Conclusion

This research has sought to explore how different regimes in India, both at the centre and at the sub-national level in West Bengal, have framed healthcare policies across time, between 1991 and 2015. It has further explored how healthcare has been delivered through healthcare workers like nurses and *ayahs*, who are often slighted/ignored. In doing so, it has engaged with discussions on healthcare policies in India, healthcare policies in West Bengal, the role of careworkers like nurses and *ayahs* and how all of the above can be understood conceptually. Some of the key findings have been discussed below.

When India got independence, it not only became a democracy but it also adopted the ideals of a welfare state. The Preamble to the Indian Constitution expresses its commitment towards the attainment of a social order based on socio-economic and political justice (Robson 1954, 116). In India, healthcare as a primary good is intrinsically linked with the idea of welfare. Any variant of welfarism (including welfarism of populist regimes) at the subnational level in India needs to ensure good health for the people, if not for anything else, at least for the smooth governance. Since healthcare is crucial to the well-being of the people, it is intrinsically linked to democratic governance (a system of governance where, ideally speaking, the idea of 'people' is at the centre).

Recognising ill health and illiteracy to be important deterrents to a democracy like India, one might call for the distribution of these basic goods on 'non-market principles'. Since ill health and various other forms of social and economic un-freedoms coexist with civil and political freedoms, India comes out as a paradox (Neera Chandhoke 2009, 71- 72). It should be reiterated here that whatever be the system (nature of regime), healthcare delivery is planned through policies in every country. Let us briefly sum up what came out of our analysis of healthcare policies in India:

After ascertaining the fact that the newly independent, democratic republic of India, had adopted welfare principles which required providing the public good of healthcare to its people, the first problem that it had to face (and still continues to face), was/is the problem of ensuring *healthcare access to all*. Geographic locations of patients have an important role to play when it comes to accessing healthcare services. In India, people residing on the margins have limited access to healthcare (De Vise 1973; Shanon and Dever 1974). Hence, looking

into the healthcare access of the people residing on the ‘margins’, was an important step in this research. What became clear from the interviews conducted in the ‘margins’ , is the fact that the vulnerabilities clubbed with the geographic locations of the residents of these areas, hide them from the purview of healthcare delivery from both the private and public sectors, thus raising the question as to how justice with regard to healthcare delivery is realised in the margins.

Another factor seen to be influencing access was the general *perception* of people seeking services (Anderson and Newman 2005). During research, especially during field work, I came to realise that perception also dictates who would access private or public healthcare delivery services. For instance, middle-class people might view subsidized or almost free healthcare services to be less reliant or to be of inferior quality, as became evident on the chapter on West Bengal. Further, the nature of *delivery system* involving how resources are distributed across regions, across departments, how the organization is set up etc. are necessary considerations as well (Anderson and Newman 2005, 212). Again, in the Indian context *fear of debts/indebtedness*, leads to unwillingness to seek care at an institution which also hinders access (*Tribune India* November 26, 2019).

The above problem of healthcare access was attempted to be addressed through several policies since independence. Be it the Bhore Committee Report or National Health Policy 2017 or others, several documents have tried to improve healthcare access in India. For instance, the Bhore Committee in its recommendations suggested that healthcare services should be situated nearer to the people, those that are to be served (Bhore Committee, vol 2, 17).

Despite limitations of healthcare policies in achieving their desired goals, it needs to be highlighted that before liberalisation, India had manged to improve life expectancy, child and maternal health since the time of independence. Through the launch of several vertical programmes by successive governments, diseases like malaria, tuberculosis, could be checked substantially. India’s persistent thrust on training of various cadres of healthcare workers (though at times seemed to be overlapping), needs to be applauded (Panda 2022).

However, after liberalization of India’s economy, a shift from ‘universal’ to ‘selective’ healthcare is observed, due to rolling back of state funding which affected this access. However, access to some is an ambiguous term and is more of a 'political than operational

idea', as how policies are framed and how access is defined in them, seems to be more important., (Aday and Anderson 1974, 208).

While analysing healthcare policies in the Indian context, one cannot ignore the fact that there exists a gap in terms of how policies are planned and conceptualized and how are they executed. The gaps could have stemmed from epistemic problems like lack of consensus or absence of clear idea on matters regarding the role of say indigenous practitioners, with different committees giving different judgements to now, where IMPs in rural areas are somewhat mainstreamed. But these epistemic problems overtime took the form of organisational problems as well. For instance, several plans reiterated, the need to restructure policies to cater to the increasing demands of healthcare, especially for the poor (target based). However, the need to have a decentralized system to deliver services like public healthcare, makes the works of disease control and prevention more 'fragmented and disease –specific rather than comprehensive'. Again, the programmes are vertically structured for separate diseases and in reality, the 'vertical programmes are technology-centric and work in isolation of each other' (Banerji 1985, 142). So, the plan to decentralise healthcare delivery, unintentionally gave rise to fragmented efforts at disease control.

Despite the government spending 1-3 percentage of the total expenditure on health in India, several donor agencies greatly influence health policies and continues to alter the goals of the government. Governments in turn without addressing more pressing concerns, divert attention and focus to programmes for which such donor agencies are paying (Mishra et al. 2003; Baru and Jessani 2000). These compromises have been affecting the framing and execution of policies in India (Gupta and Gumber 2002) and also impacted healthcare access. However, since the very beginning, India had to struggle with lack of funds and apparently, *no other factor* had 'affected the policy and governance in the health sector so much as the external influence exercised by the aid and lending (donor) agencies', (Saxena 2010, 97).

For instance, before the nineties, the focus was on dealing with malaria and leprosy, then the thrust was on family planning, immunization etc., and now in post reform period, there was lot of funding to keep the spread of HIV/AIDs under control (Saxena 2010, 98). Since the nineties, the World Bank has come up as an important donor for developing countries as a part of the Structural Adjustment Programmes, a move that was severely criticized by UNICEF, WHO and NORAD, whereby it (World Bank) allowed "selective state intervention", in the health sector. The discussions between health policy experts and the team

from World Bank that led to the World Bank report, *India: Health Sector Financing* was not devoid of controversy as it was claimed that many of the participants, did not have sound knowledge or understanding of political, social or economic realities governing health in India nor were they aware of the basic literature related to 'growth and development of public health practice in India', (Banerji 1993, 1207).

Though gradual changes were introduced with liberalization of the Indian economy, however in 2000, Foreign Direct Investment (FDI) in hospitals was made possible. In order to make healthcare accessible and affordable, private healthcare was strategically pushed to fulfil the unmet demands of public healthcare institutions (NHP 2017). Further with the introduction of third-party administrators in case of insurance, the private and corporate hospitals benefitted a lot. The rise of private sector also led the state propagating for an increase in *Public-private partnerships (PPP)* in the health sector which resulted in the outsourcing of sanitary and other services, handing over PHCs to private organizations etc. (Baru 2016; Prasad 2018). However, the involvement of non-profit private sector in providing healthcare in the interior parts where government provisioning of healthcare is absent in not only West Bengal, but the whole of India, is worth appreciating. But in case of for-profit private sector, the collaboration is not always fruitful because the intention or focus of the government and private sectors might not be the same (Roy 2017).

Reliance on the private sector for healthcare delivery can also stem from the problem of shortage of healthcare workers, an important component in the delivery of healthcare services and also impacting healthcare access. The concern for the dearth of healthcare workers have also been resonated in several policy documents. Both the volumes of Bhore Committee, talked of the shortage of healthcare personnel[1]. Several five-year plans and other policy documents along with various studies done on health personnel by different international organisations highlight the shortage of health personnel in India. In the first decade of the twenty first century, in India, the aggregate density of doctors, nurses and midwives totalled to 2.08 per 1000 population, which fell short of WHO's critical shortage threshold of 2.28 (WHO 2016).

[1] In order to successfully implement the recommendations of the Bhore Committee, the total number of doctors required was 2,33,650, that of nurses including public health nurses was 6,80,000 while only 47,500 doctors and 7750 nurses including health visitors were present. In case of midwives the number was 5000, while the required number was 112500, for pharmacists it was 75, and the required number was 84375 (Bhore 1946, vol 2,31).

Politics and Policies in West Bengal:

As is evident from the present research, healthcare delivery is characterised by myriad forms of inequalities. The rural-urban divide, unequal availabilities of healthcare facilities in the interior parts of West Bengal, the hierarchical body of healthcare workers, the formal-informal or regular-contractual divide all reek of multiple layers of inequality. Since 1990s, there seems to be a tension between the ideology of the Left Front regime and compulsions of the government to make room for private players. For instance, while the government was courting private players to invest in the healthcare sector by setting up a 'medicity' in the state, which required huge tracts of land, it had faced resistance on ideological grounds from its alliance partners like Revolutionary Socialist Party (RSP), Forward Bloc and Communist Party of India (CPI), in its attempt to amend the West Bengal Land Reforms Act.[2]

Policies are turned into realities through the diligent activities of healthcare workers providing healthcare on a daily basis. However, most of the policy documents also give primacy to the providers of medical care – the doctors, over the ones providing care, like the nurses. In such a situation, it becomes imperative to reiterate what many of the interviewed nurses had stated: while doctors visit once or at the most twice (depending on the seriousness of the patient), time-time monitoring, looking after the diet of the patients, their basic hygiene or overall day to day, 'care' is the responsibility of the nurses. Apart from the apparent involvement of T. K. Adranvala[3], in the framing of a section on nursing, they are seldom involved in policy making process and in policy documents they got subsumed in the category of 'para-professional manpower' (Healey 2013, 229).

The Case of Careworkers:

From our reading of government documents, it becomes clear that the category of nurses working in the government sector featured in various documents whenever the issues of their total strength, training, shortages and so on got addressed. The issue of their salaries also got addressed through various government orders. But issues like poor housing facilities for nurses in rural areas, which prevent nurses from seeking promotion (as promotion would mean transfer) barely get addressed. Lack of facilities affect nurses posting in rural areas, which in turn affects access. However, for the nurses working in the private sector, there is an *absence*

[2] See https://www.livemint.com/Politics/ewQB4mSUycfULyKeByjgVJ/Bengal-rejects-Bill-that-would-have-allowed-private-buying-o.html. Last accessed 03.09.21; https://economictimes.indiatimes.com/hindujas-may-set-up-medicity-in-kolkata/articleshow/2752156.cms?from=mdr. Last accessed 25.08.20.

[3] She was the Chief Nursing Superintendent, Directorate General of Health Services, New Delhi, India.

of policies and the government fails to ensure standardised pay structure and ensure their welfare due to the contractual nature of their job. This highlights an aloofness or indifference on the part of the government.

Another thing that was addressed in this work is the presence of strong unions among the nurses working in the public sector and the relative absence of unions for nurses in the private sector and the stratification of the category of nurses. This might imply that the latter (nurses in private sector) are in a more vulnerable position, especially, when it comes to claiming of rights. Further, the division between regular, contractual, ANM and bedside nurses make claim-making, a difficult proposition. Having said this, it is imperative to mention that the mere presence of unions (platforms to resist and raise one's voice against exploitation and suppression) does not rule out small scale incidences of violence, oppression that takes place in their place of work on a daily basis. Which issues get co-opted to be highlighted, represented or articulated through unions also depend on the standing of the nurse in hierarchical set up of the institution, her political affiliations, and 'perceived' seriousness of a certain issue, and so on.

For instance, on one occasion, a respondent had narrated that she was subjected to derogatory comments made by a support staff. In this case, a male patient required X ray to be done, for post-surgery requirement and accordingly, a time-slot was arranged with the Radiology Department. However, on repeated summons, the support staff did not arrive with the wheelchair as a result of which the appointment could not be kept. When he had finally come, he had hurled casteist remarks (after some altercations) on the ward sister and the respondent nurse. His words were, *Jana ache apnara ki bhabe chakri peyechhen, oi toh quotar jol dhuye. Age hole amar paye hat diye khoma chaite hoto* (I know you got this job because of reservation of seats [the respondent nurse belonged to Other Backward Class A and the ward sister belong to Scheduled Caste category]. Had it been earlier days, you would have had to touch my feet and ask for forgiveness). This incident could not become an important agenda for the members of a certain union. A verbal apology from the male staff, in the presence of Deputy Nursing Superintendent is all that they received[4]. According to the respondent, such an event would never have occurred in case of a doctor as they are placed at the top of the hierarchical plane, thus leaving the nurses open to such harassment at work, by those placed below them, patient's party and others. Further, the instance of a junior doctor verbally abusing a senior nurse (as

[4] Interview conducted on 09.08.18 in Kolkata.

mentioned in the chapter of nurses) is also indicative of the range of everyday violence, that nurses have to negotiate with.

If the above is the case for careworkers like nurses, it goes without saying that the position of untrained careworkers like *ayahs* is nothing but precarious. As already mentioned earlier, policy documents do not address them at all. The structural inequalities existing in the labour market do not favour these untrained careworkers, who perform menial work in both institutional and private settings. The presence of numerous placement centres for *ayahs* suggests that the need for care in public settings has increased as nurses are burdened with a lot of managerial work, leaving them less time to provide overall care for the patient.

As is evident from the chapter on *ayahs*, one can find traces of 'servitude' influencing how the work of *ayahs* are perceived. It centres on the "rhetoric of love," which frequently brings together employers and employees while masking exploitation (Ray & Qayum, 2010). A similar argument is made by Sen and Sengupta (2016). They state that workers can occasionally use this to their advantage by attempting to form reciprocal, familial bonds that have significant material and intangible advantages, such as enhanced job security, advanced payment of salary, procuring loans from the employers and so on.

However, various attempts are being made to give a professional facelift through hiring of *ayah*s through various placement centres that requires intimation in local police stations, proper documentation (submission of Aadhar Cards and Voter Cards with the placement centres as well as local police stations, provision of identity cards by service agencies or placement centres, fixing a minimum duration of service provision by the *ayah*, prior to joining of work and so on. on. Despite such efforts, there continues to be an overlap with work done by *ayahs* and work done by domestic workers that takes away any chance from getting the work of these women, recognised as a profession. Manju Sarkel[5], a respondent *ayah* had stated that it is wrong to state that *ayah*s are not 'trained' as they have got training during their course of work. Just as a carpenter cannot develop an expertise without physically working on a block of wood, similarly *ayahs*, gather knowledge from caring about patients. Her argument was that if what the carpenters do can be regarded as a profession, even when they are not always educated, why is there a discrimination with regard to what the *ayahs* do.

[5] Interview based on 06.09.10 in Kolkata.

What also becomes evident from this research is that *ayahs* have been operating in the healthcare sector for a long time mostly in Kolkata and gradually they started operating in the private spaces in major towns like Burdwan, Siliguri and Durgapur. The spread of placement centres to these towns are relatively a new phenomenon. However, advertisements pertaining to placement centres have increased with time and this might be an indication of the rise of placement centres. This rise also warrants policy decisions with regard to regulating these centres.

After the liberalization of the Indian economy, one can see a shift from 'low-productive agriculture to relatively higher productivity in the manufacturing and service sectors' (Eggimann and Kendzia 2022, 4). Further, 'internationalisation of white collar' jobs has led to the rise of a 'business service sector' in India where Multi-National Corporations have started customer service operations, operating out of suburban areas of cities like Chennai, Bangalore, Pune, Kolkata and others (9). Further, with the rise of a professional middle class in India, various services like personal care, private healthcare providers and so forth would also be increasing (Beinhocker et al. 2007; Mukherjee 2013, 8). In West Bengal, the setting up of a service township (wherein professionals of the IT sector work as well as reside) especially in Rajarhat-Newtown area, has in turn led to the development of ancillary service sector comprising careworkers, security guards, washer-men and others. The rise of various placement centres for *ayahs* needs to be understood in this context.

Even though Kolkata had private hospitals like the age-old Woodlands, originally known as the East India Clinic, Belle Vue (1967), Calcutta Medical Research Institute (1969), Wockhardt (1988, now Fortis), and others, it was not until the middle of the 1990s, with the opening of private hospitals like Peerless Hospital, Ruby Hospital (1995), AMRI (1994), and some other state-of-the art private clinic facilities when an increase in investment in the private healthcare industry became noticeable. In addition, private investment in the healthcare sector has increased with the start of the new millennium and the opening of hospitals like Apollo Gleneagles, R.N. Tagore International Institute for Cardiac Treatment (RTIICS), Bhagirathi Neotia Woman and Child Care Centre, Desun and others (Basu 2018,114). With current hospitals increasing their bed capacity and establishing several units throughout the city, the pace of privatisation in healthcare has significantly increased[6]. For instance, previously, in

[6] See *Express Healthcare*, 'Kolkata: Nucleus of the East', July 2010 at, http://healthcare.financialexpress.com/201007/market01.shtml, accessed on 15 September 2016.

Rajarhat-Newtown area, there was no public hospital, only two primary health centres, one block health centre, one family welfare centre, one in each panchayat and municipal area had existed and the area had a poor vaccination history (Dey, Samaddar and Sen 2013, 123). But now one can also find several posh looking government urban health centres[7] several private hospitals, such as, Ohio Cardiology, Tata Medical Centre, Bhagirati Neotia Women and Child Care Centre and other private healthcare facilities, which have started operating in the area[8].

Healthcare is increasingly viewed as a commodity which needs to be purchased from the market and not get distributed as a public good. For those who cannot purchase healthcare from the market, like the poor sections of the population, government subsidies have been issued. However, the relatively richer sections are availing the subsidies intended for the relatively distraught class. (Selvaraj et al. 2021).

With the scaling up of operations in the private healthcare sector a dichotomy cannot be overlooked among careworkers: we see increasingly large numbers of skilled and trained women from all over India are migrating to big cities within India and also to abroad from the big city hospitals as workers in the hospitality industry and care industry. At the same time, another section of uneducated, unskilled women is migrating to the nearest big towns or cities, in search of a bare livelihood. Thus, in terms of circulation of careworkers, we discovered two types: for the more skilled and trained nurses, the big city (mostly private and especially in Kolkata) hospitals are like the 'transit points', from which there remains a possibility of *migration* to other countries (mostly to the West Asian or Western countries), while for the *ayahs*, Kolkata might be the destination. Even when they are working in industrial towns like Durgapur, they do aspire to work in Kolkata for a better pay and more opportunities. " *Kolkatay ke na kaj korte chaye bolo? Chhele- meye er o bhalo hobe.*[9]"(Who does not want to work in Kolkata? Working there would be good for my children.'). Being unskilled, these women do not have much bargaining power in the labour market. They end up working in the construction industry, household industries or the informal care industry, which is operative in private households or in certain cases in formal institutions like hospitals (both public and private) or

[7] Photos attached in the appendix
[8] Based on field work conducted in 2021 and data extracted from www.north24parganas.gov.in. Accessed on 15.6.20.
[9] Telephonic Interview on 25.05.20.

nursing homes. Since their names do not feature in the payroll or due to the absence of contracts or benefits, they get relegated to the position of workers in the 'unorganized sector'.

Limitations of the study:

Due to paucity of time and resources this work could not address the issues of various categories of careworkers who play crucial role in providing healthcare like the ASHA workers, working in the rural areas of West Bengal. Though ASHA *didis* have been mentioned while discussing healthcare provisioning in sub-centres and PHCs, however in this study not much attention could be given to their work. Similarly, more case studies could be done undertaken, but the above two factors acted as deterrents. The on-going pandemic too had severely restricted my access to the field. Since the period of study overlapped with the pandemic, this present study could have more engaged with discussions centring around the pandemic and careworkers, across subnational states as well as national boundaries.

Way Forward?

This research had tried to flag how healthcare provisioning cannot be properly understood, without addressing the issue of careworkers like nurses and *ayahs*. While one category (nurses), though 'present' in the policy documents, are not part of the policy making process, while, the other category of *ayahs*, are *absent* in policy documents. With the rise of private healthcare sector in West Bengal, the reality of circulation of labour also comes to the forefront. (Basu 2018). Based on the migration of *ayah*s from suburban areas to the urban slums, one can say that big cities are 'extracting something harder to measure, something that can very much look alike love' (Ehrenreich and Hochschild 2003,6).

The study of careworkers in both the government and private sectors also reveal that at present the story of careworkers is also the story of 'fragmentation', wherein newer hierarchies are taking shape. One can easily notice another change which is underway in the field of care is the entry of big corporate style placement centres or organizations like Portea Medical, India Home Health Care, C3 Home-healthcare and so on, which have tied up with big private hospitals[10]. These corporate-style placement centres have been operating in Kolkata for almost

[10] See http://www.indiahomehealthcare.com/, www.porteamedical.com, accessed on 2 December 2016.

a decade now. Increasingly, these companies are offering care or medical assistance in homes, or in-home healthcare services. The sick or those who have just been released from the hospital will have access to doctors, physiotherapists, and trained nurses through these companies. Organizations like *Deep Probeen Porisheba* (Deep Service Centre for the elderly) are enabling people from other locations to care for elderly or unwell parents of non-resident Indians. Field interviews revealed that such organisations handle everything, including admitting patients, assigning nurses to care for them (at home) and setting up routine check-ups. The management of such organisations project their respective facilities as distinct from low-grade *ayah*-centres operating out of garages in residential areas, or in shops of market areas. It was during the pandemic that even middle-class households sought out their services because there was a shortage of *ayahs* in several *ayah* centres due to the suspension of local trains, following lock down during COVID-19 pandemic. Only time can tell whether it would further stratify the market of the informal care providers, like the *ayahs*. Exploring further stratification among informal careworkers might provide scope for future research.

Further, based on the chapter on nurse, it becomes evident that the relative standing of nurses within the hierarchy of healthcare professionals has not changed considerably with time. Their relative absence from the policy making processes indicate a non-participatory, top-down model adopted in the framing of healthcare policies. One of the members, associated with the organisation, Nurses Unity had stated that nurses cannot fully do justice to their jobs as there are gaps between ground realities and governmental policies that are being framed. "*Ground reality ta ki, seta toh ar thanda ghar e boshe hobena, field e giye kaaj korte hobe"* ('The ground reality cannot be assessed while being seated in an air-conditioned room, hence one needs to go to the field to get the whole picture')[11]. How service provision can be improved at the ground level in order to overcome the problem of healthcare accessibility, can be best done, with an active involvement of nurses.

Findings:

Despite the above-mentioned limitations of the study, this research also has discovered certain important findings. First, what became evident from the interactions with the nurses and *ayah*s

[11] Interview on 25.11.21, held in Kolkata.

is that women and their work often fall prey to *stereotypes which devalues the work that they do* (Crocker and Quinn 2003). The existing literature on careworkers (as has been discussed in the section on literature review) that had flagged the problem of devaluation of carework, only got confirmed during field work. Second, this devalued perception leads to their further de-recognition as active workers. This is particularly true for *ayahs*. Third, it needs mentioning that on one hand (as is evident from the chapter on *ayahs*), there seems to be a move towards 'proto-formalisation' through the mushrooming of placement centres assigning work to informal careworkers in the city spaces. Fourth, this research also brings to the fore the issue of circulation of careworkers. For one category of careworkers like nurses (to be specific migrant nurses) working in private hospitals, Kolkata (the capital of West Bengal) might act like a transit point, while for most of the ayahs, Kolkata might be their destination (Basu 2018).

Now let us turn to our findings on policies, which most importantly raises the question of social justice. To attain social justice, policy making processes have to become more *democratic and inclusive* in nature. Thus, the *ayahs* – the underbelly of care should be accommodated in policy documents. Special attention should also be paid to nurses working in remote and marginal areas. Further, the nurses should be given opportunities to participate in policy making processes. Finally, while doing this research, a question that has lingered on over time was, how far can policies overlook micro realities involving different requirements for a diverse and unequal society like India and the state of West Bengal in particular. If the above findings are considered for implementation, they might improve the working conditions of different categories of careworkers. While it might humanise the working conditions of *ayahs,* it might also improve the working condition of nurses and the general perception of the nursing profession.