life Expectancy at Birth – Selected Countries

Country	1980	1990	2000	2005
Albania	72.3	75.9	78.0	79.5
Belgium	76.8	79.4	80.8	82.4
Canada	79.8	81.0	81.7	81.8
Denmark	77.3	77.7	79.0	79.1
Estonia	74.1	74.9	76.0	78.1
Finland	77.6	78.9	81.0	82.3
Germany	76.1	78.4	81.0	81.8
Hungary	72.7	73.7	75.6	76.9
India	54.7		63.3	65.3
Japan			84.1	85.7
Kazakhstan	72.0	73.4	71.6	71.7
Luxembourg	75.4	78.7	81.9	82.2
Malta	72.7	78.1	80.2	81.4
Norway	79.2	79.8	81.4	82.5
Pakistan			59.5	64.8
Russian Federation	73.0	74.4	72.4	72.4
Sri Lanka			75.0	75.6
Tajikistan	69.4	72.6	73.9	69.0
United States	77.4	78.8	79.6	80.4
Vietnam				75.7
Yemen				63.1
Zambia				40.6

Source – data.worldbank.org

Some of the variables influencing women's status are -

(i) women's literacy,
(ii) women's age at marriage,
(iii) birth rate and mortality rate, and
(iv) women's access to health care facilities.

While these may not be the most important factors they are indeed the critical ones in that they contribute to raising the position of women in society (Nair, 1988). Naturally, therefore, women's health has emerged as one of the vital areas of health economics. A simple truth to be admitted: health programmes launched anywhere will neither be complete nor successful if women are left in

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the periphery. This realization has manifested in the thrust given to programmes of health of mother and child (Hans, 1997).

Limited autonomy or powerlessness of women in family roles, and lack of health-seeking behavior were found to be the major factors adversely affecting women's health. Since the health of woman and child forms a continuum from one generation to another, it was noticed that there is not only an inherent vulnerability in the biological and behavior aspects of reproduction, growth, development and nutrition, but also the social, cultural and historical situation of societies. Health rights were accepted as the important means of women's empowerment and their quality of life (Murugan, 2005).

Slowly but steadily, directly and indirectly, health perspective of women development is coming to occupy vital space in development literature and policy circles. Whether in the name of female education or the call of women empowerment – through socio-economic compulsions and motivations – the risks to and requirements of women's health are getting due attention. The realization that women's issues cannot be compartmentalized and isolated as secondary issues in development has emerged as a constant value. Therefore, the empowerment and development of women have become crucially related issues for the world community, although cross country achievements are not only diverse but leave neglected areas vying for attention in the field (Tapan, 2000).

For the developing countries like India with sizeable female population gender studies that focus on health disparities are very useful. The trend today in India is to make inter-state and studies using the relevant parameters.

Women do not use health care facilities as frequently as they should because the health-care system does not adequately address their needs. Providers make no effort to educate households about the specific health needs of women. The national school curriculum lacks information about reproduction, safe sex, HIV/AIDS, and other sexually transmitted diseases. Decisions made at the household level can sometimes prevent women from accessing health care. This situation may gradually improve as long-term efforts to improve human capital and economic productivity give women greater status and bargaining power in the home (World Bank, 1999). Add to this the poor infrastructure like bad roads and lack of transportation, the plight of women, particularly pregnant women is deplorable. In India deaths due to reproduction related complications is very high even though 70 per cent of the maternal-related deaths are preventable (Azad India Foundation, 2004)
Women's Health in India

One of the guiding principles adopted by the Bhore Committee – appointed in October 1943 for evolving health policies and services in India – was that the health services should be located as close to the people as possible to ensure maximum benefit to the communities served. (Sagar, 2006; Hans, 1997, op. cit.). But even today in a typically backward village of India, women travel long distances not only to fetch potable water but also to get treatment for their ailments and for deliveries. According to the National Council of Applied Economic Research (NCAER), in nearly 20 per cent of cases of illness rural people traveled more than 10 km for treatment. In the state of Meghalaya, in 54.56 per cent of rural illness cases and in the state of Orissa, in 33.47 per cent of

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rural illness cases, patients traveled more than 10 km. Woeful inadequacy of health workers has resulted in high incidence of deaths, particularly among mothers (Hans, 2008).

Demographic research over the past two decades has confirmed that psycho-social factors like preference of sons over daughters, coupled with economic discrimination against women and girls have conspired to ensure that boys have greater access to health care and even food than do their sisters. Such a tendency amounts to overt neglect of girls and marginalization of women. At the extreme it may even assume proportions of social and political oppressions at the local level. While representative democracy may succeed in institutionalizing inclusive growth, conflicting opinions and priorities may make the power equations to ignore or under-represent the interests of the deprivileged – women (Chandoke, 2007). The pro-women public health interventions being inadequate has made the proactive role of voluntary sector essential.

That women have been losing in health care is also evident from the striking gender differences in health care expenditure. A study by Ashokan (2005) reveals that in rural Kerala the average outpatient (OP) expenditure by male population is Rs.265.49 whereas by female population it is Rs.224.48; in case of patient (IP) the figure is Rs.5790.99 for males and Rs.4180.45 for females; and the OP-IP ratio is 20.52. Also, ceteris paribus, females are less privileged to quality and specialized health care (Ashokan, 2008).

Yet neither their true potential nor problems have been adequately attended to. When the goal of "Health for all by 2000 AD" was set in the 30th World Health Assembly (1977), all the signatories i.e., members of WHO (including India) planned to achieve it as targeted. (Nalini and Elango, 2005; Hans, 1997, op. cit.). This called for not only a jump-up in health care spending by the government but also effective complementary polices by national, state and local governments. Complete state of health is what the women need but there is still an adverse position of women in the education-health-employment nexus (see box 1). Women workers' contribution to nation's economy is generally overlooked or dismissed as 'marginal'. They are often victims of forces unleashed by change and development and hampered by their lack of understanding or skills necessary for a competitive economy (Mazumdar and Kumud, 1975).

Gender discrimination has put social integration in danger. Even the health programmes are in jeopardy. Jayati Ghosh draws attention to the problem of poorly paid female labor in the National Rural Health Mission (NRHM). They are paid very low and the payment in many states is described as 'honorarium' and not wages. (Ghosh, 2008). More than 15 per cent of the total female workforce consists of unpaid family workers. Over 90 per cent of women are in the informal sector with discrimination in the form of low-paid and insecure jobs.

Under-enumeration in the country's data collection system, operational biases etc have led to "invisibility of women in the economy". From ploughing to harvesting, from cooking to total child care activities, in India there more than 20 activities that women do but are not valued as productive activities. "Missing women-syndrome" has adversely affected the allocative efficiency and distributive justice, both at the micro level and the macro level of economic activities. Over-invoicing of inputs and under-valuation of output in women centric activities is not uncommon. This imposes constraints on efforts at gender equity.

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Health and Economics In India

Investments in health, particularly health beyond illness care, have the potential to benefit India significantly. A young population's promised productivity boost can be safeguarded. When domestic needs are met, this expanded health workforce will also be able to meet global health needs. Innovative health technologies and low-cost pharmaceutical products for domestic and global markets can be mass-produced. Increased public funding for the health sector is required as a result.
India stands to benefit greatly from investments in health, particularly health beyond illness care. The productivity boost promised by a young population can be protected. When domestic needs are met, this expanded health workforce will be able to meet global health needs as well. Innovative health technologies and low-cost pharmaceutical products can be mass-produced for both domestic and global markets. This necessitates increased public funding for the health sector.

Constraints Faced by Women

Women play an important role in our society's economic development, and their contribution is equal to or greater than that of men. Even so, women face a number of issues and problems in the form of constraints. In some workplaces, women are treated equally, while in others, they are treated inferior to their male coworkers. In some cases, they do not receive the same benefits as male employees because their work is undervalued and underestimated. This instils in them a sense of inferiority. This syndrome causes stress. It worsens when they are confronted with an unequal pay structure, insecurity, sexual harassment, insufficient family support, and so on.

In order to meet the increased need of the households, they work by lips and bounds. They take up full day jobs and handle all the matters related to households simultaneously. If they work in highly time bound manner to meet the deadline of work, they are forced to cut few hours of sleep to handle the workplace's matter to household. Its ripple effects are so stressful and intense that they work considerably to get the expected outcomes. They handle harassment's at their workplace; sometimes just overlook things to ensure that their job is not jeopardized in anyway. Side by side, women living with their parents and in-laws face a natural compulsion to care for them. This adds on their perceived constraints. Any critical crisis at the household is intimated to women, even when they are carrying out essential responsibilities at workplaces. This trend retards their motivation for work.
Moreover, women seem to be taking males' help in their financial management. When their income is invested, it is uninformed and intended to long term household requirements. Their requirements are not taken into considerations. Even if invested income is theirs, the power to dispense does not belong to them. This is a serious challenge to their earned income. Thus, the two- way pressure to handle professional assignments and household liabilities flush them in duress. The constraints faced by women can be identified as under:

1. Role conflict or multiple roles create a constraint. Women perform multiple roles, such as managing work at their organisation, managing their families at home, and fulfilling other societal obligations. Working women in the service sector face a significant challenge in balancing work and family life. Working women with strict schedules report more domestic problems than working women with flexible schedules. This issue stems from the time constraints that working women face while fulfilling family and work obligations.

2. Insufficient maternity & paternity leaves are another crucial constraints faced by working women in service sector. It not only affects their performance at workplaces but also

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influences their personal lives where family considerations are issue.

3. Ineffective family support is one of the reasons that working woman in service sector face. Women are necessarily scouted while leaving household and joining office hours. They also resist working late hours in office which affects their health and mental balance.
4. Due to ineffective security arrangements at workplaces and surroundings, women face tremendous pressures.
5. The root of gender discrimination is inbuilt in the structure of Indian households. It is not the society alone which criticizes women for stepping out to get a job but individuals who are the members of same household. They are preached and taught to take care of households, take care of in- laws, child care etc. In certain community, women are forced to obey Purdah(veil).
6. In spite of technological advancements, women in the society have been discriminated on the grounds of its inaccessibility to them. The practice of disapproval to go for work outside the household is still considered demeaned social status. External engagements for women in conservative and even slightly modernized households are considered out of bounds.
7. India has not reached a stage where nodes and the matrix of communication and transport are advanced. Commuting from home to workplace is still a difficult exercise for women. Technological backwardness is a major issue that fails to create an informed balance.

The unwelcome sexual advance, request for sexual favor and double standard expressions are the probable reasons of constraints women face in their everyday life. Supreme Court of India has already issued necessary instructions against sexual harassment as a separate category of legally prohibited behavior. At workplaces the employers need to make the working environment safe and secure. A prevention policy in every organization should be designed to ensure zero tolerance in matters of sexual harassment.

The family members of working women should also help minimizing obligatory expectations. They should share their burden and allow them to step in job market. The child care, domestic work, care to elderly people should be equally shared by men and women. A policy in connection with the restructuration of household jobs should be put in place where equal participation of men and women should be ensured.

The bullying behavior about working women should not be tolerated. Employer should also ensure that such incidence should not take place. Even on the occasions of host exchanges among women employees, bullying attitude should be complied with draconian measures.

CONCLUSION

India's missing women cannot be brought back but the roots and branches of gender bias and its consequences are being researched upon. Gender sensitization is touching vital aspects of human development – health, education skill and enterprise. Gender sensitivity approach and strategies need to go beyond family welfare and Reproductive and Child health (RHC) Programme to holistic view of woman's life – personal life, family life, community life, work, and life after retirement.

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Total security is what women and all those concerned with women empowerment genuinely should aim at. The gender gap is harmful. Gender equity is required to improve women's productivity and performance in various roles in society. It is on India's agenda for long-term livelihoods. Our multidisciplinary and robust systematic review of existing literature on women's health and economic development supports four major conclusions. For starters, more educated and productive societies benefit from healthier women. Second, ensuring women's fertility control can hasten economic growth and development. Third, through intergenerational spillovers, maternal health is critical to subsequent generations' health and economic well-being. Fourth, more research on the health, household, and societal productivity of women is needed.

How a country educates and provides opportunities for its women determines how well it develops and performs. Mothers give birth to the next generation of workers, and physically and emotionally healthy workers are more productive. Societies that invest in women's health are more likely to have better overall population health and to be more productive for future generations.

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