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

Abstract: The papers presented at a recent seminar “Rethinking Gender and Body in Times of Health Sector Reforms in India” highlighted the criticality of health research and the urgency for integrating gender studies in order to understand the complex scenario in which health reforms have brought for different social categories of people. It also stressed on the need for tracing historiography of public health care of India and methodologically, its necessity 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. These changes are precipitated by new health and allied policies which at the surface level carriy the impression of bringing structural reforms. However, the only structural transformation visible is massive privatization of health care coupled with hardline nationalist language. Ironically, 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. Yet, 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 return of old diseases such as Tuberculosis and anemia. These developments beg to question what is body and gender order? It invoked 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, we planned to organize a national seminar on this theme at the Centre for Studies in Society and Development, Central University of Gujarat with few invited speakers, with funding 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 articulated how such theorization 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 and 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.

Seminar began with Imrana Qadeer’s address cogently advocating for public health approach, built around the perspective that provision of basic needs is key to good health. In this context, she differentiated comprehensive public healthfrom ‘*swachhata abhiyan*’ undertaken by Indian state which is reduced to construction of toilets and most disturbingly transferring the public health responsibility to the private players. In tracing the history of public health in post independent India, she outlined the changes in the health sectors over the decades – 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. According to her feminism offers a lot to understand health condition and provides scope to critically analyze health policies in India. Linking the issue of livelihood, basic medical care with gender inequality, she brought the example of Traditional Birth Attendants (TBAs) and the politics of stigma enforced by the state. 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.

Matching with Qadeer, Ghanshyam Shah’s lecture interrogated health reforms that have happened in the neo-liberal era. While neo-liberal economy is touted with providing many choices, freedom and efficiency, he accorded that Black feminist theorization helps us 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, reforms in the health sector resonated as 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 argued that there is high income inequality coupled with increase in landless among farmers. And health expenditure constitutes the single largest expenditure for households. In historically mapping the health sector reforms in the post independent era, he pointd 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, culminated in terms of state promoting privatization of health services. One of the striking trends he brought forth is growing amount of commercialization, evident in communist ruled states like Kerala. The nexus between politicians and liquor lobby, real estate lobby and other corporate companies has paved the way for the private companies to receive public subsidies. He maintined 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. 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.

Rukmini Sen in her presentation pointed out how amendments to the Maternity Benefit Act, 2017 stabilize hegemonic sexual order and class differences. These prejudices are mainly seen in terms of exclusion of women workers in informal sectors and sexual subaltern like sex workers, lesbians, surrogate mother, etc. from availing these benefits. In tracing the history of Maternity Benefit Act in India, she invoked the debate 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, 24 weeks leave is granted to women who have two or less surviving children.Though recent amendments is projected as a progressive move in terms of 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 undermining the needs of poor women.

Asha Achuthan joined the debate on democratization of health care through a different approach. By narrating many case studies, she emphasized on 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 to multisided and multilingual aspect in order to bring equity in health care. Simultaneously, she highlighted how clinical setting becomes a site, where normative structure on gender and sexuality are enacted and pathologisation of gender identity are enforced. Further, she tried to explain the changing meanings of health, disease, body and gender under the shifting relation between clinic and “laboratory” in diagnostic settings from 19th Century under hospital medicine to 21st century under laboratory medicine. She discussed how authority of the clinic has been diversifiedunder the component of molecularisation. 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 advice ways of managing our healthy body in such a way that we do not fall into trouble.

Rajini Palriwala and Deepa Venkethchalm’s papers focused on the plight of women from disadvantaged sections 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 and their resistance. Building upon Joan Tronto’s theorization on ‘care ethics’, Palriwala argued that very often care work has been normativized and given a moral tone, creating the notion that care work is voluntary and unskilled. However, she argued that the notion of care is not neutral rather it involves power relations. Devaluation of care labour also makes it gendered. In Indian context, paid care work is set to be corrupt since care work with moral tone limits payment by defying it as work. Predominantly it is women from the weaker sections who constitute the major workforce of care economy. Extending the same logic, 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. 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, their protest is termed as immoral by officials for expecting in return of *seva*.

Venkethchalm deliberated on surrogacy against the backdrop of commercialization of health care and shrinking public health care on one hand and growth of care economy on the other. According to her, practice of surrogacy is located in the very large clout of ART industry, which is primarily in the private sector. This industry colludes with institution of family, which enforces the value that motherhood is compulsory and natural, leading to ostracization of infertility. Due to its very location in private sector, brokerage economy gets facilitated in this industry. In the whole transaction surrogates are placed at the margins due to the stigma attached to the work. Their low socio-economic standing, further allows 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.

Chayanika Shah’s presentation traced the root of regulation of body in health set-up. She narrated how governance of body started with birth control which essentially tried to fulfill the logic of capitalism and demographic calculation. Eventually, through birth control programmes categorization of bodies i.e. young, sex workers, queer, etc. took place and they became the object 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, medical perspective commensurate with the existing social norms. 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 argued that queer bodies challenge the health system and its concepts of sex, gender and body.

Starting the lecture from her personal experience, Bhargavi Davar critiqued health care system in India in dealing with mentally ill persons. According to her, on the one hand there is a predominant tendency to lebel unconventional, assertive women as mentally ill. On the other hand, once they are brought to the health system and identified as mentally ill, health care system itself depersonifies the person’s body. On many occasions the harmful effects of 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. 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.

In critically looking at recent developments in health sector through the lens of gender diversity, this seminar contributed immensely to the health studies. It was agreed that reforms in health sector has increased social inequality and reinscribed a hegemonic hetero-normative structure. Methodologically, the papers pitched the need for researchers 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)