REPORT

Critical reflections on health sector reforms in India: A seminar report

ASIMA JENA, MADHUMITA BISWAL

Abstract

The papers presented at a recent seminar—"Rethinking gender and body in times of health sector reforms in India"—highlighted the urgent need to integrate gender studies into critical health research in order to understand the complex scenario brought about by the health reforms, and its impact on different categories of people. They also stressed on the need for tracing the historiography of public healthcare in India and the need to scrutinise values not just facts, and develop a dialogic process of learning in order to fully grasp multiple issues.

Introduction

In recent times, health and allied policies have resulted in a major restructuring of healthcare. However, the only structural transformation visible is massive privatisation of healthcare coupled with hard-line nationalist language, even as fundamental deficiencies in provision of safe drinking water, sanitation, labour security, basic medical care remain, affecting the health of the majority and resulting in the continued presence of diseases such as Tuberculosis and Anaemia. Social movements have also been articulating new problems namely de-personalisation of the patients and violation of the right to self-determination as witnessed in the disability rights movement, AIDS movement, queer movement, campaign against clinical trials, etc. These developments led us to conceptualise a seminar to stimulate an animated discussion on gender and body with scholars working on diverse yet interrelated areas. Precisely, two thrusts were kept in mind—giving a methodological direction to research students working on these themes and exploring new areas/optics of enquiry.

Therefore, a national seminar was organised with funding support from ICSSR and the Central University of Gujarat, at the Centre for Studies in Society and Development, Central University of Gujarat with a few invited speakers, on October 30-31, 2017. Titled "Rethinking Gender and Body in Times of Health Sector Reforms in India", it mapped theoretical shifts in gender and sexuality studies, and articulated how such theorisation offers a framework to understand reforms in the health sector. Taking cues from third-wave feminism's critique of homogenous and binary representation of women and men, and its emphasis on difference and existence of multiple patriarchies, our focus was to unravel interlocking forms of oppression, the complex scenario brought about by the health reforms and its impact on different categories of people. Themes such as commercialisation of healthcare, democratisation of healthcare, recasting gender and body, debates on care economy, disability and mental illness were intensely debated.

Authors: **Asima Jena** (ashimajena@gmail.com), Assistant Professor, Centre for Studies in Society and Development, Central University of Gujarat, Gandhinagar, Sector-29, Gujarat; **Madhumita Biswal** (madhumita25@gmail.com), Assistant Professor, Centre for Studies in Society and Development, Central University of Gujarat, Gandhinagar, Sector-29, Gujarat

To cite: Jena A, Biswal M. Critical reflections on health sector reforms in India: A seminar report. Published online on October 11, 2018. *Indian J Med Ethics*. DOI: 10.20529/IJME.2018.078

© *Indian Journal of Medical Ethics* 2018

Health policies in a neo-liberal economy

The seminar began with Imrana Qadeer's address cogently advocating for a public health approach built around the perspective that provision of basic needs is key to good health. According to her, feminism offers a lot to understanding the state of healthcare and provides a lens to critically analyse health policies in India. Tracing the history of post-independence public health in India, she outlined the changes as follows: during the first few decades after independence there was, at least at the level of planning, some commitment to public health, but by the 1990s health investments were at their lowest and public-private partnerships took over. She differentiated between comprehensive public healthcare and "*swachhata abhiyan*", undertaken by the current Indian state, which is about construction of toilets and, most disturbingly, transferring public health responsibility to private players. Linking the issue of livelihood and basic medical care with gender inequality, she gave the example of Traditional Birth Attendants (TBAs) and the politics of stigma enforced by the state. She argued that a TBA's role in reducing maternal mortality was quite effective when they were included under the public health programme and that we should refrain from the tendency of framing it as "tradition versus modern".

Ghanshyam Shah's lecture interrogated health reforms in the neo-liberal era. Drawing from data on the maternal mortality rate in Gujarat, he argued that when women's health programmes such as *Janani Suraksha Yojana* were in the public sector there was a substantial reduction in maternal mortality rate, but this changed with the introduction of the private sector into the programme. He asserted that Black feminist theorisation helps us understand the contradictions

inherent in the very "potential" that the neoliberal economy boasts of. Shah substantiated his argument by explaining how social location determines choice and freedom. For instance, in the context of a booming surrogacy industry in Gujarat, he highlighted the need to critically examine how concepts of freedom and choice for some creates "constraints" for others. According to him, reforms in the health sector are reinventions of patriarchy. His lecture urged for methodological interventions in health studies that would interrogate not just facts but also values.

Drawing on Thomas Piketty and Lucas Chancel's study (1) and other reports, Purendra Prasad's paper argued that there is high income inequality coupled with increase in landlessness among farmers. Health expenditure constitutes the single largest expenditure for households. One of the trends he highlighted was the growing amount of commercialisation evident in states with communist governments, like Kerala, with private companies receiving public subsidies. He maintained that government policy documents, such as the National Health Policy 2017 (2), do recognise, as a serious concern, growing inequalities in access to healthcare and rising health expenditure. However, health insurance is projected as a solution for these issues, even though health insurance is often a means for transferring public resources to the private sector.

Gender, sexuality and health sector reforms

Rukmini Sen showed how amendments to the Maternity Benefit Act, 2017 (3) stabilises the hegemonic sexual and class order. These amendments exclude women workers from the informal sector and the sexual subalterns—sex workers, lesbians, surrogate mothers—from availing benefits. She traced the history of the Maternity Benefit Act in India, from the debate around the Bombay Maternity Benefit Act in 1929 through the amendments of 1961 to the 2017 amendments. In 1929, while the women workers of textile mills demanded maternity benefits, neither the state nor the mill workers wanted to bear the financial responsibility. Later, with the 1961 act and its amendments, there was an attempt to connect maternity benefit with the number of living children. She referred to Lotika Sarkar's argument against such proposition that the benefit was for women to recover their health after childbirth and had nothing to do with the number of children. The 2017 amendments, however, grant 26 weeks leave only to women who have two or less surviving children. Though recent amendments are projected as progressive, such provisions only suit the interests of the middle-class working women undermining the needs of poor women.

Asha Achuthan joined the debate on democratisation of healthcare through a different approach. She narrated case studies and urged critical feminist advocacy for a clinical dialogue between doctor and patient rather than a technological dialogue (through X-rays, pathology reports, etc) and methodological attentiveness to multisided and multilingual aspects of equity in health care. Simultaneously, she highlighted how clinical settings become sites where a normative structure of gender and sexuality are enacted and pathologisation of gender identity are enforced. Further, she traced changing meanings of health, disease, body and gender in diagnostic settings from the 19th Century hospital medicine to 21st century laboratory medicine and how we now have a wide variety of somatic experts—genetic counsellors, insurance agents, patient forms, gym instructors—who advise in the management of our healthy body.

Chayanika Shah's presentation traced the roots of regulation of the body in a healthcare set-up. She narrated how governance of the body started with birth control, which essentially tried to fulfil the logic of capitalism and demographic calculation. Eventually, through birth control programmes, categorisation of bodies ie, young, sex worker, queer, etc, took place and they became the object of control. She argued that queer bodies challenge the health system and its concepts of sex, gender and body. She spoke about gender affirming medical interventions in relation to queer bodies. Since they were considered unnatural, abnormal and to be cured, medical perspectives were also reflective of the existing social norms. When this section of people approaches the public health system, they are subjected to moral judgements, while in private clinics, the interest of the healthcare provider lies in making profit. Such an approach forces stigmatised groups to choose private clinics.

Voices from the margins of healthcare

Rajni Palriwala discussed how care-related work has metamorphosed into the notion of *seva*, allowing room to curtail the rights of ASHA workers and labelling their resistance as immoral. Building upon Joan Tronto's theorisation on "care ethics", Palriwala argued that very often care-work has been normalised as voluntary and unskilled and given a moral tone. She argued that the notion of care is not neutral, it involves power relations. Devaluation of care labour also makes it gendered. Women from the weaker sections constitute the major workforce of care economy. ASHA workers are called health workers but they are entrusted with the responsibility of delivering healthcare at the village level, with minimum compensation and without any substantial training in medical care.

Deepa Venkatachalam deliberated on surrogacy against the backdrop of commercialisation of healthcare and shrinking public healthcare on one hand and growth of the care economy on the other. According to her, the practice of surrogacy located in the assisted reproductive technologies (ART) industry, is primarily in the private sector. This industry colludes with the institution of family, to enforce motherhood as compulsory and natural. Due to its very location in the private sector, it facilitates a brokerage economy with surrogates placed at the margins, under-paid and stigmatised. Through techniques of surveillance, such as regulation of their diet, physical movement, and sexual relations, surrogate

women are de-personified, and dominant medical values, idealised bodily and spiritual practices imposed on them.

Starting from her personal experience, Bhargavi Davar critiqued the way our healthcare system deals with mentally ill persons. According to her, on the one hand there is a predominant tendency to label unconventional, assertive women as mentally ill. On the other hand, once identified as mentally ill, the health care system itself objectifies the person's body. Often the harmful effect of drugs paves the way for full-blown disease. She argued that the treatment of the mentally ill is based on a colonial framework, where the control of human being becomes the key concern in such instrumental care. Further, calling the Mental Health Act, 2017 linguistic sophistry and she found that the Convention on the Rights of Persons with Disabilities (CRPD) may be more promising in addressing mental illness.

Conclusion

This seminar contributed immensely to health studies by critically looking at recent developments in the health sector through the lens of gender diversity. It was agreed that reforms in the health sector have increased social inequality and reiterated a hegemonic hetero-normative structure. Methodologically, the papers pitched for researchers to be sensitive to critical issues, learning through dialogic process and interrogating dominant values, not just facts.

References

1. Chancel L, Piketty T. Indian Income Inequality,1922-2015: From British Raj to Billionaire Raj. *World Inequality Database*. 2017 Jul. Available from: https://wid.world/document/chancelpiketty2017widworld/
2. Ministry of Health and Family Welfare, Government of India. National Health Policy – 2017. New Delhi: MoHFW; 2017.
3. Legislative Department. The Maternity Benefit (Amendment) Act 2017. New Delhi: Ministry of Law and Justice, Government of India. 2017.