**Critical Reflections on Health Sector Reforms in India: A Seminar Report**

Abstract: The papers presented at a recent seminar on “Rethinking Gender and Body in Times of Health Sector Reforms in India” brought the attention about the criticality of health research and specifically brining gender studies –and more pertinently the interlocking forms of oppression – to the center stage in order to understand the complex scenario which health reforms have brought for different social categories of people. It also stressed on the need for historiography of public health care of India and methodologically, the urgency to scrutinize values not just facts, dialogic process of learning, etc. in order to encapsulate the myriad issues.

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One can see profound changes in terms of restructuring health care in recent times. Arguably, these changes are precipitated by new health and allied policies which at the surface level carries the impression of bringing structural reform. However, the only structural transformation visible is massive privatization of health care coupled with hardline nationalist language. Importantly, if we analyze deeply, fundamental issues remain along with emergence of new problems and regulation of body in the lines of confirming to normative structure. Social movements have been articulating new problems namely de-personalisation of the patients and violation of right to self-determination as witnessed in disability movements, AIDS movement, queer movement, campaign against clinical trials, etc. along with commercialization of health services. At the same time, core concerns like provision of safe drinking water, sanitation, labour security, basic medical care, etc. are undermined which not only affect the health of majority of downtrodden but also become the main cause for the return of old diseases such as Tuberculosis and anemia. These developments begs to question what is body and gender order. It pressed the desire in us to conceive the idea of organizing a seminar in order to have an animated dialogue with scholars working on diverse yet interrelated areas. Precisely, two impetuses were in mind – giving a methodological direction particularly for research students working on these themes and exploring new areas and optics for enquiry.

Though generating discussion on rethinking gender and body is significant, given the climate of shrinking space for free debate and concerted attack on social sciences and more strikingly gender studies[[2]](#footnote-2), we planned to organize a national seminar on this theme in the Centre for Studies in Society and Development, Central University of Gujarat with few invited speakers and without much publicity. Somehow we managed to get funding (though limited) from ICSSR, and Central University of Gujarat at a critical juncture.

A two-day seminar on “Rethinking Gender and Body in Times of Health Sector Reforms in India” was held at Central University of Gujarat from 30th to 31st October 2017. The seminar mapped the theoretical shifts in gender and sexuality studies, and tried to articulate how such theorization offers us a framework to understand reforms in the health sector. Third-wave feminists’ critique of homogenous and binary representation of women and men and emphasis on differential social locations of women and interlocking forms of oppressions which operate from the matrix of class, ethnicity, race, religion etc. are pertinent. In short, difference and recognition of the existence of multiple patriarchies has been brought to the centre in order to unravel the complex scenario which health reforms have brought for different social categories of people. Themes such as commercialization of health care, democratization of health care, recasting gender and body, debates on care economy, disability and mental illness were intensely debated.

**Challenges to Public Health Care**

Seminar began with Imrana Qadeer’s address cogently advocating for public health approach which built around the provision of basic needs as key to good health. In this context, she differentiated comprehensive public health – where sanitation and people’s livelihood are given equal importance – from ‘swachhata abhiyan’ undertaken by the state which reduces it to construction of toilets and most disturbingly transferring this responsibility to the private players. She pointed out that public health is a state responsibility. In tracing the history of public health in post independent India, she outlined the changes in the health sectors over the decades – the first few decades after independence some commitment was shown to public health at least at the level of planning, by 1990s health investments were lowest, and public private partnership took over. She pointed out that feminism offers a lot to understand health condition and provides the scope to critically understand the process of reforms in health sector in India. Linking the issue of livelihood and basic medical care with gender inequality, she brought the example of Traditional Birth Attendants (TBAs) and the politics of stigma enforced by the state. Countering this, she asserted that TBAs role in reducing maternal mortality was quite effective when they were included under public health programme and argued that we should refrain from the tendency of framing “tradition vs modern” in binary lens.

Equally matching with Qadeer, Ghanshyam Shah’s lecture critically reflected on health reforms that have happened in the neo-liberal economy. While neo-liberal economy is touted with providing many choices, freedom and efficiency, he accorded that Black feminist theorization is better equipped to understand the contradictions inherent in the very “potentials” which neoliberal economy boasts about. Substantiating his arguments with examples of women’s health issues in the context of Gujarat, Shah explained how women’s social locations determine choice and freedom. For instance, in the context of booming of surrogacy industry in Gujarat, he highlighted the need to critically examine the concepts of freedom and choice, and urged for thinking about how freedom for some (affluent sections of women) creates “constrains” for others. According to him the reforms in the health sector is also a reflection on reinvention of patriarchy in diverse forms. Drawing from data on maternal mortality rate in Gujarat, he argued that while women’s health programme such as Janani Surakshya Yojana was in public sector there was substantial reduction in maternal mortality rate, however a rise in maternal mortality rate is seen with the introduction of private sector into the programme. His lecture urged for bringing methodological intervention in health studies in terms of interrogating “values”.

Drawing on Thomas Piketty and Lucas Chancel’s study and other reports, Purendra Prasad’s paper discussed that there is high income inequality coupled with increase in landless among farmers. On the one hand, while there is high poverty, on the other hand health expenditure is the single largest item of expenditure for households. In historically mapping the health sector reforms in the post independent era, he points out that in the last few decades there is drastic de-emphasis on public health care institutions and decline in the government spending on health. Interestingly, the state has promoted privatization of health services by allocating government resources to these private sectors. One of the striking trends he brought forth is growing amount of commercialization is even evident in communist ruled states like Kerala. The nexus between the politicians and liquor lobby, real estate lobby and other corporate companies has paved the way for the private companies to receive public subsidies. He argued that the government of India policy documents from time to time recognize the growing inequalities in access to health care and rising health expenditure is identified as a serious concern and the National Health Policy 2017 document also echoes similar concern. Health insurance is projected as an answer to resolve these issues. Ironically, health insurance becomes a means again for transferring more public resources to private sector.

**Democratization of Health Care**

Democratization of health care does not just entail provision of equal access to medical care, it also includes addressing concerns related to employment, loss of income, etc. In the context of vulnerable sections like women, intervening this issue becomes highly significant. Rukmini Sen in her presentation convincingly pointed out how the amendments to the Maternity Benefit Act, 2017 stabilized the hegemonic sexual order as well as class biases. These prejudices are mainly seen in terms of exclusion of women workers in informal sectors as well as sexual subaltern like sex workers, lesbians, surrogate mother, etc. from availing these benefits. She started her lecture by discussing the history of Maternity Benefit Act in India which started with the Bombay Maternity Benefit Act in 1929. Sen narrated that while the women workers of textile mills demanded for maternity benefits, neither the state nor the mill workers wanted to bear the financial responsibility that the maternity benefit is accompanied with. Further she pointed out that in 1961, the central government Maternity Benefit Act was passed. Though from time to time there are amendments to Maternity Benefit Act of 1961, there was an attempt to connect maternity benefit with the number of living children the woman has. However, she critiqued this attempt by referring to Lotika Sarkar’s argument against such proposition on the ground that the benefit was for women to recover her health post child birth and had nothing to do with the of number of children. However, the recent amendments in the maternity benefit Act in 2017 restricts women who have two or less surviving children can only avail maternity benefit of 24 weeks. She forcefully argued that though the recent amendments is projected to have introduced many positive changes in the previous Act such as: extending the leave provision, reducing the number of days of continuous service, providing leave for adopting mothers and commissioning mothers, such provisions only suits the interests of the middle class working women. The poor women’s needs remain unaddressed.

Dr. Asha Achuthan joined the debate on democratization of health care through a new approach. By narrating many case studies, she emphasized the urgency to use critical feminists’ advocacy for having clinical dialogue between doctor and patient rather than technological dialogue (through X-rays, pathology reports, etc. through which doctors in medical set-up make sense of disease and body) and methodological attentiveness in multisided and multilingual manner in order to bring equity in health care. Simultaneously, she highlighted how in clinical setting too become a site, where normative structure on gender and sexuality are enacted and pathologisation of gender identity are enforced. Secondly, she tried to explain the changing meanings of health, disease, body and gender under the changing relation between clinic and “laboratory” in diagnostic settings from 19th Century under hospital medicine to 21st century under laboratory medicine. Precisely, she discussed about how the authority of the clinic has been undermined under the component of molecularisation. She asserted that the language of life sciences has shifted to metaphors, when humans begin to relate themselves through the modicum of body, understood through its genes, not completely reduced to it. What we get is a wide variety of somatic experts – genetic counsellors, insurance agents, patient forms, gym instructors – who are talking about ways of managing our healthy body in such a way that we do not fall into trouble.

**Interrogating Care Economy**

Rajini Palriwala and Deepa Venkethchalm’s papers also echoed the plight of women from disadvantaged section in the health sector. Palriwala discussed how care related work is metamorphosed into the notion of *seva*, which allows a room for curtailing the rights of ASHA workers. Venkethchalm raised the ordeals of surrogate mothers and how through the systems of surveillance, surrogate mothers are forced to comply with the values of medical establishment and commissioning parents. She too extended the notion of “*seva*” through the notion of “altruism” and “sacrifice” by focusing on the new surrogacy Bill.

Palriwala in her paper “The labour and morality of care: policy contestations and practices” emphasized on the labour exploitation of the ASHA workers within the health sector and their resistance to such exploitation. Building upon Joan’s Tronto’s theorization on ‘care ethics’, Palriwala argued that very often care work has been normativized and given a moral tone, which creates the perception that care work is voluntary and unskilled. However, she argued that the notion of care is not neutral rather it involves power relations. The devaluation of care labour also makes it gendered. In Indian context she argued that paid care work is set to be corrupt since care work with moral tone limits payment by defying it as work. Predominantly it is the women from the weaker sections who constitute the major workforce of care economy. According to her, alluding the notion of care, the ASHA workers are termed as health workers in rhetoric without any substantial training on medical care. Contrarily, with minimal work compensation, they are entrusted with greater responsibilities in delivering health care at the village level. At the same time they are expected to be dissociated from their familial role or free from motherhood responsibility. Framing such care work through the notion of *seva* enables the state to exploit the labour of ASHAs. When ASHA workers contest these notions and assert their right to work entitlements, most prominently their right to health, their protest is termed as immoral by officials for expecting in return of *seva*.

Deepa Venkethchalm’s paper discussed surrogacy against the backdrop of commercialization of health care and shrinking public health care on one hand and the growth of care economy on the other. According to her, the practice of surrogacy is located in the very large clout of ART industry, which is primarily in the private sector. This industry colludes with the institution of family, which enforces the value that motherhood is compulsory and natural. Because of such perception infertility is stigmatized. Due to its very location in private sector, there is heavy presence of brokerage economy in this industry. In the whole transaction the surrogates are placed at the margins due to the stigma attached to the work as well as their marginal socio-economic standing. This allows for a space for exploitation of the surrogate mothers. Through the very techniques of surveillance surrogate woman gets de-personified. Dominant medical values and the idealized bodily and spiritual practices get superimposed on her. In the whole process there is also emasculation of the husbands of the surrogates. Surrogates are prohibited from having sex with their male partners. Payment given to surrogate is pittiance and the clinics and brokers make the whole deal.

**Critique of Binaries in Medical Systems**

Chayanika Shah in her paper entitled “gender affirming medical interventions and health system” traced the root of regulation of body in health set-up. She narrated how regulation of body started with birth control which essentially tried to fulfill the logic of capitalism and demographic calculation. Eventually, through family planning programmes categorization of bodies i.e. young, sex workers, queer, etc. took place as well as they became the subject of control. With many insights, she narrated gender affirming medical interventions in relation to queer bodies. They were considered to be unnatural, abnormal and to be cured. Hence, the medical perspective commensurate with the existing social norms. Shah pointed out that while these sections approach public health system, it makes moral judgments on such persons. But, in the private clinics, the interest was not making moral judgments rather the main concern is profit. Such approach forced the stigmatized groups to often choose private clinics. She argues that the queer bodies challenge the health system and its concepts of sex, gender and body.

Starting her paper with an example from her personal experience, Bhargavi Davar critiqued the health care system in India in dealing with mentally ill persons. According to her, on the one hand there is a predominant tendency to level the non-conventional, assertive women as mentally ill. On the other hand, once they are brought to the health system and identified as mentally ill, the health care system itself depersonifies the person’s body. On many occasions the harmful effects of the drugs paves the way for full blown disease. She argued that the treatment of mentally ill is based on the colonial framework, where the control of human being becomes the key concern in such instrumental care. Once the person is identified with mental illness, is considered as ‘civil dead persona’. And the person gets treated as medico-legal subject. Further Davar critiqued the 2017 Mental Health Act as linguistic sophistry and rather considered the CRPD (Convention on the Rights of Persons with Disability) as promising one in dealing with mental illness.

The seminar contributed immensely in the health research in terms of critically looking at recent developments in health sector such as commercialization of health care, care economy, universalization of health care, maternity benefit Act, etc. through the lens of gender diversity. It was agreed that reforms in health sector has increased social inequality as well as reinscribed a hegemonic hetero-normative structure. Some of the lectured delivered actually dwelt on emerging areas of research- particularly on care economy – as well as provided a new understanding. Methodologically, the papers pitched the need for the researcher to be sensitive to critical issues, knowing through dialogic process and interrogating dominant values rather than just facts.

1. Asima Jena and Madhumita Biswal are with Central University of Gujarat. [↑](#footnote-ref-1)
2. For Details, see Prof. Romila Thapar’s talk at public meeting organized by JNUTA (Jawaharlal Nehru University Teachers Association) on JNU’s contribution in higher education, held on February 28, 2018. [↑](#footnote-ref-2)