Chapter 1: Literature Review

As already mentioned in the previous chapter, in order to have a better understanding of how healthcare policies operate and what is the role of careworkers, one needs to look beyond policy documents. In order to disentangle the intertwined concepts of healthcare, policies and careworkers, the following section, which contextualises the books and articles with pertinent themes, is a review of extant literature that has been grouped into various categories, thematically.

The definition of 'health' has come a long way since the days of Hippocrates, the father of western medicine. It has taken a radical turn in recent history (1948), when the Constitution of the World Health Organisation (WHO), defined health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'[1]. Health can also be seen as 'normal functioning' and where 'the normality is statistical and the functions biological' (Boorse 1977, 542) or can be viewed as 'the absence of pathology', highlighting an individual's ability to function just as other members of her species normally function (Daniels 2008, 37). A holistic understanding might equate health with 'the ability to attain' one's 'vital goals.' With time a biologically dominant understanding of health has paved for an understanding of health, stretching beyond biological in order to include behavioural and social determinants as well (Saad and Prochaska 2020, 2).

The primary site where ultimately a healthcare policy, gets implemented, is an individual's body (which includes both physical and mental health). It should be also reminded here that any research involving health, healthcare, healthcare policies and carework, is bound to get entangled in co-related but diverse and contesting conceptual arguments. State can do *welfare* to it (by providing subsidised/free COVID-19 vaccines, for example), it can try to *control* it (through sterilisation programmes, for instance) or treat it as a *consumer of healthcare* (in a neoliberal state, where patients have to purchase healthcare from the market). It also needs to be mentioned that all the above activities can happen simultaneously. It is not an overemphasis to say that the issues of healthcare policies, role of healthcare workers etc. need to be posited amidst a wider conversation that is taking place directly or indirectly around them. Keeping that in mind, this chapter aims to engage with wider discourses, diverse ideas that often impact

[1] See https://www.who.int/about/governance/constitution. Last accessed 12.04.21.

any discussion of healthcare policies and the case of healthcare workers. Thus, themes have been interwoven with existing literature, in this part of the discussion. The current research has used general theories as lenses to understand the significance and the particularities associated with multiple facets of healthcare.

1.1 Statement of the Problem:

For policies to become effective, proper implementation is necessary. And for healthcare policies to be effectively implemented, healthcare workers play a crucial role. However, much of the discussion gets confined to mere numbers of careworkers in terms of availability, requirements etc. But various socio-economic and cultural factors and power dynamics at work often get overlooked, which otherwise create myriad forms of realities that healthcare workers need to address on a regular basis. Healthcare delivery, in order to be effective, cannot afford to overlook these conditions that affect the life and work of the healthcare workers. Most of the policy decisions also overlook the ground realities which affect healthcare workers and the delivery of services. Further, there is limited discussion on the interactions between various categories of careworkers in the healthcare sector. There is also neglect when it comes to doing research on informal careworkers in private spaces. Thus, an all-round and well-meaning research is ardently needed to address the 'problems' mentioned above.

Let us undertake a detailed review of literature and find out whether the existing literature has adequately addressed these serious issues involved with healthcare policies and healthcare workers.

1.2 Literature Review:

The present study is posed with a challenge – how to investigate both policies (in this case healthcare policies) which lies in the domain of objectivity, reason, impartiality, non-affect, and the case of careworkers, central to which is the idea of carework. There might be multiple ways to approach the current research, for instance, healthcare has been approached from medical, epidemiological perspectives and though that literature is rich, it is beyond the scope of this current research. However, the role of healthcare providers or healthcare workers in determining the nature and quality of healthcare delivery, is another angle from which research on healthcare can be undertaken, as has been done in the present one.

In order to navigate the challenge, mentioned above, an attempt has been made to understand how policies are shaped by various regimes, how ideology and macro-economic developments impact decisions of various regimes. In order to situate this study, in a globalised world it was also pertinent to look into healthcare's entanglements with various levels of power apart from the State like international donor agencies, inter-governmental bodies like WHO, business groups, market and so forth. Using this as the background, this chapter tries to understand the role of careworkers (like nurses and *ayah*s) in delivering of healthcare services, both within and outside India. Though healthcare financing is an important ingredient affecting healthcare delivery, it would be outside the remit of the current study. Before initiating a discussion as to how policies are framed and how they are provided in different regimes, the understanding of entwinement of healthcare, policies and politics is needed.

A thematically divided review of existing literature has been done in the next section, which will contextualise the books/articles with relevant themes.

1.2.1 Politics, Policies and Healthcare:

The present study focuses on the period 1991-2015, a time when a lot of changes have taken place. Policies in general and health policies in particular, have undergone changes all over the world with the onset of globalization and with structural reforms being pushed through international financial institutions. When problems or concerns of the people get addressed by policies or when they get ignored by policies, both the actions on the part of the policy makers, affect their lives and realities. Along with policies framed, the role of the 'changing actors,' and the various 'processes and contexts of policy-making' are also factors shaping healthcare (Lee, Buse and Fustukian's 2002, 4). In investigating how health policies affect the health sectors of various developing countries in a globalized world, many has urged the adoption of 'alternative approaches to global policy that can result in improvements in human security and justice' (279). In order to find the right way through which healthcare would be delivered, first, one needs to address the problems of inequities and differences that globalization has brought about across the world, and second, be wary that each state has unique set of problems. However, with global shift in power, contents of national policies get affected (256).

While talking of policies, discussions need to move beyond power or 'shifts in power' and should also include determinants of health among other things, so that healthcare can be improved in a 'cost-effective and politically acceptable way' (Abel-Smith 1994). Initiating the discussion with the words, 'all people have a right to health' (viii), he has tried flagging various

determinants of health that play an important role in the framing of health policy. Determinants like nutrition, sanitation, education of women, various health hazards like tobacco and alcohol, the availability or dearth of clean drinking water and so on, guide policy makers, economists, experts and politicians to frame policies in such a manner that it helps them to address the concerns at the ground level. Apart from the above factors, health service planning, health service financing and ways to create user friendly and efficient health services, are also concerns that shape policies.

While addressing the policy making process in developing countries, it needs to be noted that the problem faced while framing policies in developing countries would always be how to maintain the current level of spending in health. Abel-Smith (1994) acknowledges that the realities of the developing and developed countries are different, but one might question to what end has his prescriptions kept this 'difference' in mind. For instance, to improve healthcare in developing countries, he had suggested boiling water for drinking and having nutritious meals (within one's budget). The question remains how effective those suggestions for a fuel scarce society are [2] or for those approximately three billion people who cannot afford nutritious meal[3]. Thus, addressing the issue of inequity existing in society, when it comes to healthcare, becomes imperative. Inequities in healthcare can be reduced by doing away with unequal power relations embedded in institutions dealing with healthcare and inadequate policies which fail to meet the needs and requirements at local levels (Kuhlmann et al. 2015).

However, it needs to be reminded that the framing of healthcare policies depends on the nature, philosophy and ideology of various regimes. Let us shift our attention to healthcare policies under various regimes.

A. Healthcare Policies as framed by different Regimes:

1) Liberal Regimes:

There is no universal agreement, within the liberal tradition, on whether the right to health should be seen as a positive or a negative right. Some people hold the opinion that everyone should be free to work toward achieving their own personal health and well-being and health, just like any other commodity should be bought and sold from the market. The State has little or no part in promoting health as it is up to each person to decide whether to receive treatment and from whom. Since each person's healthcare demands are unique, any interference would

[2] See Gilliman and Skillicorn (1985), 157-163.
[3] See https://news.un.org/en/story/2021/11/1106342. Last accessed 23.8.22.

not be the best course of action. This difficulty arises from deciding which healthcare needs should be given priority over others (Moskop 1983,218-220). Many within this tradition prioritise the right to property and the freedom of employment as fundamental liberties and rights and favour using legislations to meet medical and healthcare issues.

Jeremy Bentham, for instance, had urged societies to ensure greatest happiness of the majority of the people. Others from the liberal tradition put forth the idea of offering the most basic healthcare services, which are thought to be important for preserving life and dignity. Many also argue that though liberal approach might be used to understand bioethics with its focus on individual's health related choices, however, it cannot be used to understand public health ethics which is tied to the notion of public good (Radoilska 2009, 135). Again, those who interpreted the right to health using the Rawlsian lens, had advocated that health care be treated as a priority since it is necessary to ensure equal social conditions and is necessary for individual's growth (Green 1976, 146-147) or in other words, having good health is a prerequisite to ensure equal basic opportunities (Rawls 2001). In history, the Beveridge Report of 1942, and various post-war efforts at socio-economic reconstruction, required tweaking existing liberal policies and thus evolved welfare policies (Glennerster 2020, 2).

2) Welfare Regimes:

It is difficult to define welfare and certainly more difficult to measure it. However, in social science, welfare is equated with the idea of 'well-being' (Greve 2019,7). Positive welfare may be understood through a state's social investments (Giddens 1998, 100-103). Post-war liberal countries in Europe adopted welfarism to balance the increasing inequalities. Welfarism lies at the crossroads of liberalism, Fabian socialism, conservatism and there might be no definite philosophy or ideology determining the policies of a welfare state (Robson 1976, 12). Healthcare is intrinsically linked to the idea of welfare because of the different types of goods and services that are distributed in a welfare state, healthcare is of utmost importance. Still discussions on healthcare policies seldom engage with wider discourses on welfarism and discussions on welfarism also do not always engage with healthcare policies (Moran 2000, 135). For instance, in a society, where individuals are subjected to multiple forms of marginalisation, welfare measures might provide solution as there is strong evidence that welfare measures have helped to reduce inequalities in income, housing quality, access to health care, and other social and economic outcomes (Kautto et al. 2001; Mackenbach 2012).

Generally speaking, there exists a consensus among policymakers at various levels (both national and international) that it is obligatory to provide for some form of healthcare to all, however, no consensus could be determined about the nature and scope of that obligation (Bole 1991,1). Welfarism can be seen as a position taken up by the state pertaining to its policies, though propagators of free market perceive it as a hitch for the effective functioning of free market economy. Esping-Andersen (1990), had classified welfare regimes as a) Anglo-Saxon liberal welfare states – characterised by mixed model of modest social transfers; b) the Conservative Corporatist regimes – characterised by the market providing for welfare and c) Social democratic regimes – where one finds the state fulfilling welfare goals through its commitment to full employment, income protection, high levels of taxation etc. (ibid; Esping-Andersen 1992).

Joachim Vogel (2003) tried to understand welfarism with the help of two strategies. The first one is *regulation* that aims at controlling how resources are distributed in the labour market, not only among individuals but in families. Through legislations or less formal rulings, it tries to reduce inequalities and increase welfare in the labour markets and within the family. The second one is *repairment by redistribution* which includes government intervention in the form of imposing/raising/doing away of taxes, giving subsidies etc. Various income substitutions in the form of unemployment benefits, pension benefits and so on exist along with uncertainties in the labour market (374). A welfarist approach to healthcare can be **right-based** and be linked with the idea **distributive justice** or it can be **non-right** based and developed on the idea of **populism.** But before delving into populism, let us discuss first about Global Human Rights Based Regime.

3) Global Human Rights Based Regime

Simply put, a right-based approach to health is a strategy to achieve health outcomes, based on human rights principle. Here the proponents urge the policymakers to adopt a more participatory, equal, non-discriminatory, transparent and accountable healthcare policies (Bustreo and Doebbler 2020, 89). Jonathan M. Mann et al. (1991), Brigit Toebes (1999), Sabine Klotz et al. (2017), Eduardo Arenas Catalan (2021) have propagated that the availability and access to healthcare for all is a pre-requisite for the fundamental well-being and dignity of every human being, hence it is non-negotiable in nature. Although the right to health and human rights in health are ideas used interchangeably, it is pertinent to mention that while right to health is broad, it is however more constrained than a human rights-based approach, and using

a larger 'lens' may lead to a thorough and successful plan of action (Hunt 2016). A human rights approach to healthcare is also critical of the growing global health inequalities.

Linking human rights and health started gaining prominence since 1993-1994 (Hunt 2016) and it came to limelight when the then UN Secretary General Kofi Anan had urged various UN agencies to accommodate human rights in everything they do (Gruskin, Bogecho and Ferguson 2015, 134). Though a broader view, while dealing with healthcare, is needed, healthcare and human rights have seldom been explicitly linked, apart from the instances of human rights abuse like torture, which centres on the very idea of health (Mann et al 1994, *passim*). At the same time, the cosmopolitans were of the view that all people are morally equal and our decisions concerning the scope of justice must consider universally accepted demands for the fulfilment of optimal human health. Justice related to health or healthcare should not be limited to citizens alone and hence they propagated a right-based approach to healthcare (Brown and Paremoer 2014, 87). Thus, World Health Organisation (WHO), the United Nations Agency promoting health has been urging member states to include a human rights-based approach to health[4]

If policies, while addressing healthcare issues, end up mellowing down or vaguely addressing the central role of the international right to health as reflected in the constitution of the World Health Organisation and ratified by various states, then it becomes a problem. As Hunt (2016) warns, a rights-based approach to health ends up losing both legitimacy and credibility, when accommodated in various policy documents of various states and only 'implicitly includes the right to health' in it. Though a broadening of the scope of the right to health is very much required, scholars also caution that even when looking through human rights lens, the proper emphasis should be given on 'international right to health' (*Ibid*). Right to health should never get lost in the wider human rights discourse.

4) Neoliberal Regimes:

Proponents of the neoliberal view highlight that as more areas are covered by the market, fewer areas remain for political decision making, and thus, the state should intervene for only those tasks which cannot be undertaken by the market (Hayek 1994, 44; Friedman, 2002, 24). Thus, from this point of view, matters like health and healthcare should stand *outside* the purview of

[4] See https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health#:~:text=strengthening%20the%20capacity%20of%20WHO,including%20the%20right%20to%20health. Last accessed on 06.06.20.

the state. Although most of the literature dealing with impacts of neoliberal reforms on healthcare, are critical of the whole process, authors like Kailash and Rasaratnam (2015, 41) suggest that neoliberal reforms can be used for 'reregulation', whereby state can preserve and expand power. Neo-liberal framework views the expansion of informal sector to be in concomitance with rational choice. This view without a doubt is being upheld by most of the liberal scholars, who think that global capitalist economy facilitates competition and leaves both the producers and consumers with a lot of 'choices.' Scholars like Colin C. Williams and Anjali Gurtoo (2011) in doing their study on women entrepreneurs in the informal sector, have used both these frameworks in analysing the informal sector.

On the other hand, some of the scholars argue that the rise of finance capital in the garb of globalisation will create zones of inequalities within a country and between regions of the globe and its impact on vulnerable groups including disabled persons, would be detrimental (Mooney, 2012; Dahlgren 2014; Sakellariou and Rotaru 2017a and 2017b; Navarro 2020). Gradually, since 1980s, the world witnessed the rise of market-based capitalism or neoliberalism and later with the rise of finance capitalism, the Fordist accumulation led to a somewhat Toyotist accumulation[5], characterized by more and more decentralization. In the Indian context, it led to contracting and sub-contracting of jobs that were earlier thought to be of permanent in nature. Further, while market plays an important role in today's world, there is a marked absence of proper regulatory framework for drugs, various types of private players in healthcare, private-public partnerships, laws with regard to patents, among other things.

A conspicuous divide between the *formal* and the *informal* sectors is a characteristic of neoliberal regimes, which warrants a small discussion on the *formal/informal* divide. The *formal sector* is characterised by (a) the presence of permanent jobs; (b) that it is registered and regulated by the State or the market; and is characterized by (c) a system of fixed wages; (d) working hours; with (e) benefits like Provident Fund, insurance etc. (though the IT sector in India might be an exception); and that it is marked by (f) the presence of unions.

Similarly, *informal sector* is often linked with *mobile labour*, a sector which is not regulated by laws of taxation or other regulatory laws of the state, thereby thought to be involved with the kinds of mobile exchange and production and with the criminal business activity. Further,

[5] Toyotism is characterised by a system comprising a core comprising full time, privileged, hence 'secure' workers, who are also skilled and mostly male and a multitude of part time, contractual workers, who are mostly female immigrants, on the other hand. For details see marxist.org.

scholars have defined informal workers as those who produce legal goods and services, however remaining without any labour, health benefits (Portes, Castells, and Benton, 1989) – hence, the nature of work is wage driven and flexible and thereby it incorporates various types of workers like part-time, ad-hoc etc., where benefits and status decline along with the decline in the wages. Outsourcing, irregular work routines are also features of this sector (Breman and Linden 2014).

Again, the *informal* gets associated with *unskilled* and that is why, the amount of skill deployed in small-scale industries has been generally underestimated by many scholars. Then comes the linking of the informal sector with *low class-ness* and also there is a feeling that they lack a sense of solidarity. It is present contrastingly, in various unions operating at the formal levels. Some believe that recruitment of workers along the lines of primary group identities also hinders the development of solidarity in a wider scale. Here, we must not forget that though there is some degree of solidarity among the workers of formal sector, it is not based on the realisation that workers all belong to an undivided working class. Another stereotype attached with the 'informal' is the notion of hidden, indirect resistances, though scholars working on informal labour, believe on the contrary that workers in the informal sector, get involved in everyday forms of resistance which is, however, not very channelized (Harriss-White 2004; De Neve 2005; Breman 1996; 2013). Thus, these unconnected everyday struggles are not tangible like the organised/unionised struggle of the workers in formal sectors, which might be one of the reasons why resistance by formal workers' unions have caught more attention of academicians and researchers alike.

Neoliberal policies have given rise to new set of uncertainties like job loss, conversion of permanent jobs into contractual ones, decline in salaries, reduction of social benefits and constant price rise among some of the concerns (Frankel, Ossanden, Pallesen 2019). A further stratification of the labour market has taken place in neoliberal times and following the financial crisis of 2008. The crisis had forced various states to adopt fiscal austerity measures, making the question of how to redistribute goods and benefits, a chief concern. The demand for anti-austerity measures (from political parties hailing from the left, centre and right), gave way to **populist politics** in neoliberal times**,** for instance in Greece in 2015 (Halikiopoulou 2020).

The rolling back of the welfare policies has led people to look for alternatives. Not upholding the need for a minimal state, populist right-wing parties in Western Europe are favouring

welfare towards select groups, which are considered to be in need of welfare (Chueri 2022). Populism emphasises on the idea of "people," it presents a vision for how societies should be making, validating, and enacting collective decisions, it can be considered a form of politics – a politics from below, serving the interests of the masses and not the elites (Halikiopoulou 2020). Going by various populist measures adopted across time, it seems that the second strategy as expressed by Vogel including *repairment by redistribution* (mentioned earlier in this chapter) has been used by various populist governments including India.

5) Regimes inspired by Marxist Ideology:

Using Marxist lens to analyse existing healthcare system, across the world would include a commitment to improve healthcare system along with necessary changes or improvements in the economic, social, and political spheres (Waitzkin 1978). Thus, probing the issue of healthcare, using the Marxist line of thought would reveal an increase in stratification in advanced capitalist countries as well as in developing countries (Navarro 1976). While attempting to understand how the working class lived, in capitalist societies, Frederick Engels had probed why various diseases like tuberculosis, typhoid affected them and had linked it to reasons like poor housing, poor water supply, malnutrition etc. Rudolf Virchow also found that a disease had multiple factors as its cause, among which material conditions of people's lives was an important factor. This can also be seen reflected in his study about infections and diseases affecting the army (Virchow 1879). He also referred to medicine as Social Science and politics as medicine, albeit in a bigger scale. He had also compared the state to a living organism comprising individuals and had stated that proper response to health needs were more political than medical actions (Mackenbach 2009). Further, specialisation, in healthcare or professionalisation often segregates, giving rise to new hierarchies (Bullough and Bullough 1975). New works do also address the issue of precarious nature of work and their impact on health outcomes (Vosko 2006). These hierarchies not only affect access to healthcare services but also give rise to hierarchies among healthcare workers.

B. Healthcare Provision by various Regimes:

1) Liberal Regimes:

The Liberal regimes in countries like Great Britain, Canada, U.S.A and so forth, give primacy to market forces and the rich are more powerful than the poor labouring class and hence, income disparity is also severe. They have a residual and assistive welfare state, with public social spending going to those with the greatest needs. Public healthcare spending is modest

there and some amount of welfare services is also provided by the private sectors (Borrell et al. 2007). Even when healthcare as a right got recognition in constitutions or other legal documents, the question remains how to finance it. The liberal regimes, thus favour the idea of insurance, in the provision of healthcare. Insurance can be arranged from private sector through voluntary contributions or through compulsory contributions made to a social institution, in case of social insurance. In both the cases, people can reap benefit of insurance, after making payments (Bodenheimer 2005, 1430).

2) Welfare Regimes:

Welfare role of the state can also be viewed as residual, in which the welfare state seems to provide a safety-net consisting of certain benefits aimed at providing relief to the 'victims of capitalism.' This safety net acts as a cushion against unemployment, sickness, and other uncertainties. Those who need the most, should only be given welfare benefits like healthcare benefits, albeit selectively. The benefits are minimal because the net is close to the ground, and subsistence levels may vary greatly depending on local needs and requirements (Sandfort 2010)[6]. Another way of distributing welfare is through the model of social insurance. It propagates ways to prevent destitution, and zeroes on the issuance of insurance cards for the purpose. Contributions made during one's work-life entitle her to getting protection against various future uncertainties. Thus, the focus of this is on equitable treatment and not on equalising of income (Marmor 1991, 41-42).

The idea of distributive justice is associated with the idea of welfare. Rawls in his book, *A theory of Justice*, speaking about multiple inequalities wrote, 'The natural distribution is neither just nor unjust; nor is it unjust that persons are born into society at some particular position. These are simply natural facts' (Rawls 1999, 87). In the end of it, what differentiates "just" from "unjust" is how organisations handle these realities (Ibid). He also viewed healthcare as a public good which the state might procure from either the public owned firms or the private sector, if the state decides to 'politically allocate and finance it' (42). Norman Daniels (1981), at the time of using Rawls' difference principle (while analysing social goods like healthcare) argued that among all forms of social goods, healthcare has a different position. Even in societies characterised by uneven distribution of social goods, there should be mechanisms to distribute healthcare equally, as only through just arrangements can a reasonable share of certain basic social goods, be guaranteed 'which constitute the relevant-truncated-scale of well-

[6] Also see https://evans.uw.edu/wp-content/uploads/2020/09/cura_safetynet_2010.pdf

being for purposes of justice' (162). He opined that different health outcomes should be viewed as just, if they result from the few instances of inequality, those are acceptable under the theory of justice as fairness and the eradication of unfair inequalities in health's social determinants (Daniels 2008).

Amartya Sen concurred that health and equitable distribution of healthcare resources were crucial as it affected individual's capability to perform reasoned activities autonomously. However, Sen was critical of the fact that by giving primacy to the distribution of resources, Rawls (and Daniels) has ignored the outcomes. He had argued that individuals have different characteristic features and all do not have equal capacity to convert resources into outcomes. Implying that states, which fairly distribute opportunities for achieving good health, but ultimately fail to address structural disparities in health outcomes have failed in upholding the principles of healthcare justice. (Sen 1999, 74).

3) Global Human Rights Regime:

There is already an existing consensus that states have an obligation to protect and promote the health of their citizens and that of non-citizens residing in its territory. Various international treaties like the Universal Declaration of Human Rights (Article 25), the International Covenant on Economic, Social and Cultural Rights (Article 12), and General Comment 14 of the UN Economic and Social Council are instances of the above consensus. Even WHO's definition of health as 'a state of complete physical, mental and social well-being,' has taken the focus beyond the 'biomedical and pathology-based perspective' (Mann et al 1994, 9). Thus, human rights promotion and protection regarding healthcare would imply preventive measures used to prevent the spread of diseases as well as care, once somebody is affected by a disease (12).

However, a tension between WHO and World Bank regarding how primary healthcare has developed would be provided (on a comprehensive or selective basis) has developed since the 1990s with the World Bank controlling WHO's reports, policies through its control over budget. According to Qadeer, Saxena and Arathi (2021), the shift to Universal Health Coverage (UHC), from comprehensive primary healthcare in India, is based on the demands of World Bank, which affects the welfare activities of the state. Absence of Universal Health Coverage talks of access or coverage and does not guarantee comprehensive healthcare, but 'clinical coverage through public as well as private institutions' (xvi). According to them, UHC is not

universal as it excludes more than it includes and has nothing to do with care as it is primarily driven by profit motive (viii).

Faced with strong criticisms, World Bank started propagating since 1990s that states should provide a 'package consisting of perinatal and delivery care' (Desai 2004, 39). Impact of such propaganda can be seen as reflected in various perinatal schemes operating in India and the formation of Accredited Social Health Activists (ASHA) volunteers looking after the health of pregnant mothers and infants can be cited as examples from India. Further, feminists point out that neoliberal policies have severely limited the demand of women's right to health to include only reproductive health focussing on women of childbearing age. Reducing maternal mortality and morbidity warrants an increase in spending in health. Thus, to many, the need is to 'link gender with macroeconomic policy in international intergovernmental policy-making arenas from a human rights perspective' (Global Health Watch 2005, 140-142).

4) Neoliberal Regimes:

Neoliberalism is frequently used to refer to low government involvement, laissez-faire market practises, and individualism over collectivism (Harvey 2006). Neoliberal regimes prioritise private sector over public sector as the former is considered to be more efficient. The government oversees and controls the health care industry and reliance is on the private sector to offer health services and insurance. In reality, under neoliberalism market-oriented policies have favoured selective primary care over comprehensive primary care in an effort to reduce costs. This has been done to "maximise" public funding, as providing comprehensive care is perceived as an expensive and difficult to option. In neoliberal regimes market-oriented policies are accorded more importance which are driven by profit motives, idea of "choice" of customers or patients, decentralised decision-making, and private sector rivalry (Hartmann 2016).

Neoliberalism minimises the social determination of health paradigm that is the cornerstone of social medicine by prioritising biological, specialised, and curative health care practises.

5) Regimes influenced by Marxism:

Health has traditionally been viewed through the lens of a biomedical model that focussed on an individual-level biological function, viewing disease as aberrations from the normal range of quantifiable biological (somatic) variables, and defines health as the absence of disease (Engel 1977, 129-130). In such regimes, health is socially produced and the role of the market

is negligible if not insignificant. Regardless of ethnicity, religion, political convictions, economic situation, or social standing, the state has a duty to ensure that its citizens have access to the best degree of health that is reasonably feasible. Regimes influenced by Marxist Philosophy is aimed at facilitating equity in healthcare (Roy 2020).

Healthcare under the above-mentioned regimes, would be provided to the people for free, and the regimes would be more concerned about dealing with preventable diseases than providing curative care. The issue of health would also be linked with wider issues of prevailing socio-economic conditions, housing conditions etc. Further in such regimes, like in a socialist system, there would be no hierarchy between healthcare professionals and the patients they treat. Medical Technology and scientific developments would be aimed at benefitting the people and not private players in the market (Deacon 1984, 454-460).

C. The Question of Governmentality:

Susie Tharu (2010) argues that historically speaking health has been an administrative category, where governmentalisation of health shifts focuses on population from people, making medicine accountable to the state and not to the sick (80). Healthcare involves a hierarchical knowledge structure and as a tool, it is used by states to gather knowledge about the population they control and have power over. The concept of governmentality cuts across different types of regimes. For instance, with the exception of countries like Cuba, former USSR or China, it seems non-democratic regimes (some might label them as dictatorships) do not seem to improve healthcare scenario (Deacon 2007).

Further, in dictatorial regimes, healthcare might be used as a tool to control the population and prevent the development of any possible dissent. Further, such regimes also witness human rights violation like imprisonment and torture of dissenters, which directly impacts health. These regimes are characterised by the presence of corrupt leaders who amass wealth and public goods might be used to benefit the politically influential groups (Deacon 2007, 242), while common people do not have access to basic needs like nutrition, healthcare, education etc. Any improvement in the health parameters thus, might be considered as a by-product of such repressive acts (Rechel and McKee 2007; Geloso, Berdine and Powell, 2020). This might lead one to believe that basic needs like healthcare, education so forth, are better provided in democracies. Health and education are considered to be "lower visibility goods" and do not suffer from neglect in 'highly democratic countries' (Mani and Mukand 2007, 516). Ensuring the provision of public goods like health to include as many people as possible, takes into

account civil liberties, but it needs mentioning that democracy is never a homogenous terrain (Dall'Alba, Germano and Rocha 2022).

A closer reading of Michel Foucault would reveal that, on earlier occasions, medicine was expected to provide society with strong individuals, who would be capable of working consistently and medicine enabled this consistency in the work field, leading to the improvement of the nature of work and of the workers and reproduction of the work force. It was an essential instrument for the maintenance and reproduction of the work force crucial for the functioning of modern society. At present, medicine connects with the economy by another route. Not simply in its capability of reproducing the work force, but also in *making health a commodity*, which is always in 'need/demand' and thus, can directly produce wealth. In this way, health becomes an object of consumption, which can be provided by doctors, pathological laboratories, pharmaceutical companies etc., and consumed by both the potential and actual patients. As such, it has acquired economic and market value. It is also where the state policies become very important. When the human body enters the market, through the mode of health consumption – various phenomena appear which lead to the dysfunctions in the contemporary system of health and medicine (Foucault 2004, 16).

The site of individual body, be it through various educational programmes, prison rehabilitation programmes etc. was imagined as something that needed to be disciplined and through the act of disciplining bodies are transformed as 'docile bodies'. Thus, an individual's body became the centre of numerous programmes aimed at improving the life and performance of individuals, which in turn forced the government to be concerned about the health, sanitation, living conditions of such individuals. This has been dubbed as 'biopolitics' or the time referring to life's introduction into history, or the moment when the careful management of life and the management of bodies (Foucault 1978, 141-147) became the priority of the administration.

In the context of colonial India, it can be stated that medicine had a modernising mission: to modernise or transform the domestic and intimate habits of the Indian subjects (Bashford 2004). The act of refashioning of patriarchy in the nineteenth century required the construction of *bhadramahila* (women of the educated upper classes) to be guided by with western education while retaining her Indian values and spirit. The issue of 'emancipation' of women in this new patriarchy was tied to education that would impart modern ideas about everything including hygiene and ways of running their private spaces, or households (Chatterjee 1989).

However, the charges levelled against the colonial government by the National Planning Committee (NPC), set up by the Indian National Congress, was that the colonial administration 'did not possess the will, the knowledge, or the confidence to intervene deeply enough in Indian society to ameliorate health conditions' (Amrith 2009, 9). What the new country aspired was to control the health of the population, look after their welfare through deep intervention, using the latest technologies, which might also include sterilising the unfit (Ibid).

Despite such claims made by NPC, David Arnold noted that during colonialism, the extent of governmental intervention was so deep, that the body of the subjects became sites of colonial authority and control (Arnold 1993, 8-10). According to Daniel Headrick (1981), medicine was also used as a tool of the British Empire and researches on cholera, dysentery, leprosy, malaria etc. stemmed out of the need to control the environment and the people, as a result of which many medico-topographical surveys were conducted during the colonial times. The adoption of several vertical programmes or the implementation of family planning programmes in India can also be cited as examples of how bodies were controlled.

1.3 Healthcare Provision and the Case of Careworkers:

A very important part of healthcare is healthcare services, which involves the contested terrain of carework. The very word carework runs the risk of ending up being misconstrued as anything less than active labour, due to its association with the word care, which might answer as to why carework by healthcare workers like nurses of various categories, nannies, nursing aides and other careworkers, is so devalued and not addressed adequately in political science research. Carework is a gendered concept and the very idea of 'care' (which is also labelled as affective labour [Hardt 1999]) is associated with the idea of 'knowing', which is different from 'knowing' practiced in the domain of reason, non-affect. Mothers, through their acts of caring for their infants, or a nurse caring for their chronic patients, end up making caring a hybrid 'ethico-epistemic' process (Dalmiya 2016, 34).

During colonial times, women's traditional knowledge of healing oft referred to as *totkas* in Bengali (which means curing by application of some age-old local knowledge on herbs and other practices, which are not generally endorsed by registered doctors), and their knowledge of their own bodies were derecognised by biomedicine. This had not only relegated the indigenous systems of healing as unimportant, but it also rendered women practitioners of

indigenous healing useless as well, while there have been examples of famous and successful female practitioners of local medicine. Their medical knowledge existed within households and successfully fulfilled health needs of both men and women alike (Mukherjee 2012, 17). While the postcolonial state has readily accepted women careworkers trained in western/modern system of healing (like nurses), it has been unsure of untrained careworkers (like *ayah*s) or careworkers having traditional knowledge of healing (like quacks practicing Ayurvedic medicine). Dorothy Smith (1987), while talking of conditioning that has led to the silencing of women throughout history, cited the cases of midwives in England and United States. According to her, when English midwives were brought into a subordinate relation in the medical profession, the traditions perpetuated by the older art of midwifery was lost and the direct access to women's own knowledge of their sexual and procreative functions was cut off. It somehow, reiterated the binary position which situates women close to nature and men close to reason (education). Thus, education, from the very beginning was meant for men, and women were given knowledge only in a limited way. Knowledge, which could enhance her work as a daughter, wife, mother, only within the peripheries of the "private", was made available.

However, in 1970s, feminist research on domestic work or housework paved the way for studies in carework. 'The International Wages for Housework Campaign (WfH), the Marxist feminist movement in Italy, the United States, the United Kingdom, Canada, Germany, and the Caribbean and its revolutionary feminist critics in the US and the UK', who happened to be active in several feminist or leftist groups, had provided broader definitions of housework, to include both paid and unpaid carework and service performed at home, workplace or community (Forrester 2022, 1). Domestic labour theorists had criticised Marxism for not recognising the role of unpaid domestic work as crucial in creating economic value. They were critical of the 'so-called Marxists', who viewed that under capitalism, the family did not have any producing role and hence not related to social production (Costa and James 1975, 10). Later, the European Post-Marxists scholars like Michael Hardt and Antonio Negri have argued that the division between productive and reproductive labour has never been rigid and proposes a new theory of value through their work on affective labour, where economic production and social reproduction are indistinguishable (Hardt and Negri 2011).

Initially, care was synonymous with unpaid work undertaken by female family members for dependent members of the family and the perception being that good care could be provided by unpaid carework, which was based on a sense of commitment, obligation and love. It was

difficult to situate and 'conceptualise' at-home care provided by an outsider (Graham 1991, 68) since it lacked commitment and was not based on positive feelings. Doubts were expressed if it could be perceived as care at all (Ungerson 1990, 19). On one hand, formal care was equated with bureaucratic rationality. On the other, the unpaid care work by women, which was the focus of feminist research, tried getting attention of policy makers so that informal care could receive public money, making informal care a 'political and public concern' (Anttonen and Zechner 2011,19). It also needs mentioning that in earlier researches by British feminists, research on care implied looking at the unpaid informal care of the elderly and did not include care for infants, while the Nordic researchers working on care emphasised the paid carework (Ibid).

It was also perceived that the act of caring needed something more than just labour, it required love. To convey the meaning of care or caring as an 'intimate and emotionally demanding labour,' Hilary Rose (1983, 83) had used the 'ideologically loaded term "love"'. This extremely taxing work (care) requires women to give a part of themselves to a child or a person in need of care. Therefore, Rose points out that how people are produced differs fundamentally from how things or objects are produced. The former 'requires caring labour – the labour of love' (Ibid). Feminists had earlier also questioned social policies that reinforced community provision of care by women and had criticised these actions as ploy to keep women out of the labour market, so that they could provide continued care albeit, unpaid, to family members in need (Finch 1983,6).

Arlie Hochschild had tried linking *affect* with the process of marketisation in the 80s and spoke of emotional labour to refer to work that needed emotional connection or to put it simply, service work (Hochschild 1983, 153). Emotional labour required face-to-face or voice-to-voice connection and how it affects others was crucial. But emotional work was perceived in another way, wherein it was used to refer to 'efforts made to understand others, to have empathy with their situation, to feel their feelings as a part of one's own', and in doing so it required, 'some permeability of the boundaries between oneself and the other' (England and Farakas 1986, 91). What was also needed was the will and 'ability to unearth and experience the feelings of another' (Ibid). Michael Hardt (1999), while analysing the changing nature of what he termed as 'affective labour' or 'immaterial labour'[7] in the capitalist economy, stated that affective labour is 'itself and directly the constitution of communities and collective subjectivities' (89)

[7] Since no material or durable goods get produced (Hardt, 1999, 94).

and contrary to various claims, has always been integral to capitalist production and recently has been ‘at the very pinnacle of the hierarchy of labouring forms’ (90). Affective labour marks the transition from the dominance of industry to the dominance of services and information in the age of what he refers to as ‘economic *postmodernization*’ or ‘*informatization’* (Ibid). At a time when jobs in traditional industries is shrinking, or when according to Hardt, modernisation has come to an end, we see, a shift from industry to service jobs[8] or what is known as the tertiary industry.

What needs to be mentioned here is that the concepts of ‘global care chain’ as formulated by Hoschschild, was built on Marx’s idea of surplus value. She had linked global care chain with global capitalism which according to her creates a system of a ‘Third World supply of mothering,’ which in turn creates ‘a First World demand for it’ (Hochschild 2014, 257). She offers a solution (knowing that this is not so simple) wherein the financial plight of the migrants should be addressed first, in order to lessen ‘the incentives to migrate,’ which would entail developing the economy of the country of origin (260). Rhacel Salazar Parrenas’ (2000) term for referring to this division of reproductive labour has been ‘international transfer of caretaking’ (561). In her work on Filipina domestic workers, she revealed how rich white households purchase services at low rates from Filipina women migrant workers, who in turn hire the services of local careworkers at even lower rates (Ibid). Both the scholars used the concept of Marx’s supply chain to analyse the situation of migrant workers and demonstrate the ways in which global structural inequality produces and is perpetuated by a racially and gendered international division of labour (Brown 2016, 211).

In her work *The Second Shift*, Hochschild highlighted that women have two work shifts comprising their paid job and their unpaid carework at home. As per her calculations, after taking into account the second shift, women worked more each week (15 hours more), when compared with men. In a year, women work ‘*extra month of twenty-four-hour days a year.’* Thus, while at work there exist a wage gap between men and women and at home there exist a ‘leisure gap’ (Hoschschild 1989, 3-4). Though earlier formal and informal care were treated differently, nowadays, the concepts of both formal and informal care can be seen getting integrated into the very idea of ‘care’ (Ungerson 2004) and since the 1990s’ studies have also tried looking into care receivers along with careworkers (Anttonen and Zechner 2011,22). Since 1990s, attempts have been made to widen the concept of care. Increasingly attempts are

[8] By using the word ‘service’ Hardt included jobs in the sectors of education, health care, entertainment etc., where primacy is given to knowledge, information, affect and communication (Hardt 1999;91).

made to look into care through the concept of intersectionality, meaning that while looking at care, various categories intersecting the category of gender like class, caste, ethnicity etc. should be considered.

On the other hand, Noddings (1992), Gilligan (1997), and others view care and caring responsibilities to be the key to the understanding of female ethics because women are concerned primarily with creating caring connections between members of their family and the community. However, Tronto (1993) sees it as a civic virtue that is politically significant (it is also significant to the public). Though, the present study does not perceive *care* ***only*** *as a feminine activity but tries to link it to the socio-politico-economic realities.* For the above reason, the study uses the definition as given by Shahra Razavi, that 'care' is a work, involving direct care of people, whether on a paid or unpaid basis. Care work could take place in private homes, where it can be done on an unpaid basis by household members or on a paid basis by non-household members, like domestic workers. It could also take place in public and private institutions such as hospitals, nursing homes, old-age homes, etc. (Razavi 2007).

In this respect, it is pertinent to comprehend that a limited understanding of the word care, has rendered it not-so-interesting to academicians, ***as it was caught in between 'feminist' socio-political perspective and 'feminine' ethic of care concerns*** (Tong 1993; Hunt 1997; Gilligan 1993). Though, as pointed by the above group of scholars, care is private and involves sentiments and emotions, the present researcher would like to argue along the line of Tronto (1994), that care has political implications. She has also stated that feminist movement is a part of other global movements fighting for liberation, justice etc. But those old paradigms cannot adequately describe the realities and hence what is required is a reimagining. Focussing on women's morality, she urged to uphold morality as a powerful strategy in order to usher in or bring about a political change. Though she knew by treating women as morally superior has not benefitted women, rather throughout human history, one could see their exclusion. This ambivalence made Tronto to talk of the "blurring boundaries" in order to build an inclusive system or society. Here, morality should not be treated as morality per se, otherwise, care-ethic, a term that she favours over women's morality, would fail to influence/ exert pressure (power), in the discussions in philosophy and political theory (Ibid).

Sen (2014) stated that carework is generally looked at through binaries like productive/reproductive, factory/home, exchange/use-value labour, where the first part of the pairing has been associated with the men and the second with the women. This binary position

has ignored the importance of the phenomenon of the commodified reproductive work like domestic work, and this mind-set is generally extended to carework as well. Care, according to Sen, lies in the liminal space of productive-reproductive work. However, while working on careworkers in private spaces (though it is difficult to distinguish between careworkers and domestic workers in private households as their works overlap a lot), scholars did not directly address the issue of inequality which is *given* between two sets of women in that private space – one who is employing and the other, who is being employed. Based on experiences in United States, Tronto (1993) made it clear that women careworkers in private spaces would be employed with the pre-understanding that her wages would be lot less than the woman, who is hiring the services of the careworker.

Feminist research on care and caregivers were first undertaken in the early 1980s (Finch and Groves 1980; Finch 1983; Graham 1991). However, the recent COVID-19 pandemic has brought about a shift in focus wherein several studies have been done on *healthcare workers*, a category which otherwise receives less attention[9]. Further research works research linking healthcare policies and healthcare workers, research has been scant. Bradshaw and Bradshaw (2004) had tried to help practitioners in Britain in interpreting policies as they had realised that there remains a gap between policy framing and policy implementation. They argued that a gap is being created because policy framers frame healthcare policies keeping in mind the larger idea of collective good, while healthcare workers always provide individual or patient specific services. Developments in modern medicine and in social policies have followed different trajectories but now policies must be in sync with not only developments in medical field but also social demands. It also addressed the issue of weakened leadership in NHS when doctors refrained from taking leadership positions. Though this work tried linking policies with healthcare workers, this has been an attempt to sensitise healthcare workers or professionals about policies and not sensitise policy makers about the experiences of healthcare workers. Also in the discussions, it has given more emphasis on doctors while discussing about healthcare professionals.

Since, the present work involves the category of nurses, understanding the development of nursing as a profession seemed to be crucial. Though, tracing the development of nursing in the post-colonial scenario, in another country, Shula Marks' (1994) work, helps in understanding the trajectories of nursing profession in post-colonial India. Her work on the

[9] For further reference one can look into the work done by Chang et al. (2020); Leiblfinger et al. (2020); Samaddar (2020); Billings et al. (2021); Wenham et al. (2021); Basu and Basu (2022); Bismark et al. (2022).

nursing profession in South Africa, can help one understand the development of nursing in India and South Africa. She had highlighted that, nurses mediated more than doctors, when it came to directly dealing with western biomedical services. As also in India (as has been discussed by Healey), nursing in South Africa had to go through struggles to establish itself as a profession and such struggles could not exclude the influence of race, gender, socio-economic realities. Nurses had to fight for their place in medical councils and within the medical profession. Nurses thus, had to fight on one hand with male health professionals and health attendants who were low class Afrikaner women, within the nursing profession. This might seem similar to experiences shared in the chapter on nurses. Marks further pointed that adopting white nursing values also created a divide between black nurses and between them and the poor patients they served. The idea of 'divide' as expressed in her work, has acted as an important tool in analysing the divide between various categories of healthcare workers in an institutional set up, who otherwise have a united role in improving the conditions of a patient. Second, how does this idea of 'divide' affect or shape the interaction between the trained nurses on one hand and poor people in government hospitals.

Using 'multidisciplinary and international range of perspectives' (1), based on case studies from India, USA, Germany, Philippines, England, South Africa and Australia, the edited volume by Rafferty, Robinson and Elkan (1997) tries to bring the various experiences through which nursing profession had to pass, at different times and under various regimes, together in one book. From obedient German nurses following Nazi health policies to the racist practice of appointment of white nurses in South Africa which started in the late 18th century, from the problem of abundance of skilled nurses detached from the needs of the indigenous people in Philippines to political debates surrounding the nursing profession, this book is important in building an idea of the development of the nursing profession in various parts of the world. One chapter, in particular, in this volume provided important insight for the current research as it deals with female medical missions in India who offered care specifically for the women (Fitzgerald 1997). It argues how scientific changes that took place in the medical field and the agenda of the missions seemed to be compatible to one another.

Further, Rafferty (2005), highlights the struggle of nurses against the prevalent image during Victorian era of them being husband hunters and seductress, the image that was also sustained through fictional literature of that period. Due to such portrayal, it was thought that nurses needed supervision and controlling, which led to reforming the image of nurses as the epitome of 'Christian piety and virtue.' The civilising mission for such reformed nurses, was to spread

such virtues to the colonies, they were recruited to serve in. This work helps to look at nurses arriving in several colonies as part of the colonising project. It also looks at the quest of such nurses to work autonomously in a new setting, which would pose challenges to them, the autonomy which they had lost in their home countries (6-8). This search for autonomy within the medical profession is a constant one, something the chapter on nurses would later reveal.

Another binary concept associated with carework is the notion of clean/unclean, hence, it is closely linked to the current research. The dual concepts of clean-unclean/ sacred-profane are also crucial to our understanding of carework. A diseased body is normally not associated with the idea of clean and lot of stigmas is also associated with it. For instance, a person infected with HIV faces stigma or COVID patients and careworkers during the pandemic had to face stigma, because of the notion of clean and unclean. Working in close proximity with someone's bodily fluids is generally considered to be unclean jobs. In Indian context, religion, coupled with patriarchy, has labelled certain types of work (mostly manual) as menial and therefore dirty and thus are meant to be carried out by members from the 'low-caste.' It is important to mention here that the two categories of women careworkers (who are the focus of this research) – *ayah*s and nurses – though both associated with carework, are also positioned in a hierarchy.

1.4 The Indian Scenario:

Though the very ideas of health equity and distributive justice were re-invoked in COVID-19 crisis (Galiatsatos, Kachalia et.al. 2020; Oliver M. Fisher et.al 2020; Jean-Louis Vincent and Jacques Creteur 2020) but for a resource scarce country like India, ideally speaking, these ideas are applicable forever. Gross inequalities in health, is a reality not only between developed and developing countries, with better indicators of overall health being naturally present in richer countries (Marmot 2006), but also within a developing country like India. Hence, policy assessments and policy decisions must be made based on a thorough understanding that a myriad of such inequities lead to health inequalities (or health inequities), exacerbated by hierarchical social structuring and processes of social stratification that are results of unfair social, economic and political practices, which in turn affect *access* to healthcare. The social determinants movement in understanding health equities has been gaining popularity as a response to neoliberal market-oriented policy reforms, which has led to wider chasms both within and beyond nations (De Vogli 2011).

1.4.1 Different types of welfarism:

Welfarism in various states of India is shaped by regional politics and public spending which is linked with elections. Similarly, a decline in welfare activities is seen to be linked with weak organization of labour. Within India, there is a belief that leftist regimes (as present in Kerala under the LDF Government, or earlier in West Bengal under the Left-Front rule), are more inclined to social democratic values. Thus, the perception was that policy making in these states were aimed at the betterment of the lower classes. According to Atul Kohli, this is an ideal type; and to others, it is sort of an exception in the wider Indian context. Kohli also categorizes states into *neo-patrimonial regimes* where there is lack of vision when it comes to public welfare and the regime is characterised by patron-clientele relations, meaning those who do not support the government might be excluded from benefits, as it happened in Uttar Pradesh and Bihar. On the other hand, in *developmental regimes*, governments work closely with business to usher in private sector led economic development, as it has happened in Gujarat, Maharashtra, Karnataka, Andhra Pradesh, Punjab or Haryana. The latter category has mixed results when it comes to poverty reduction (Kohli 2012, 146-155).

Based on several categorizations, Tillin et al identify *six broad subnational regimes* under two clusters of consistent performers of welfarism and less consistent performers of welfarism. The first cluster comprises, "social democratic" regimes; then there are the "competitive populist regimes" like in Andhra Pradesh and Tamil Nadu. Here they are influenced by John Harris, who states that both these states, having populist regimes have a welfare agenda that has helped them fight poverty better than expected. In these states, there is policy continuity despite change in political regimes. Chhattisgarh and Odisha are categorized as "incorporationist" regimes where a small section of socio-economic elite dominates, while the lower classes/castes are weakly organised. However, there are social protection programmes for the poor. In a few states in this cluster, one might witness protected or guaranteed 'public provisioning of social services' like the presence of 'public hospitals under health insurance schemes in Kerala and Tamil Nadu' (Louise Tillin 2015, 17-18).

In the second cluster, we find "pro-business states," where welfare policies are not well articulated and social sector spending is not high either, though economic growth can be noticed as in the case of Gujarat. In the "competitive clientelist regimes," we find a struggle for power between competing political parties that both strive to attain power by winning the support of the lower castes. Here we find a lack of policy stability across regimes; and the

services are given for the targeted groups than for universal beneficiaries. Uttar Pradesh and Bihar are examples. The last category of states has been referred to as "predatory states." These are states having abundant supply of natural resources like Jharkhand, where clientelism is promoted due to personalization of power (Tillin et. al 2015, 19). While talking of healthcare in West Bengal of the recent times since 2011, it would be pertinent to keep the categorizations of both "social democratic" and "populist" regimes in mind.

Prasad (2018) opines that political elites in India anyway wanted to opt for selective healthcare provisioning and when they received funding from international agencies, it became easier for them to justify such a shift (8). Scholars working on healthcare in India, have expressed concerns about the 'syndicate of rich countries' that have been mobilising resources through institutions like WHO, UNICEF etc. have been lobbying for the provision of selective healthcare since 1979. This got strengthened after the liberalisation of the economy, but despite spending a lot of money, internationally sponsored vertical designs have had limited success in India (Banerji 2009,808).

1.4.2 Welfarism and Healthcare Policies in Neoliberal Times:

Welfare might be linked with the idea of distributive justice, but planning in India did not serve 'redistributive ethos,' as the distribution of resources, benefits, necessary for socio-economic growth was never made egalitarian. Perhaps that is why, the implementation of 'health for all' programme has been deferred many times (Prabhu and Sudarshan 2002, 4-5). Leena V. Gangolli, Ravi Duggal and Abhay Shukla (2005), in their work on healthcare policies of India, had hailed the 1980s as the golden days of public health, and labelled the '90s as the days of retreat. While beginning with health system in general and then moving on to specific health programmes undertaken by various governments, they had situated healthcare system within the larger issues of development. That decentralization in most cases means delegation of duties and not devolution of powers has been rightly flagged by the authors. Further, they have highlighted that the pauperization of the general public due to the out-of-pocket system has been the result of government's inability to resist pressure from international financial institutions. The authors argue that respective governments have failed to build an effective health system, through effective policies. This, clubbed with the absence of policies regulating the private sector have been highlighted as problems plaguing healthcare in India.

Though many health programmes were state driven, and the state remained an important financer of health in India, private players in health had existed since colonial times (Bagchi

2010). Even when the presence of big private hospitals was an unthinkable phenomenon in mofussil towns, there still existed a market for private practitioners, which in rural areas comprised informal medical practitioners (Das et al. 2016). With the liberalization of the Indian economy in 1990s, there was a decline in expenditure in various welfare schemes and private players in the market increased manifold (Bagchi 2010). So, since 1990s, be it providing food subsidies or healthcare benefits, government programmes aimed at benefitting targeted population only.

Needless to say, the process of privatisation in healthcare clubbed with the effects of globalization has increased healthcare inequalities. While addressing the issues of equity and access in healthcare, Purendra Prasad and Amar Jesani (2018), opined that corporatisation of healthcare has been facilitated by the market where accumulation and profit maximisation are the main driving force and where patients are increasingly being perceived as consumers (3). The above authors contend that social inequity is a form of injustice which can be avoided if proper access to goods, services, benefits, and opportunities can be ensured. Labelling the current health system as a medical-industrial complex, authors argue that even commercialisation of education has affected standard of medical training, coupled with increase in specialised trainings, healthcare at primary and secondary levels have been impacted badly. Inequity in healthcare has also increased manifold with the shift from comprehensive to selective primary healthcare. Thus, according to a host of scholars, a market-driven approach cannot be propagated for a country like India which is fraught with multivariate levels of inequality (Nandaraj et al. 2001; Qadeer, Saxena, Arathi 2020).

While the rural and urban poor, the displaced persons, tribal people and nomads have limited access to healthcare, it was found that the rise of health insurance market has further commodified health services which further affected their access to healthcare. Thus, Debabar Banerjee wanted Indian policymakers to delegating important healthcare roles to AYUSH (Ayurveda, Unani, Siddha and Homeopathy) practitioners, through policies, in order to meet the scarcity of practitioners of biomedicine to be an appropriate move (Banerjee 2004). Further the actions of political elites in metropolitan cities, like courting private investors, in order to make urban spaces more aesthetically beautiful (MacLeod and Ward 2002: 155) also increases gap between not only rural and urban spaces but also within urban spaces. Thus, within cities there are well developed spaces, having state of the art, world class hospitals coexisting with zones of underdevelopment.

From dilution of patent laws in India to the problem of introduction of user fees in government facilities; from healthcare of disabled persons to health of sex workers, equity and access to healthcare in India has been seriously compromised (Prasad and Jesani 2018, *passim*). Further, the triad of liberalisation, privatization and globalisation has had negative impacts on the poor, especially on poor women (C. Sathyamala 2005). The over-use or dependence on medical procedures like caesarean sections, hysterectomies by upper middle-class women and the inability to access similar services by poor women, in current times, leads to stratification in healthcare service delivery.

Again, with the onset of neoliberalism, structural gender inequalities have increased, leading to feminization of poverty, exploitation of labour (CWDS 2000, Bergeron 2001) and the state by not introducing welfare policies is facilitating 'finance capitalism,' 'technological intensiveness,' and 'jobless growth' (Agarwala 2018: 243). Capitalism had succeeded in making activities or duties performed by women in their homes, which were seen as an extension of their feminine nature and hence formed part of unpaid work, marketable.

Despite economic reforms which underscore the importance of transparency, corruption in policy making in India continues as the government's discretionary rights over resource distribution in many areas have not been eliminated by economic liberalisation (Sridharan 2014, 2). Samiran Nundy, Sanjay Nagral and Keshav Desiraju (2018), highlight that various decision-making process with regard to healthcare, is mostly done, without public scrutiny or without the involvement of various stakeholders and are not 'based on context-specific scientific research' (26). There has also been a 'shift of allocations from general health services to techno-centric programmes' (17) which has increased malpractices since the 1990s. \Further, what comes to the fore is the realization that when a healthcare system that gives care is replaced by a system that sells care, provided by both public and private institutions, in order to access state healthcare (subsidised), people get entwined with various facets of corruption (373, xix), which affects their ability to access healthcare.

The inability of policies to ensure effective healthcare delivery in India has been addressed by K. Sujatha Rao (2017). She states that India's health system can be best understood as a system of 'paradox,' wherein big hospitals providing "world class" treatment has given rise to medical tourism, on the other hand, malnutrition, Japanese encephalitis, tuberculosis and malaria continue to claim lives, even that of children. Using her experience as a senior bureaucrat, the author has brought to fore stories of both success and failure of various health initiatives and

has declared that health has been neglected in both Nehruvian and post-liberalization times. Her suggestion has been an increase in public spending and increase in accountability. She also underscores the disconnect between the planners, who are seated in Delhi and the ground reality, where healthcare workers are trying to transform their plans into reality.

Major academic work in India on healthcare have critically dealt with policies, financing, management, the role of indigenous or informal medical practitioners, among other things in neo-liberal times and provide important insights. However, the works by Banerji (1992;2004;2009), Gangolli, Duggal and Saxena (2005) or Rao (2017) fail to treat healthcare workers as agents or social beings, who have an existence beyond government policies or other government programmes. Apart from one ethnographic study on Community Health Workers (Prasad and Jesani [2018]), attention to problems and realities of healthcare workers has either been sparse or biased in favour of doctors. Nundy, Nagral and Desiraju (2018), even when highlighting on the success stories of various institutions in delivering healthcare based on equity, did not specifically focus on healthcare workers. Even when Qadeer, Saxena and Arathi (2021), call out that when it comes to healthcare, doctors function as specialists, dominating the health sector, they suggest giving primacy to new professionals (71). But to what extent a profession like nursing, which is dominated by women, would be allowed to play a dominant role in healthcare, is a question worth asking.

Feminists are as such critical of the decision-making process in general, because they argue that the world of decision making or policy making is not gender neutral and hence decisions regarding increasing or decreasing government spending in various programmes or schemes related to healthcare is also not gender neutral. They have also criticised the neoliberal healthcare policies through their work, documenting how policies that give primacy to market over people, affect women. They see the World Bank Programme of Health Sector Reforms as part of neoliberal global health reform, which included changes in the managerial, financial and service delivery fronts. Reduction in state spending implied a tilt towards privatisation. They have argued that privatisation implied that few number of women, especially poor women would access paid healthcare services and would rather save that money to access healthcare for children or other family members (Desai 2004, 39).

Further, it is pertinent to mention here that with an increase in privatisation and reduction in government spending, India has witnessed a rise in **populist policies** overtime. Though one can trace populist policies since the 1960s, a time that had witnessed the rise of peasant

populism, based on the creation of a divide between rural poor population and rich urban residents, but one can concur that they were more rights-based (Basu 2019, 3). In the recent times, when the scheme of Rajiv Arogyashri was rolled out in Andhra Pradesh (undivided) in 2007, it set the ball of populist tendencies in healthcare, rolling (Bhaduri 2022). Modi's election as the Prime Minister was based on right-wing populism steeped in the politics of dignity and self-respect, which got manifested through various schemes like *Jan Dhan Yojna* (People's Wealth Scheme), *Swachh Bharat Abhiyan* (Clean India Mission), *Ayushman Bharat* (National Health Protection Scheme) and so forth (Jaffrelot 2022, 217-221). In West Bengal various schemes rolled out after the coming of Mamata Banerjee led Trinamool Government in 2011, like *Kanyashree* (scheme providing stipends to female students), Sabuj Sathi (green-vehicle scheme providing bicycles to students in class 9-11), Swasthya Sathi (Health Insurance scheme) and so on will fall under populist schemes. However, populism in West Bengal would be different from that of Modi's, as the former is influenced by the 'legacy' of the Left which had governed the state for over three decades before Mamata Banerjee's TMC coming to power (Basu 2019).

1.4.3 The case of careworkers:

It is important to reiterate that no discussion on healthcare or healthcare policies in neoliberal times is complete without any mention to healthcare workers and addressing the issue of migration of healthcare workers, something that would be addressed time and again in this work. Neoliberal policies in a globalised world results in the flow of labour and services from the under-developed zones to the developed cores of a country and also in the world, which is also a reality for healthcare workers (Hardt 1999; Reddy 2015; Basu 2018). Since an important part of the present research is concerned with careworkers like nurses and *ayahs*, it is pertinent to mention that, though we find a lot of writings on healthcare policy, work on healthcare workers like nurses and *ayah*s, currently working in the health sector is still less in number. Further, the very idea of 'care' is a concern for feminists because of the gendered aspect attributed to it. Though care or the act of caring is as old as human civilization, commodification of care is a recent development.

When it comes to understanding the development of healthcare workers like nurses, in the Indian context, reference needs to be made to the volume by Trained Nurses Association of India (hereafter TNAI, 2001). The volume is an important document, worth reviewing as it tries to weave together the past and present of the nursing profession in India. This volume

traces the development of nursing profession in India and sensitises the readers regarding the negotiations that has taken place between the government and the nursing body (both prior and post, independence) to improve overall healthcare delivery and the profession of nursing in India. The voices of the nurses, their relationship with the government is reflected in this volume by TNAI. The issue of lack of leadership roles in healthcare has also been highlighted here. This discontent has been echoed by various respondents in the present study.

'Formal scholarship on the subject of Indian health providers is also limited…the policy literature, dominated by economists and development scientists, tends to view health providers as little more than resources or instruments to be manipulated in the fulfilment of policy objectives,' (Sheikh and George 2010,2). Sheikh and George in their edited volume, sets out to fill the above-mentioned gap and focuses on healthcare workers like ANMs (Auxiliary Nurse Midwife) playing important role in improving rural healthcare, HIV counsellors, doctors lacking in commitment to social welfare, traditional providers, faith healers, role of family care givers etc. The role of private practitioners in public health initiatives, the problem of decision making by doctors, movements organized by the medical community, efforts by NGOs at training male multi-purpose workers and the issue of sexual harassment experienced by healthcare workers try to take the readers' attention beyond policy documents to understand the ground level reality. This volume proves to be interesting because it addresses healthcare workers like rural health assistants as 'social beings,' thus not limiting discussions to policy documents. Though ANM and ASHA workers find place in this volume, not enough attention is given to other categories of nurses. Further, even when family care (for HIV patients) has been highlighted, the role of paid informal healthcare providers for other types of patients is absent.

Further, Madeline Healey's monograph (2014), dealing with the history of nursing covering a period from 1907 and 2007, is an important work that can never be overlooked while working on healthcare and nurses. While modern medicine was developing in South Asia, India was gradually becoming an exporter of medical professionals including nurses. Narratives collected from nurses set the tone of the chapters dealing with the emergence of modern nursing within the sociocultural realities of both colonial and post-colonial India. The strive to attain the status of a respectable profession, the negotiations with the state and the role of foreign aid and its impact on nursing, have all been well documented by the author. Focusing mainly on the TNAI, this work tries to look into the development of nursing organizations. Highlighting on the failure of TNAI and the rise of trade-union like activism, Healey also pointed how nurse as an

active agent had earlier disappeared from the policy documents to make a reappearance in policy discussions since 1987 (192) when a wave of unrest engulfed Delhi. This happened after the recommendations of the Fourth Pay Commission were not implemented. It had suggested revision of pay scales, increasing food and uniform allowance for the nurses among other things. Since this work covers a long period of time, it manages to critically look at the impact of migration on the profession in India. Healey points out that the medical tourism industry in India is thriving because of the nursing care and state recognition for India to become a world class supplier of nurses, has led to new thrust in training of nurses (237). She concludes with, 'the deep-seated reluctance…to take women's work seriously must be confronted courageously' (305). It is on this line that the present study hopes to expand.

Needless to say, no work on nurses or *ayah*s can evade the question of migration today, more than ever. Highlighting on nurse migration from India to the United States of America, Sujani K. Reddy (2015) interrogates the link between Indian nursing leadership and a global medical market, which is centred on USA. She opined that Rockefeller's role in improving public health in India was an extension of 'imperialism without colonization,' which necessitated the creation of new markets for capital growth and inclusion of national/local actors through 'imperial networks' (9). Further, the involvement of US mission in mofussil towns, where the British government were yet to reach out with healthcare services, was an attempt to shift dependence in favour of USA based mission (Protestant missionaries), under whose patronage medical care was extended to Indians, during colonial times (24). This saw more women from low caste and class getting converted and some ending up working as first assistants in several medical missions that initiated the rise of a group of women workers (45-47). She also probed how the above link affected the nature of women's work, women workers and what led to a 'diaspora of decolonization', which was marked by 'migration in the pursuit of professionalization', which was laced with the notion of choice as opposed to the feeling of compulsion which was present for earlier batch of migrants, like the indentured labour from South Asia (11; 128-129). Further, when the 'Third World' became the new source of migration, women started replacing men as sought after 'migrant labour' (200). This shift is crucial in analysing the circulation of nurses not only within but globally. Narratives of migrant nurses also revealed that migration opportunities changed the status of not only Indian nurses but also their relatives as it brought along new opportunities, freeing them from traditional familial and social structures, providing them with an agency.

Another work, worth mentioning in this regard is by Marie Percot (2005). Based on field work in Oman and Emirate and Kerala, she has brought to the fore the stories of Kerala diaspora in the Gulf countries. She highlighted the role of English as a medium of instruction in several private schools in Kerala, which help in preparing nurses from this state to deliver healthcare services at the global stage. This also helps them in scoring well in their TOEFL (Test of English as a Foreign Language) and CGFNS (Commission of Graduates of Foreign Nursing Schools) tests, both of which are required for migrating into an English-speaking country and America, respectively. Her work also explored the role of contractors acting as mediators between the administration/ employer and the employees.

As already discussed earlier, the stratification of the market after liberalisation of the Indian economy into formal and informal sectors demands a brief discussion. An important aspect associated with careworkers in the informal sector is the aspect of 'mushrooming' of nurse/*ayah* centres in several prominent cities of West Bengal, with Kolkata in the lead. Various scholars, activists working on healthcare in India, has used the word and the present researcher has also consciously used this word ('mushrooming') to indicate the phenomenon where countless centres have come up and are operating without any major form of supervision from the authorities. They also operate in grey areas or in liminality. Once they come under the radar of local authorities, they shut the centres if they were operating 'illegally.' Or, in other cases, if they had successfully come to an agreement (by paying off police and other local authorities) then they continue operating, or, else they shut doors and start operating in a new place under a new name. This phenomenon can be compared to the concept of 'rhizome' as used by Deleuze and Guattari. In their words, '…principal root has aborted, or its tip has been destroyed; an immediate, indefinite multiplicity of secondary roots grafts onto it and undergoes a flourishing development' (Deleuze and Guattari 1987, 5). A rhizome is a subterranean stem, present in certain plants, which the authors have contrasted with a conventional plant root. They have also argued that some animals that live in packs like rats, can be considered rhizomatic. They write,

> A rhizome ceaselessly establishes connections between semiotic chains, organizations of power, and circumstances relative to the arts, sciences, and social struggles. A semiotic chain is like a tuber agglomerating very diverse acts, not only linguistic, but also perceptive, mimetic, gestural, and cognitive… (7)

Increasingly in India, the line differentiating formal from the informal is getting blurred following contractualisation of permanent workers working in formal organisations. Such a blurring of boundaries has also affected careworkers working in government sector. For instance, in sub-centres in West Bengal ANMII nurses are all appointed on a contractual basis along with and ANM1 nurse who is a permanent staff. One can find the presence of various categories of careworkers, availing different sets of benefits, securities etc., something that has been explored later in this work. This division between formal and informal also reinforces the notions of clean/unclean associated with carework.

Ideas of pollution might mirror social order and hierarchy; hence it affects how carework is perceived. For instance, David Arnold's book, *Colonizing the Body*, begins with the story of an untouchable Dom, someone who works with dead human bodies and has an unsophisticated knowledge of human anatomy. In most of the morgues of Indian hospitals, the men from 'lower' castes (like Doms) dissect the dead bodies, takes out the parts of the body for forensic investigation, and later prepare the body (by stitching) for the relatives/friends of the dead. Yet, they are never considered as 'specialists' rather they are generally seen with disrespect for their so called 'lowly' jobs. This 'derecognition' also happens in case of women and traditional careworkers (like *dai* or traditional healers) by the hegemonic western system of medicine and hospitals. This has also been highlighted in Sujata Mukherjee's important work (2012).

Further, in neoliberal times, Henrike Donner's work (2008), highlights that the concept of clean/unclean might affect the choice of the mode of birthing. In her work she has revealed, 'Caesareans represent the mode of birth for *bhadramahila*' (115) as the blood lost during childbirth is considered to be equally polluting and thereby shameful and thus, should be best avoided. Through her interaction with upper middle-class respondents, she highlighted the general perception that C section makes patients weak, and the baby thus, cannot be breast fed but bottle fed (115-117). These narratives, make the presence of careworkers in the form of *ayah*s, in middle-class homes imperative.

Since the present work revolves round West Bengal, an understanding of the evolution of carework by women in colonial Bengal was important, in understanding about the socio-cultural, political and economic landscape in which carework has developed, here. Ambalika Guha (2018) notes that there was a link between colonial government's attempts at sanitising intimate or private yet natural processes of women like birthing, with attempts at institutionalising female careworkers like midwives or traditionally known as *dais*. She traces

how in colonial Bengal, midwifery as an academic subject and an integral part of medical discipline emerged and how traditional female caregivers, *dais* and others were excluded. The very process of institutionalisation got active support from the middle-class Bengali *bhadraloks.* She further notes that with the development of print media, *bhadramahilas* were even conditioned through vernacular journals, texts on becoming an ideal housewife etc, which meant adopting scientific medical practices as opposed to traditional knowledge-based practices that they were earlier used to.

Amrita Bagchi's (2010, 2023) work on the changing patterns of private healthcare sector since independence has helped the present research. Despite a lack in recorded history, which makes making an exact estimate in time for the beginning of private healthcare sector difficult, she tries to trace the evolution of this sector in Kolkata. She also unveiled who owned those private institutions, how were they run, what was the profile of their clientele etc. With the rise of big corporate hospitals, she observes that a shift in healthcare from service to a commodity has taken place, which made this sector lucrative for-profit earning. While Bagchi focussed on the development of the private healthcare sector in Kolkata, Panchali Ray (2014; 2019) has explored the inter-linkage of gendered subjects and the healthcare industry in contemporary Kolkata. She concurs that due to the rise of several ranks in the nursing profession, it is no longer a homogenous profession (2019, 3). While investigating their presence in archival records, she pointed at the absence of nurses in pre/colonial time's records. While women's workforce participation has declined, however, their employment in the myriad service sector has increased considerably. Resorting to archival materials and ethnography, she has tried exploring the power dynamics that determine and to some extent construct her work not only in her workplace but also in their private spaces, their households. Thus, while addressing the issue of stigma, how family's honour and shame determine nurses work has also been looked into (Ray 2019, 28;116). However, both the works have been restricted to probing care in the institutional set up only.

Academic work on *ayah*s is almost non-existent. Mandar Mukhopadhyay's work (2017; in Bengali) has tried documenting the lives and works of *ayah*s, in her household while they were offering care for her mother, who was suffering from Alzheimer's. Her work explores the relationship of *ayah*s with the employer (herself), the patient and the permanent household domestic workers and raises questions like, who takes care of the child while she is working in someone's home or what is the relation between various Non-governmental Organisations (NGOs) doing social work in the city and various placement centres that recruit women from

poor socio-economic backgrounds, role of local political party in mitigating disputes between centres, *ayah*s and clients etc. Her work is written in the form of a diary and the author uses the style of first-person narrative, implying that the observations in this work are made from the perspective of the employer.

Further, while talking about carework in West Bengal, it is pertinent to mention that after independence, a considerable body of 'working-class' histories were written. These endeavours were dominated by concerns of modernisation, national politics and working-class consciousness. Little attention was paid to questions of gender (Sen 2008). Since 1950s, various care-giving courses were introduced for Bengali women in the post-partition period, which though made them part of the working class, but still they were separated from the rest because of the place of their work, which was in hotels, homes of rich people or in other words, in the "private sphere" (Sengupta 2018). The present study has tried to explore as to how one set of careworkers, situated in a particular plane, in a hierarchical set up, interact with others in lower planes.

Before concluding, it seems pertinent to mention here that several academic/research works pertaining to West Bengal have been published. They have investigated the role of the communist party, its role in agrarian reforms (Operation Barga and its aftermath), its ability to decentralize power through Panchayati Raj Institutions (PRIs), its hegemonic ability to percolate social spaces etc. (Franda 1971; Mallick 1993; Chatterjee 1997; Samaddar 2013; Bhattacharya 2016; Chatterjee and Basu 2020) and all of them barring a few (Chatterji and Basu 2020), have addressed the issue of healthcare in passing. Needless to say, careworkers too, just like healthcare has not garnered attention. It also needs to be acknowledged that researching about careworkers like *ayahs,* in the informal sector, who also work in the domestic spaces of their clients runs the risk of getting mixed up due to similarities between duties performed by an *ayah* and a domestic help. However, this work would try to reveal that despite similarities there are glaring differences, which makes attempts at demarcating duties of a domestic help and an *ayah*, possible. Hence, the ideas of *servitude* (Ray and Qayum 2000) and *pragmatic intimacy* (Sen and Sengupta 2019), have been helpful to differentiate carework by domestic workers and by *ayah*s. Despite overlaps, the above ideas have helped me in teasing out carework of *ayahs* in domestic spaces.

The next section tries raising a few relevant questions for the present research and also throws a glimpse as to how the whole research was conceptualised and carried out.