Healthcare Policies in West Bengal (1991-2015): A Case-study of Women Careworkers in select Formal and Informal Sectors

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Synopsis

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Good health is intrinsic to one's well-being. But it is believed that in India health has not received enough attention either in 'public debates or in democratic politics' (Dreze and Sen 2013, 143). This study has attempted to investigate the ways in which healthcare issues have been handled through policies by various regimes in the sub-national state of West Bengal. Though health is in the state list, healthcare in West Bengal (like other states in the country) is guided to a large extent by policies framed at the central level. Hence, any discussion on healthcare policies in West Bengal would not be complete without an attempt to understand how various regimes at the centre have dealt with healthcare through policies.

Healthcare is a political issue because it is intertwined with larger socioeconomic and political systems; hence, healthcare policies are a part of a larger public policy agenda. In the Indian context, Article 38 of the Indian Constitution has stated that the Indian state would guarantee welfare to its people and ensure social, economic and political justice. Further, the Supreme Court of India stated that providing medical services to the people is the joint obligation of the Centre as well as the state governments.[1]

The study's time frame, which runs from 1991 to 2015, includes the post-liberalization era. Putting the spotlight on West Bengal, this research looks at the adjustments made by the liberal reforms of the early 1990s in a state that had been shaped by welfare since its inception and had been under a Leftist government for a long period of time. Along with engaging with healthcare policies, this research looks at the case of careworkers. As effective policy implementation at the local level significantly depends on healthcare workers, any discussion of healthcare policies would be severely constrained if it excluded them. Every day, several types of healthcare professionals work to provide care for various populations of patients. The categories of nurses and *ayahs* are two of them that were selected for the current study.

[1] Paschim Banga Khet Mazdoor Samity vs State of West Bengal (1996)

Although medical care is crucial for preserving lives, nursing care is as crucial for recovery and rehabilitation. Further, in light of rising demands for more individualised care, untrained, semi-skilled women, or *ayahs*, who make up the underbelly of care and operate in both public and private settings while working in the informal sector, are also becoming more and more important. Yet, this latter category of careworkers is ignored by various policy documents.

Setting the Context:

Since the eighteenth century, looking after the health of the citizens was a general trend for the states, as it meant having a healthy labour force, which would increase production and also ensured the presence of a robust and healthy military. With the introduction of Beveridge Plan in 1942 Britain, health became a chief concern for the state, as it benefitted the people. The claim of the right to life was taken a step further, by including right to a 'healthy life' which was also integrated in the state budget (Foucault 2008, 6; Wunderlich 1943, 235). It is important to note that India's Committee on National Health (CNH), chaired by Col. S. S. Sokhey, formed under the umbrella of the National Planning Committee of the Indian National Congress (INC) was inspired by the Beveridge Plan and considered that maintaining good health of the population was the state's responsibility, something that got reiterated in the Bhore Committee report (Bhore 1946, 22).

Despite 'health' or 'healthcare' being absent from public debates, the Indian state has made significant investments in medical care by focussing on education, development of infrastructure, research and training (Baru 1992). Whenever, references to healthcare workers like nurses, were made in policy documents, they were done so while addressing the various needs like the need to have more trained nurses, the need to set up of more training institutions, the need to create more posts for nurses in order to improve healthcare delivery and so forth. However, the everyday experiences, ground realities of nurses that actually affect healthcare delivery or the implementation of healthcare policies were not given much importance. Thus framing of policies mostly remained insulated from ground realities of careworkers, especially due to the almost absence of nursing leadership in policy making processes (Healey 2013). This makes it imperative to have more discussions on the everyday experiences or realities of careworkers operating in a diverse and highly stratified society like India in general and West Bengal, in particular.

Post-independence, the development of industries and infrastructure took precedence over health and education. A review of the various Five-Year Plans would reveal three main

developments during the 50s, 60s and 70s in healthcare. First, the government prioritising monitoring of contagious diseases and family planning, which influenced the organization of primary health. Second, the lack of health care workers and doctors made teaching hospitals a necessity. The third was realizing that the attempts made at building a strong primary health care system was highly inadequate (Rao 2017,13). While, the 1950s and 1960s saw an increased public spending but since then, it has remained flat through the 1970s and 1980s. This stagnation of expenditures has made room for the expansion of private sector (Baru 1992).

The Time under Study:

The need for India to focus on primary healthcare got resonated in the Alma Ata declaration of 1978, which asked to re-emphasise on Primary health, as a result of which, the Sixth Five Year Plan laid the goal for 'health for all by 2000 AD', but a shift from comprehensive to selective healthcare over the years, can be noticed in India, following the economic reforms of 1991 (Qadeer, Saxena and Arathi 2020, viii). When in July 1991, the Narasimha Rao government adopted Structural Adjustment Programme (SAP), it liberalised the Indian economy (BM 1992, 623). Health sector reforms (HSR) were an integral part of SAP, which ushered in the state's withdrawal phase, followed by the privatisation of healthcare (Nandraj 1997, 1). It should be noted here that private healthcare sector has existed since colonial times, and it continued well after India's independence. But tendencies toward privatisation can be traced back to the eighties (Saxena 2010, 10-17). However, after HSR the already existing inequalities across various regions in India, exacerbated healthcare inequities (Gangolli, Duggal, Shukla 2005, 3).

Though preventive healthcare or vertical programmes were implemented through various plans, planning in post-independent India did not give much emphasis to curative healthcare. Thus, with health sector reforms in 1990s, a shift to selective healthcare can be noted in policies. It was after United Progressive Alliance (UPA) came to power and through its engagements with National Advisory Council, that certain welfarist schemes like National Rural Health Mission (2005) and later National Urban Health Mission, which were later subsumed under National Health Plan (2013), tried to address the problem of inequities in healthcare.

Research on healthcare policies in India have received a wide range of attention from scholars like Ravi Duggal (2001; 2009; 2012; 2018) , Debabar Banerji (1985;1986; 1993; 2004a; 2004b), Imrana Qadeer (2005; 2020), Rama Baru (2012; 2018;2019), K. Sujatha Rao (2017), K Srinath Reddy (2018; 2019) , Purendra Prasad (2018) , Monica Das Gupta (2005) and others.

Leena V. Gangolli, Ravi Duggal and Abhay Shukla (2005), hailing the 80s as the golden days of public health, label the 90s as the days of retreat. Situating the healthcare system within the larger development issues, researchers have highlighted that decentralisation in most cases meant delegation of duties and not devolution of powers. The government's inability to resist pressure from international financial institutions during post-liberalisation era has substantially increased the phenomenon of out-of-pocket system, which in turn has led to pauperisation of the general public, thereby generating critique of the government policies. From addressing various governments' failure to build an effective health system, to addressing the collective failure to regulate the private sector, scholars have undertaken detailed work. However, the severity of their criticism varies. For instance, while Baru, Qadeer and Duggal are extremely critical of foreign agencies' role like World Bank, International Monetary Fund etc, scholars like Monica Das Gupta, though critical of the organisation and financing of healthcare are not so critical about foreign agencies' role.

The Case of West Bengal:

West Bengal offers an important case study because at the time of economic reforms of the 1990s, it was under a Leftist government. Making of public policies take place within the constitutional framework of any country. In the Indian context, policies are guided by the philosophies as expressed in various sections of the constitution, namely the preamble, directive principles, fundamental rights, parliamentary form of government and federal structure of the state (Maheshwari 1987, 336-337). As stated earlier, health comes under the state list, but policy formulations are mainly done at the central level and the states act as implementing agencies. West Bengal had the same trajectory as the rest of India with regard to the evolution of healthcare policies. After independence, though the state plans were largely determined by central Five-Year Plans, the state tried to respond to the distinct needs of the people of the state through various schemes, though the main focus remained on growth through industrialisation (as can be seen in the state plans).

However, even during the rule of a Leftist government in West Bengal, healthcare did not get the necessary attention. When it came to research on healthcare in West Bengal, there has not been much work. How much healthcare services are provided by commercial and public service providers, and at what expense, has been the subject of study by Achin Chakraborty and Subrata Mukherjee (2003, 5021-23). While Moni Nag (1983 and 1989) conducted comparative studies of health and education in Kerala and West Bengal, Arijita Dutta and

Montu Bose (2015; 2016) have underlined the disparity when it comes to accessing healthcare in urban and rural areas. Panchali Ray (2019) attempted to comprehend the situation of careworkers in a few hospitals in Kolkata, while Mridula Bandyopadhyay and Stewart MacPherson (2018) attempted to delve into questions of child and maternal health. Amrita Bagchi (2010) attempted to trace the history of private hospitals in Kolkata.

Though various writings during this period highlighted party organisation of the left, decentralisation of power through panchayat system, land reforms etc. only passing references were made to health or healthcare (Frand 1971; Mallick 1993; Chatterjee 1997; Samaddar 2013; Bhattacharya 2016; Chatterjee and Basu 2020). Recently, a volume edited by Chatterji and Basu (2020), has addressed the issue of healthcare during the Left-Front rule. Further, as gradually, the state adapted to the changes brought about by economic reforms of the 1990s, the Public-Private-Partnership (PPP) model and the introduction of user fees in the government facilities, became realities. These developments have raised concern, among proponents of 'healthcare for all', who fear that health inequalities would increase already existing inequalities.

The Realities 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 care work by healthcare workers like nurses of various categories is so devalued. Arlie Hochschild (2012) tried linking affect with the process of marketisation in the 80s. With the onset of neoliberalism, structural gender inequalities have increased leading to feminization of poverty, exploitation of labour (CWDS 2000, Bergeron 2001). Capitalism has 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. Michael Hardt states that though the theorization of what he terms 'affective labour', is not something new, but what is new is the fact that currently it is at the centre of economy per se (Hardt 1999). At a time when jobs in traditional industries is shrinking, or when according to Hardt, modernization has come to an end, we see, a shift from industry to service jobs[2] or what is

[2] 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).

known as the tertiary industry. This makes it imperative to study the realities of careworkers like *ayahs* hailing from the informal sector.

While Paula England and Nancy Folbre (1999; 2002) argue that because carework is associated with women's work, patriarchal norms devalue it, the European Post-Marxists scholars like Michael Hardt and Antonio Negri argue 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. Nel Noddings (1992), Carol Gilligan (1997) and others view care and caring responsibilities to be key to understanding female ethics; while Tronto (1993) sees it as a civic virtue that is politically significant (it is also significant to the public). The current study does not perceive *care only as a feminine activity but links it to the socio-politico-economic realities*.

Realising that there are internal hierarchies based on binaries associated with healthcare like cure/care, technical/menial, skilled/unskilled, reason/emotion – where the first part of the pairing coincides with doctors and the second with nurses, the chapters on nurses and *ayahs* have tried to address the myriad forms of hierarchies that affect the everyday lives of these women workers. The current research traces the development of nursing from ancient period through medieval period to colonial and postcolonial times. The works of British women medical practitioners in India and early native women in the same profession are well documented (Burton 1996; Forbes 1994, 516). However, equal importance has not been given to document the emergence of nursing profession in India (Sanyal 2017) with the exceptions of the works by Sreelekha Nair (2012) and Madelaine Healey (2013) in this field.

Any discussion on nurses in west Bengal would be incomplete if the issue of migration is not addressed. 1990s onwards, with the gradual rise of corporate style private medical facilities or super speciality hospitals in mainly Kolkata, the city has become a transit point for a section of nurses (Basu 2018, 117). Here, attention has been given on the nurses coming from outside West Bengal to the new corporate style hospitals located mainly in Kolkata and its adjacent areas and also in some big cities. After acquiring sufficient experience, a good number of migrant nurses seek opportunities in other destinations, especially in the Gulf countries, Europe and also in North America. The present research has also found the rise of a new stratification in the nursing profession.

Further, the present research also traces the evolution of *ayahs* as careworkers in European households in and around Kolkata from the colonial to the present time. Women from the economically disadvantaged positions, mostly join the lowest tier of healthcare workers involved with providing direct care to patients in government hospitals, middle range nursing homes or in private spaces (homes) of patients. Even at a time, when the formal-informal divide is getting blurred, *ayahs* hail from the informal sector. Apart from directly handling the work of care, the *ayahs* also have to undertake the menial work of cleaning bodily fluids, including cleaning the excreta of the patients, which the professional nurses generally would never do. These activities (cleaning work for example) further relegate them to lowest echelon not only in the overall carework hierarchy but also in social hierarchy since in India the work of cleaning is generally associated with 'untouchability', following the binary of sacred/profane.

As the members of the lowest rung of healthcare workers, the *ayahs* also stay outside the purview of the policymakers or the healthcare policies themselves. Thus, there is no effort to provide them with a basic minimum training of care, of maintaining hygiene and of imparting primary literacy. Although, often involved closely with taking care of patients suffering from terminal and infectious diseases, they are also bereft of any health insurance, or, do not enjoy any social security provided by the government. Due to the nature of their work, dignity gets dissociated in the absence of any kind of formal recognition. Thus, including the category of ayahs while doing research on careworkers seemed just.

In present day urban spaces, they find employment through various placement centres which also operate in the liminal spaces. In the past two and a half decades the mushrooming of '*ayah* centres' (a new phenomenon) was noticed in and around Kolkata, which has also been highlighted in the present study.

There might be different ways of approaching the present topic under study, but the present research has adopted a critical approach in the broad sense, which would include questioning the status quo and in doing so, it would also include the concept of intersectionality. Focussing on repressive social practices and institutions, it would deal with justice in a broad way. The present work has tried to incorporate margins of society, as the main stuff of thinking.[3]

[3] Borrowing from Ranabir Samaddar. See, Journal of Transdisciplinary Peace and Praxis, 4(1), February 2022.113-120.

Research Gap:

Although academic literature, as documented above, exhibits rich and analytical narratives of the origin and development of the modern healthcare system and various policies associated with it, the discussions on the problems and prospect of the healthcare system in West Bengal is truly scarce. Second, there is also paucity of academic literature where both healthcare policies and the realities of healthcare workers have been duly emphasised. The above gap, in previous research justifies undertaking the present work which proposes to overcome the above limitations.

Overcoming the Gap and the plan of Research:

In an attempt to overcome the gap mentioned above, the research seeks to answer the following questions. First, how healthcare and carework have been approached through different conceptual lenses in the Indian context? Second, how did healthcare and healthcare policies evolve in India? How have healthcare policies come to be shaped following the economic reforms of 1990s. Third, how did healthcare and healthcare policies evolve in West Bengal? How healthcare policies have been shaped following the economic reforms of 1990s? Fourth, what have been the experiences and conditions of careworkers in West Bengal since 1990s – a) the case of nurses and b) the case of *ayahs* and of nurses in West Bengal.

In order to seek answers for the above-mentioned questions, this research draws on materials gathered from interviews, secondary materials, archival materials and all have been important in leading this work to its fruition. Interviews with nurses, *ayahs*, experts, people associated with Public Health Movement, bureaucrats, principals and teachers of nursing schools, owners of various service centres, service seekers and others were carried out at different points. It is also pertinent to mention here that attempts were made in this research to understand the availability and access of healthcare in several pockets of West Bengal, like in the tea gardens, *charlands* and urban slums.

Interview method has been employed and both face-to-face and voice-to-voice (telephonic interviews) interviews have been conducted. The sampling technique was purposive as the current researcher conducted interviews after an appointment was fixed. Snowball technique has been used to increase sample size as nurses and ayahs interviewed were requested to refer the current researcher to their colleagues, so that they also could be interviewed. While some clicked, others did not. Though interviews began with a set of questions, however they went

beyond and took the shape of conversations. Care was also taken to diversify the interview sample, in terms of age, religion, location etc. However, it is pertinent to mention that though during this research the researcher came across a few male ward nurses (while visiting hospitals), she could interview only a few.

The current researcher has resorted to methodological opportunism, (borrowing from Adam Prseworski 1995,16) – one who 'believes in doing or using whatever works'(Ibid). Acknowl edging that there is no one way of understanding a complex problem or issue (Reeves et al. 2 008, 631-632) multiple lenses have been used to understand significance and particularities o f various events shaping healthcare.

Chapter Planning at a Glimpse:

The first chapter is titled, 'Introduction' and tries to introduce the topic undertaken for study. It tries to briefly introduce the various components like healthcare, healthcare policies, careworkers and tries to situate them at the subnational level of West Bengal since 1991, the year economic reforms were adopted by India. The second chapter deals with literature review, which has been done thematically. A discussion on healthcare policies in both national and international levels has been initiated in this chapter, touching upon issues of healthcare financing, management, external determinants of health and the role of the welfare state in the changing (Lee, Buse and Fustukian 2002; Buse, Mays & Walt, 2005, 6). How healthcare is treated under various regimes like welfarist, liberal, neoliberal or regimes inspired by Marxist ideologies and how healthcare is provided has been discussed next.

The third chapter tries to set the context of the current research. Briefly introducing West Bengal as the case study, it goes on to state the research questions and involves a discussion on 'Methodology' and it describes how the research has been approached and conducted. The fourth chapter focuses on how healthcare has evolved in India over time. It also tries to understand the factors affecting healthcare in India and the role of policies in mitigating various problems or their failure to do so. Since, much of planning is done at the central level, a discussion on healthcare policies framed at the central level, was considered to be pertinent. The fifth chapter is on West Bengal and it tries to connect healthcare situation at the subnational level to the wider socio-economic and political situation of the country. Discussions have been informed by various state plans, annual plans, legislative assembly debates, other government documents and news reports.

The sixth chapter, titled, 'The Realities of Nurses.' Based on interviews, it focuses on how neoliberal policies have affected the nursing profession in general and West Bengal in particular. It also discusses how policies must take into account the realities and daily challenges of nurses if they are to improve the state's healthcare system. It has also been examined how society views nurses and their profession as well as how these female carers deal with patriarchy and administration. The seventh chapter is titled, 'Ayahs: The Underbelly of Care Economy.' This chapter highlights that increasingly, in the private spaces like, a patient's home, issues related to care are getting gendered through the hiring of service of a female informal worker, who not only releases working women but also men of any caring obligations (Anttonen and Zechner 2011, 31).

Towards Conclusion:

The present research has looked at how healthcare has been provided by careworkers. In doing so, it has engaged in discussions about West Bengal's healthcare policies, India's healthcare policies, the role of carers like nurses, and how all of the aforementioned may be conceptually understood. The present research has underscored that in order to attain social justice, policy making processes need to become more democratic and inclusive in nature, which makes it pertinent to take into consideration the realities of nurses and acknowledge the work of nurses in policy documents as well.

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