Introduction

Due to the recent COVID-19 Pandemic, discussions on healthcare, healthcare policies and healthcare workers have gained relevance. Though the present research focuses on healthcare policies during the time following liberalisation of the Indian economy (1991) till 2015, the problems such policies have tried to address like dearth of manpower or failed to address like problems stemming at the ground level based on everyday experiences of careworkers, are relevant even now. This chapter briefly tries to uncover the meaning of healthcare, healthcare policies and understand healthcare scenario in India and a sub-national state of West Bengal in neoliberal times. In doing so, it briefly engages with the role of healthcare workers in realising healthcare policies.

Public policies in general are laced with ethical, social, economic and legal considerations, and ideally speaking, healthcare policies of any country should be filled with a commitment to ensure the good health and wellbeing of its people. The last two centuries have seen various political and legal documents accommodating different rights like those associated with 'life, liberty, property, safety and happiness'. However, it is comparatively a recent phenomenon wherein new set of rights like right to die, right to privacy, right to healthcare, and so forth are accommodated in legal documents (Beauchamp and Faden 1979, 118).

Sometimes discussions of healthcare and healthcare policies purposefully or unintentionally ignore the role of politics, power, or ideology and address healthcare in a dispassionate, value-free manner. However, healthcare is a political issue and healthcare policies are part of a wider public policy agenda as it is very much linked with a wider socio-economic and political system (Bambra, Fox and Scott Samuel, 2005; Baker 2020). Keeping this in mind, the present work seeks to explore how different regimes in India, both at the centre and states like West Bengal have addressed the issue of healthcare through various policies, starting at the temporal juncture of liberalisation of the Indian economy which happened in 1991. The period of study ends in 2015. Thus, it would look into the changes brought about by the liberal reforms of the early 90s, in a country which was guided by the spirit of welfarism since independence (Robson 1954,116).

Focussing on welfarism at sub-national level, Tillin et.al (2015), have pointed out that in the Indian context, politics cannot be delinked from the policy process and any analysis should not get 'reduced either simply to clientelism or to expansionary fiscal distortions linked to the election cycle' and studies of policies should focus on 'different regional political settlements' and the leaders (9). Therefore, using West Bengal as a case study was interesting because it was under a communist government from 1977 to 2011 and had been critical of the reforms initiated by the Indian National Congress-led government at the centre. Linked with policies is the question of provisioning – how healthcare is provided! While various components like healthcare financing, healthcare management etc. are important, this study looks at how healthcare is provided by healthcare workers. Using this as a background, the present study has focused on how curative and preventive aspects of care are delivered through various hospitals, nursing homes, health centres in both urban and rural areas by careworkers like nurses and *ayahs*. It has also tried to explore, if any, changes with regard to how careworkers are recruited, the terms and conditions of their services and their nature of work have occurred.

In this research healthcare is treated as a system through which the state fulfils its duty to provide certain preventive and curative healthcare measures for its people. The difference between health systems lies in how healthcare is provided – is it provided in a 'comprehensive manner' through public health or in 'isolation', through providing individualised medical care. (George 2019, 171). However, which would get primacy in a country – public health or medical care or both, would greatly rely on the type of political regime and how much importance is given to health in several policy documents when compared to other issues like agriculture, industry, infrastructure and so on (Roemer 1960).

Setting the Context

As already mentioned before, the study spans from 1991 to 2015. Hence it is situated in neoliberal times. It is characterised by attempts to break away from 'welfare policies' or the interventionist policies as postulated by economist John Keynes, which became prominent in the west in 1980s based on the theoretical premises developed by scholars like Friedrich Hayek, Milton Friedman (Friedman and Friedman, 1980; Jackson 2012) and others and backed by politicians like Ronald Regan and Margaret Thatcher (Ives 2015). This bunch of reforms gained a worldwide breakthrough following the collapse of Soviet Union and Eastern Bloc in

the 1990s which coincided with a process of free circulation of capital and goods throughout the globe along with/based on the advances achieved in Information and Communication Technology (ICT), setting up of new legal frameworks and institutions and other logistical supports. This process is popular as 'globalisation' (Dale and Fabry 2018).

If one looks through the lens of public policy making, then due to globalisation, 'policy making is continuously being shifted downwards, outwards, and upwards under devolution, privatisation/deregulation, and internationalisation, respectively' (Lodhi 2021, 522). Stagnation of wages, rise in contractual labour, and reduction of social security, have largely impacted the lives and livelihoods of a large section in developing countries (523). Since the last two decades the healthcare sector has been subject to reforms due to various debates concerning 'the welfare state and the role of public and private sectors with regard to health care financing and provision' (Lee, Buse and Fustukian 2002, 3). Needless to say, health is an important area which warrants policy making.

This phase is characterised by a) growing disparities between the healthcare of the 'masses', provided by the government, and the 'classes', provided by the new age hospitals developed and managed by private national/international capital (Duggal 2019) and b) the different patterns/scope of circulation of workers in general and careworkers in particular , wherein the urban centres like Kolkata are 'transit' points for migration, and for most of the *ayahs*, who migrate from rural/marginal settings to the cities, the urban centres are the final 'destination'. Finally, the present study attempts to analyses the gendered nature of the carework and reveals their 'absence' in the policymaking process and even 'absence' (particularly for *ayah*s) in the policy documents for healthcare of India/West Bengal (Nair 2012; Basu 2018).

Defining Healthcare:

Healthcare, according to Merriam Webster Dictionary is, 'The organised provision of medical care to individuals or a community,' involving efforts to maintain or restore health by trained and licensed professionals. The health systems fulfil three main functions: health care delivery, fair treatment of all, and meeting non-health expectations of the population. The aim being to achieve good health, responsiveness and financing through healthcare organised at primary level or community level, intermediate level and then central level (WHO 2004). Further,

according to Cambridge dictionary, healthcare means, ‘the set of services provided by a country or an organization for the treatment of the physically and the mentally ill’ or it might mean ‘the activity or business of providing medical services’[1]. To put it simply, healthcare involves prevention, diagnosis, treatment of physical and mental illness or injuries and aims at maintaining the wellbeing of persons through services of medical and allied health personnel.

It also needs to be clarified at the very beginning that public health and medical care, are two ways of looking at the same thing. While public health is more concerned with a collective of individuals or population, emphasising on preventing diseases, promoting good health for everyone, and it involves the use of various programmes or interventions aimed at improving and health promotion for the whole community, medical care is more concerned about the individual’s health, emphasising the curative aspect of disease involving diagnosis, treatment, and care for the individual patient (Lurie and Fremont 2009).

Healthcare Policies:

Policies can be seen as choices made by the government in fulfilling a course of action and may be understood by going through official statements, documents, reports expressing the intentions of the policy makers. Healthcare is increasingly perceived as one of the 'most dynamic policy arenas' (Kuhlmann et al. 2015, 3) and understanding healthcare policy necessitates adopting an interdisciplinary approach, where the broader and prominent term 'health policy', involving financing, governance and politics is also used (4). In general, healthcare system comprises a primary, secondary and tertiary care (Gauld 2015, 70). The making of public policies takes place within the constitutional framework of any country. In the Indian context, policies are guided by the philosophies as expressed in various sections of the constitution, namely the preamble, directive principles, fundamental rights, parliamentary form of government and federal structure of the state (Maheshwari 1987, 336-337). Apart from this, focus should also be given as to how those decisions have been interpreted and implemented, as they impact the lives of people. Everyday ordinary people, are affected by public policies in more ways, than one actually realises.

Thus, healthcare policies should also focus on factors 'external to the health system', hence be concerned about impacts of 'food, tobacco, or pharmaceutical industries' (Buse, Mays & Walt,

[1] See https://dictionary.cambridge.org/dictionary/english/health-care. Last accessed 23.5.20.

2005, 6). In case of healthcare, how the policies planned by decision makers are implemented, rely heavily on healthcare workers, professionals, public and private service providers, bureaucrats, patients and others. Thus, healthcare stands at the crossroad of the public and the private. Healthcare policies impact an individual and their private space on one hand and various decisions taken in the private spaces, might also warrant a policy decision. For example, less spending by the government on healthcare would imply that an individual would have to pay more for accessing it, which might impact their ability to procure various goods for running the household. In the second instance, decisions to give birth at home, might affect child and maternal mortality. This in turn would give rise to a government's policy to give incentives for institutional childbirth, in order to reduce child and maternal mortality rate.

Healthcare in India:

Healthcare in India is the product of both colonial and postcolonial politics, history, culture and just like societal pluralism, one can find medical pluralism (WHO 2002; Singh, Yadav, Pandey 2005; Sen, Iyer, George, 2007; Sheehan 2009). India is characterised by a certain amount of coexistence, as one finds the presence of different systems of medicine. While Unani came from West Asia more than 800 years ago, Homeopathy, Naturopathy, Biomedicine came over 200 years ago from Europe and Ayurveda can be referred to as homegrown system of medicine, leading to both ‘syncretism and contestations’ in India (Sujatha and Abraham 2009, 36). However, since the very beginning, independent India has given priority to modern western medicine (Sadgopal and Sagar 2007), even when schools of medicine had developed in both India and China long before it had developed elsewhere (Abel-Smith 2014,65). Further, since colonial times, international organisations like Rockefeller Foundation and others have been playing important roles in Indian healthcare (Kavadi 1999; 2016; Samanta 2017), which have also popularised western modern medicine in India.

Right after independence, before the first meeting of WHO's south-east Asian regional committee, in 1948, Jawaharlal Nehru had called upon WHO to move beyond the problems of America and Europe and make Asia its priority, due to the high occurrence of epidemic diseases. Highlighting on the interlinkage between various parts of the world, Nehru had stated that no part of the world could remain healthy, while other parts remained unhealthy. Nehru thus, lay claims as a representative of a sovereign nation to have access to health technologies of international standard, antibiotics, sophisticated machines like X-rays etc. On the other hand,

he used the 'deeply-rooted western fears of India as a source of contagion', to his advantage and during Cold War, it proved to be an effective strategy (Amrith 2007, 117).

In other words, India has continued with the system introduced during the British Raj with some changes, and have borrowed models from various countries and discourses on health have not been contextualised (Rao 2017). A simple reading of the Indian Constitution would reveal that the right to health or healthcare is not guaranteed as a fundamental right. But the Directive Principles in various places talks of raising the nutrition levels, overall health of workers, maintaining healthy working conditions, etc. However, various important court rulings, have also widened the scope of claim making for common people with regard to healthcare. For instance, in Bandhua Mukti Morcha vs Union of India & Others (1983), Justice P.N. Bhagawati, had asked the owners of stone quarries and the government of Haryana to ensure safe working conditions, where labourers are not reduced to bonded labourers (AIR 1984, 802) and in Rakesh Chandra Narayan vs State of Bihar (1988), the Supreme Court had stated, 'In a welfare State it is the obligation of the State to provide medical attention to every citizen' (AIR 1989, 348). Many health activists to do away with inequities, call for ensuring Universal Health Care for all, which is in tune with right to health as enumerated under United Nations' Universal Declaration of Human Rights.

India has also adopted a federal form of government with centralising tendencies and the administrative system is highly integrated one (Maheshwari 1987, *passim*). Thus, subjects that have been part of development administration,[2] like education, agriculture, public health etc. are in the state list; however, finance is concentrated in the hands of the centre. Healthcare policies, in India, were largely framed through the Planning Commission and got reflected in various five-year plans, despite health being a state subject. Policies were also framed based on suggestions of several committees comprising experts. In India, since the states depend on the funds from centre for various reasons, it exercises control, which means what the states can do is act as 'implementing agencies' of the centre (Maheshwari 1987, 337). So, any discussion on healthcare policies of any state (or Union Territories) in India, must also deal with policies developed at the central level.

However, there exists gaps when it comes to framing and execution of policies in India. It can be traced back to a decision which led to an unintended opposite result. The first one involved

[2] as coined by U. L. Goswami and later developed by Edward Weidner, which treats administrative organisation crucial in executing development programmes and projects, in the direction of nation building and progress.

the decision of the newly elected government at the centre to initiate a planning process in all sectors, including health. The second one, was abolishing the Indian Medical Service (IMS). At the same time, the cadre of Indian Civil Service was retained with its name being changed into Indian Administrative Service. The second development was felt to be causing hindrance to the first, especially when it came to health planning. In pre-independence India, IMS officers were appointed in various senior positions, at both the central and provincial services. However, following the termination of IMS, there was absence of central officers working in state ministries and vice-versa. Neither could the centre influence or control health policy implementation in the states, nor could state governments sensitise the central government, regarding their health needs and concerns and in effect influence policy making. The problem being, most of the times when the centre was framing policies, states were seldom present. The ways the centre could somewhat influence policy implementation (framed by the centre) in the states were through platforms like Central Council of Health established in 1950 and through incentives in the form of monetary arrangements through the Five-Year Plans or through other informal channels (Jeffery 2021).

Experts in this field also opine that the time in which health system of India was framed is long gone and now the challenges and realities across the country are so varied that a blanket solution is no longer possible. India is a vast and culturally diverse country with various regions posited differently in terms of growth, development, nutritional growth etc. and 'inequities across classes are very severe' (Gangolli, Duggal Shukla 2005, 3) and its health scenario is in transition. While there are new risk factors associated to health and diseases (like the use of tobacco, alcohol etc. as highlighted in recent policy documents including the latest National Health Policy of 2017 [3]), old challenges like malnutrition, maternity deaths, deaths due to preventable diseases still exist. Thus, in order to provide better healthcare, 'splitting' at the states (based on various and specific needs throughout the state) should be encouraged, and 'lumping' at the central level (including providing of leadership to states, regulating private players etc.) should be practiced (Peters, Rao, and Fryatt 2003, 249).

[3] Available at https://www.nhp.gov.in/nhpfiles/national_health_policy_2017.pdf. Last accessed 22.5.21.

Healthcare and Neo-liberal times:

India spent 0.5 per cent of its Gross Domestic Product (GDP) on health in 1960, which rose to 0.9 per cent in late 80s and before liberalisation in 89-90 it was estimated to be 3.2 per cent of GDP (Reddy and Selvaraju 1994,17). The framing of neo-liberal policies, following the opening up of Indian economy, resulted in the rolling back of the state control, which affected budget allocation towards healthcare (Behera and Dash 2018). World Bank in its World Development Report (1993) had asked national governments to lessen spending on tertiary care, increase spending on targeted care, promote private public and private insurance, which implied promotion of private sector as health care providers as they had more technical efficiency and they promoted competition (Ruger 2005). In order to create larger demand for private sector commodities and services, the World Bank, since 1980s has been promoting private sector provisioners through funding and supporting through other means. The national governments were asked to offer 'a limited package' deal of essential services to targeted groups only, implying those who cannot afford private care (Brugha and Zwi 2002, 64-65). Failure on the part of the public sector was treated as an excuse to side-line national governments and promoting private service providers (Ulgade and Jackson 1995, 530).

Further, health sector reforms (HSR) were an integral part of the Structural Adjustment Programmes (SAP) that culminated in the liberalisation of the Indian economy, playing an important role in shaping healthcare policies in India (Nandaraj 2007,1). Be it international pressure, or pressure from citizens, electoral compulsions, strategy to reduce poverty and inequity and in the process facilitate development – there can be various political causes to bring about reforms in India. In the Indian context, particularly after 1991, reforms have been linked to international pressure. Questioning the very claim of 'neutrality,' when it came to approaching reforms, from public management and administration perspective, Kesavan Rajasekharan Nayar (2014) pointed out that the 'disordering of the health services in India', can be treated as the cumulated result of various reforms, that have been initiated in post-independent India, mainly after the opening up of the economy. Hence, he opines that, reforms need to be analysed from a political economy perspective.

An important document of the department of Health and Family Welfare, titled, 'Results-Framework Document' (2014-2015) was published which aimed at achieving 'quality healthcare on equitable, accessible and affordable basis across regions', in such a way that would benefit the poor and the marginalized. The plan was to be executed through the building

up a comprehensive healthcare delivery system that would encompass efficient and functioning links with secondary and tertiary healthcare delivery systems. Apart from policy formulations, it extended support to state governments for strengthening healthcare. The document also accepted that matters like providing regulatory framework for matters in the Concurrent List of the Constitution involving matters related to medical, nursing and paramedical education, pharmaceuticals, will be the responsibility of the department of Health and Family Welfare.[4]

Further, it needs mentioning that India has a mixed healthcare system with a public sector, a private sector and an informal network of care providers. It can be defined as a system where 'out-of-pocket payments and the market provision of services predominate as a means of financing and providing services in a larger environment of publicly financed health delivery coexisting with privately financed market delivery' (Nundy, Desiraju, Nagral 2018, 62). Even the private sector can be divided into several categories like trained, semi-trained, untrained, registered, unregistered, etc. In such a situation it becomes imperative for a low middle income country like India, having a mixed healthcare system, to have the government taking up more responsibilities related to planning, regulating the private sector, etc. Based on demographic and health surveys, the top three countries in South-east Asia that mostly use the services of private medical providers are as follows:

Table 1: Top 3 countries in South-east Asia, availing maximum services of private medical providers

Country	**Inpatient (in %)**	**Outpatient (in %)**	**Total (in %)**
Indonesia	61	59.1	60
Bangladesh	59.5	55.2	57.2
India	34.3	68.8	52.6

Source: (WHO 2020, 20)

The gradual onset of the 'political paradigm of neoliberalism' has resulted in the replacement of public policies with social policies that prioritise privatisation and deregulation of the market (Samaddar 2020,11), which makes attainment of justice and equity in healthcare a difficult proposition. After the adoption of the Liberalisation-Privatisation-Globalisation (LPG) model, what is found as the most lucrative field of investment and profit is, the health sector (Reading 2010, 368).

[4] For details, see https://main.mohfw.gov.in/sites/default/files/23145104281404209746_0_0.pdf. Last accessed 23.6.20.

It is pertinent to mention that several international organisations like the World Bank, World Health Organization, United States Agency for International Development (USAID) and the United Kingdom department for International Development (DFID) have helped in the development of the healthcare sector in low-income and developing countries, like India and have been key players in influencing global health policies and their impact after 1990s on national policies have intensified (Gangolli, Duggal and Shukla 2005). For instance, India's policies regarding family planning and vaccination have largely been shaped by international agencies which also demanded the creation of new cadre of health workers, whose designation varied across time (Chadha 1963; Mukherjee 1965; Kartar Singh 1975).

The case of healthcare workers:

Any discussion on healthcare is incomplete without referring to healthcare workers. The effective implementation of policies is to a large extent dependent on healthcare workers who work at the ground level. Medical pluralism shapes healthcare in India. As a result, different categories of healthcare workers are working in India. From bone-setters, dais, spiritual healers to trained nurses, certified doctors, and others, all provide care of varying degrees to their respective clientele. At times there are overlaps, and it is during such situations that one sees conflict between two or more categories of care workers, where the diseased body becomes the site of conflict/contest between western and non-western systems of medicine. For instance, people living on the margins or people with limited access to free or subsidized institutional healthcare, mostly resort to local health traditions. In some cases, service seekers are satisfied, and no other intervention is required. But in some unfortunate cases intervention of modern healthcare might be required. It is in those times that one sees some sort of confrontation or contest between these two systems of care (modern and traditional). As of 2001, there were over 20 lakh health workers, which increased to 57.6 lakh as per data of National Health Workforce Accounts (NHWA) 2018 and NSSO 2017-18 (Anand and Fan 2016, 9; Karan et al. 2021,5) The number of doctors increased from over 8 lakhs to 19.5 lakhs (allopathic doctors plus AYUSH practitioners) and the strength of nurses and midwives increased from 6 lakhs to 23.4 lakhs (ibid).

Given the vastness of the country, coupled with diverse needs of various regions, it needs mentioning that when it comes to the workforce, there is a shortage across various categories of healthcare workers, something that has been echoed in all policy documents since the very

beginning. Further, the uneven distribution of the workforce and the rural-urban divide make the situation not so ideal. This deficit has been a concern for policy makers and all the National Health Policies have tried addressing this problem. The latest, National Health Policy (2017), keeping in tune with the previous National Policies, have laid down measures to tackle the problem by proposing to increase training and educational institutions for both doctors and nurses (just like other policy or non-policy documents). Recognizing medical pluralism in India, this policy document aimed at giving more importance to AYUSH practitioners. However, appropriating them into allopathic medicine through various special courses, might solve the problem of allopathic doctors in rural areas or in primary healthcare centres, but might pose severe challenge to the unique system of medicine that they practice (Reddy 2019, 91). The proportion of medical personnel to the population in India, just before independence was as follows.

Table 2: The proportion of medical personnel to the population in India (before 1947)

Medical Personnel	**Numbers**	**Ratio of personnel to population**	**Ideal proportion (ideal being the figure in UK)**	**Estimated ratio to be attained by 1971**	**Numbers required by 1971**
Doctors	47400	1:6,300*	1:1000	1:2000	185,000
Nurses	7000	1:43,000	1:300	1:500	740,000
Health Visitors	700	1:400,000	1:4770	1:5000	74000
Midwives	5000	1:60,000	1:618	1:4000	92,500
Qualified Pharmacists	75	1:4,000,00	1 pharmacist for 3 doctors	1:3 doctors	62,000
Qualified Dentists	1000	1:300,000	1:2700	1:4000	92,500

Source: Bhore Committee 1946,19 and First Five-Year Plan (1952)

* 75 per cent were in urban areas.

Though casualisation of the workforce in the organised sector (mainly factories) started taking place since the mid-80s (West Bengal Development Report 2010, 128), after liberalisation, further changes took place in other sectors as well, including hospitals and nursing homes and other medical facilities. Liberalisation of Indian economy is an important event in situating this present work, as this phase led to an increase in temporary jobs, contractual jobs, more subcontracting and an increase of uncertainties for a lot of workers including healthcare

workers. The rise of private hospitals driven by profit motives meant that many healthcare workers mainly in the middle and lower tiers, were not getting what their seniors had received.

Nurses and *ayah*s fall in the middle and low tiers of healthcare workers, respectively, and have been focussed in the present study. Carework associated with nursing is a combination of reproductive and productive work (Reddy 2015) and is worth studying, in any research related to healthcare because, though medicines are important in treating people, saving lives, however, a lot of deaths are preventable if only proper counselling is followed or care is offered. For instance, mere adherence to a basic hand hygiene routine can save around 21-30 per cent of children under five years of age, who die of respiratory and diarrheal diseases every year (UNICEF 2021,8).

In neoliberal times, with a rise in the private healthcare sector wherein around 87 per cent of services are provided by it, this sector also employs a huge number of careworkers (Davalbhakta et al.2020). Increase in contracts for trained healthcare workers has led to a circulation of nurses within India and outside India in present times. On the other hand, the neo-liberal economy has given employment opportunities to a large section of women who were outside the ambit of labour market, albeit in low-paying and insecure jobs (Standing 2011), like the job of an *ayah*. Women have also been engaged in providing nutrition or healthcare on behalf of the state as 'volunteers' (Jenkins 2009,15-18).

Another thing that needs mentioning is that the present research, very much in tune with Shahara Razavi's categorisation, treats healthcare workers like nurses and *ayah*s as providers of paid carework (2008,3). Out migration of trained nurses from India, affects the institutional healthcare provisioning within the country, which has made at home care provided by informal healthcare workers like *badantes* in Italy[5], *ayahs* in India (especially in West Bengal) a necessity. Further, it also needs mentioning that maintaining a distinct and objective voice while doing research on two groups of mostly female employees whose wage employment focuses on historically gendered labour/roles, is difficult since maintaining a clear division between reproductive and productive work is never easy (Reddy 2015,3).

[5] Refers to a *carer*, who looks after a sick person or young children in their home. See https://www.collinsdictionary.com/dictionary/italian-english/badante. Last accessed 23.4.19.

The Case of West Bengal:

Though Dr. Bidhan Chandra Roy, the second Chief Minister had referred to West Bengal as an industrial state, (EPW February 26, 1955) Amiya Bagchi had pointed out that since the very beginning, it had a 'vulnerable industrial structure' and a population which was mostly poor and illiterate (1998, 2973). In the absence of capital goods industries, employment was generated by medium and small-scale industries, which also received focus in the Industrial Policy of 1978 (GoWB 1978, 103-104). Policies in the states have been shaped within the larger framework of the national five-year plans. The first phase for India (as well as West Bengal) might be referred to as the social democratic regime, wherein workers enjoyed job-related benefits from the employers and the state ensured that workers enjoyed various social benefits. Since the late 1970s and mid -1980s, drives for privatisation could be felt in select spheres and 'labour was commoditized with other goods and services' (Sen and Dasgupta 2009, xiii). 1991 onwards, reforms in the labour market, greatly reduced employers' responsibility towards the workers in almost all sectors (Ibid), including the service sector, which includes healthcare. At a time when there is a decline in the welfare activities of the state, like providing quality healthcare for all, and there is an increase in private players in sectors like healthcare, when capital is global but not labour (at least not in India or West Bengal or any third -world country), it is indeed interesting to study how healthcare is administered by healthcare workers, who operate in a hierarchical and competitive setup.

Healthcare during the pandemic:

It also needs to be mentioned at this point that much of the writing was done during COVID-19 times, a time which brought issues of healthcare, policies at various levels, healthcare workers, health as a security issue, at the centre of discussions in India and beyond. Same thing happened in different states and this period showed how policy decisions at various levels, affect individual, collective health and overall healthcare system. In this work, healthcare is used to refer to a system. The pandemic has brought to the fore new debates around healthcare not only in India but all over the world. This pandemic, apart from giving faces to an otherwise faceless migrant labour-force, revealed the need to focus on both the preventive side (public health) and curative side (medical care) of health and showed us, how health can become a security issue. Several reports of people dying due to lack of healthcare facilities also highlight the need to treat healthcare as a fundamental right for every right bearing individual. In June

2020, virtual court six of the Supreme Court of India, Justices Ashok Bhushan, Sanjay Kishan Kaul and M. R. Shah took suo moto cognizance and urged for the proper treatment of COVID patients and respecting those departed (Item no. 319, Suo Moto Writ Petition (Civil) No(s). 7/2020, Record of Proceedings, Virtual Court 6, Supreme Court of India. 12/6/2020).

New infectious diseases like West African Ebola that spread during 2013-15, the outbreak of Zika virus in Brazil in 2015 (though it was reported in 1964 in Uganda and recently in Oceania 2013-14, the outbreak in Brazil was declared as public health emergency of international concern), SARS , COVID-19 that first affected China in 2002 and 2019 respectively and others have moved beyond the places of origin, calling for a global response involving various multilateral agencies, non-state actors, transnational corporations (TNCs) comprising big pharmaceutical companies, food and beverage industry, various American foundations are increasingly becoming more relevant in influencing policy decisions aimed at fighting chronic diseases at not only the national level but also the World Health Organization (WHO) which was the only multilateral agency tasked with reporting and eradication of diseases, working in coordination with sovereign states (Kapilashrami and Baru 2019, 2). Thus, the role of external elements in influencing national policies has become more and more normal in the present time.

Increasingly the discourse around health security or global health security is gaining grounds, though it needs mentioning that ‘what is’ and ‘what is not perceived’ as a threat is not something fixed, once and for all and depends on the context, pathogen or ‘who or what’ is at risk and more involvement of the military in various roles in mitigating health crisis has taken place during the times of peace (Wenham 2019, 1093). What needs to be understood is that a simple definition for health security is not available and can mean anything from prevention and control of infectious diseases to focusing on universal health coverage as a means to attain improved health systems, nationally and across borders. (Horton and Das 2015). However, ‘security’ is not the lens employed in the current study as it leads to exclusion as was evident from the treatment of migrant workers in India.

Planning of Chapters:

The first chapter is titled, 'Introduction' and tries to introduce the topic undertaken for study. It tries to briefly introduce the various components like healthcare, healthcare policies, careworkers and to situate them at the subnational level of West Bengal since 1991, the year economic reforms were adopted by India, leading to opening up of the economy to 2015. Since

the time of research coincided with the COVID-19 pandemic, this chapter has tried to briefly accommodate key issues that got prominence during this time. This chapter also gives an indication as to how the current research will proceed.

The second chapter deals with literature review, which has been done thematically. A discussion on healthcare policies in both national and international levels has been initiated in this chapter, touching upon issues of healthcare financing, management, external determinants of health and the role of the welfare state in the changing (Lee, Buse and Fustukian 2002; Buse, Mays & Walt, 2005, 6). How healthcare is treated under various regimes like welfarist, liberal, neoliberal or regimes inspired by Marxist ideologies and how healthcare is provided has been discussed next. Since this research includes carework, a brief discussion on 'care' and 'carework' has followed after situating the discussion at the meeting point of multiple, interlinked concepts like welfarism, governmentality, etc. It was also realised that in the Indian context, apart from Sheikh and George (2010), Nair (2012), Healey (2013), Ray (2014), Reddy (2015), work on the current scenario of healthcare workers in India has been scant. Given the time frame of the study is 1991 to 2015, various writings (Banerji 1986; 2004; 2009; Duggal 2001; 2009; 2012; 2018; Qadeer 2005; Qadeer et al. 2020; Baru 2012; 2018;2019; Rao 2017; Reddy 2018; 2019; Prasad and Jesani 2018; Gangolli, Duggal and Shukla 2005) that have tried to tease out the tensions between existing policies and existing realities in the Indian context were also discussed.

The third chapter tries to set the context of the current research. Briefly introducing West Bengal as the case study, it goes on to state the research questions and involves a discussion on 'Methodology' and it describes how the research has been approached and conducted.

The fourth chapter focuses on how healthcare has evolved in India over time. Realising that policies at any point of time is not a sudden occurrence and has a history from which it flows, this chapter has tried understanding the evolution of healthcare policies since pre-colonial through postcolonial to neoliberal times. It also tries to understand the factors affecting healthcare in India and the role of policies in mitigating various problems or their failure to do so. Since, much of planning is done at the central level, a discussion on healthcare policies framed at the central level, was considered to be pertinent.

The fifth chapter is on West Bengal and it tries to connect healthcare situation at the subnational level to the wider socio-economic and political situation of that respective state. Discussions have been informed by various state plans, annual plans, legislative assembly debates, other

government documents and news reports. Since West Bengal has been governed by a leftist alliance for over three decades, it has tried probing if there was any difference in approach (discontinuities with the national government), that was opted when the country had adopted the Structural Adjustment Programmes (SAP) in 1991. It has also explored as to how a pro-poor government, in neo-liberal times managed to deliver welfare services like healthcare to the poor. Based on interviews and field work, it has tried to document healthcare provision in select urban slums, *charlands* and tea gardens.

It is pertinent to mention here that though the period under study is from 1991 to 2015, interviews were conducted after 2015. However, while interviewing, a conscious effort was made to select those nurses and *ayahs* as respondents who have been in service or worked during the above-mentioned period. The only exception has been the time when nursing students or interns were interviewed.

The sixth chapter, titled, 'The Realities of Nurses', briefly traces the development of nursing from the ancient period through the medieval period to colonial and postcolonial times. It flags an important point that though the works of British women medical practitioners in India and early native women in the same profession are well documented (Burton 1996; Forbes 1994, 516), however, equal importance has not been given to document the emergence of nursing profession in India (Sanyal 2017) with the exception of Madelaine Healey's (2013) work in this field. Based on interviews, it focuses on how neoliberal policies have shaped nursing profession in India and West Bengal, in particular and how policies need to be informed by the realities, everyday struggles of the nurses, in order to improve healthcare provision in the state. How nurses and their work are perceived by society and how these women careworkers negotiate with administration, and patriarchy has also been looked into. However, since any discussion on nurses in West Bengal would be incomplete if the issues of migration and contractualisation of the nursing profession are not addressed, these issues have been addressed in the chapter.

The seventh chapter is titled, '*Ayahs*: The Underbelly of Care Economy'. *Ayah*s have been present in European households since colonial times. But today's *ayah*s, though coming from the same economically disadvantaged positions, as their predecessors in the profession, are involved with providing direct care to patients in government hospitals, middle-range nursing homes, or in private spaces (homes) of patients. At a time when the formal/informal divide is increasingly getting blurred, *ayah*s mostly hail from the informal sector. These activities (cleaning work, for example) further relegate them to lowest echelon, not only in the overall

carework hierarchy but also in social hierarchy, since in India the work of cleaning is generally associated with 'untouchability', following the binary of sacred/profane. All of these have been dealt with in this chapter.

Further, this chapter also highlights that increasingly, in the private spaces like, a patient's home, issues related to care are getting gendered through the hiring of service of a female informal worker, who not only releases working women but also men of any caring obligations (Anttonen and Zechner 2011, 31). Despite their tireless efforts for the patients, the *ayah*s seldom come in the academic gaze of the researchers in this field. The feminist scholarship in India in general and West Bengal in particular, has not dealt much with their issue. Further, since there has been the phenomenon of 'mushrooming' of *ayah* centres, this research would also probe if some form of 'proto-formalisation' has taken place in an otherwise informal sector.

In 'Conclusion' or chapter seven, I have tried to summarise the findings of the research, by tying together various threads of argument. This chapter tries to analyse the changes that have taken place in the healthcare sector since 1991, focussing on healthcare workers like nurses and *ayah*s. It also explores how the unified task of providing healthcare to a patient is done by nurses as well as *ayah*s, who, though operating in a hierarchical set-up might be seen to be posited at the two poles of a continuum marked by their 'skilled-ness' or their 'unskilled-ness' respectively. It also explores opportunities for further research on healthcare policies and healthcare workers.

Any research on healthcare, policies and careworkers cannot be limited to probing of various policy documents only. Hence, the next chapter tries probing the topic undertaken for the present research conceptually and also have a brief discussion on the existing literature.