

*Finding Gendered Inequities in Poor Women's Experiences of  
Neoliberal Health Care and Labour: Perspectives from India*

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**Abstract**

Gender equity in health is, in part, a product of women's experiences of two critically linked sectors: health care and labour. This paper is concerned with observing the trajectory of neoliberalism as the dominant global approach to macroeconomics and its effect on these two market sectors in India. Using a feminist political economy approach and the methods of a narrative literature review, the historical practices of India's development and health policy are reviewed, namely the adoption of a US-driven Structural Adjustment Program (SAP). The findings show, first, that the SAP resulted in a roll back of the state. As a result, reproductive health services have become the contextual stand in for the provision of health care to poor women. Secondly, there has been a change in labour policies that has pressed many poor women into informal work and further devalued their role in the household. A neoliberal approach to policy making has intensified women's oppression and exploitation and has confounded existing gendered and classed inequities in health.

Keywords: Women's health; gender; neoliberalism; India; labour; poverty

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## **Introduction**

This article aims to confront the relations between gender, class, labour, social reproduction, and health in the context of neoliberal development in India. Emphasis is put on poor women's position and the emergent effects of policy changes in the specific market sectors of health care and labour. It has been determined that a woman's "occupation and the social position it provides are strongly associated with differences in life chances, freedoms, opportunities, and living conditions, and thereby significantly influence the possibility of good health" (Ostlin, 2002 p. 64). These determinants that she experiences are circumscribed by the governing rationality that acts to situate her societal role in the web of relations between the market, the state and the household. Currently, in both developed and developing countries, the dominant ideology that governs the organization of health care and labour is neoliberalism. The major tenets of neoliberalism articulate the transfer of responsibility for employment and well-being from the state onto households in the form of labour participation (Bezanson & Luxton, 2006). Under this ideology, the state withdraws from welfare provision and relegates its role to the private sector in areas of social services and health care (Harvey, 2005); the main driver of the political economy is the market. This article discusses how the global growth of neoliberalism has had a strongly negative effect on equity in India. It is important to note that neoliberalism is not a monolithic process (Benoit et al., 2010). Rather, it can take on heterogeneous forms at all levels of relations. As such, the focus of this article is on a particular confluence of the inequities faced by poor women in India. The article is framed by specific policy changes in the Indian state that occurred after macroscopic reforms in the relationship between developed and developing countries that occurred in the late twentieth century. This is further situated in the historically based intense patriarchal public and private realm in which

most poor Indian women are located. The aim is to follow the consequences of these changes to illustrate how they have had a material affect on the health of poor women in India and to suggest that patriarchal and hegemonic ideologies of labour control work together to subjugate poor Indian women on the basis of gender and class.

Neoliberalism manifested itself in developing countries during the 1990s as Structural Adjustment Programs (SAPs). The Structural Adjustment Programs were prescribed to poorer countries during the post-cold war period by Washington, D.C based institutions such as the International Monetary Fund (IMF) and the World Bank as a blanket neoliberal solution to alleviate debt and economic collapse that permeated the “Third World” (Arora, 1999). India was among these countries. Many authors have criticized the imposition of these ideologies onto poorer countries and the subsequent consequences of these policy changes (De Vogli, 2011; Williams & Maruthappu, 2013). As stated previously, this article confronts a particular formation of neoliberalism in India and the consequences of this market-driven ethos on healthcare and labour practices of poor women. I argue that the 1990s neoliberal Structural Adjustment Program (SAP) in India has had a negative and synergistic effect on poor women’s health by privatizing, individualizing, and gendering health care services and labour practices. Moreover, by intersecting with pre-existing highly patriarchal family structures to further oppress poor women within the household. Although poor women’s health prior to the reforms was precarious, inequities in health have seriously intensified as a result of the policy changes. I first describe the evolution of India’s development that led to the fruition of the Structural Adjustment Program. Then, I illustrate the effects of the Structural Adjustment Program on health care and labour policies in India. I attempt to capture the policies that dictate poor women’s access to health care services and the policies that define the many labours of women.

In the analysis that follows, using the tools of a feminist political economy approach, I interrogate how the relations between neoliberal health care and the labour system articulate to reproduce class and gender inequities that determine health.

### **Methodology: A Feminist Political Economy Approach**

Jackson (2012) defines feminist political economy as “concerned with the material practices of power and the distribution of social resources” (p. 19). One of the main contributions of feminist political economy is the re-conceptualization of Marxist modes of production and reproduction from the standpoint of women, concluding sex/gender as mutually inclusive with class as mode of social organization. Research suggests that until the early twentieth century women primarily performed uncompensated work in the private domain of the household (Doyal & Pennell, 1979). This work is contemporarily referred to as “domestic labour,” “unpaid work,” or “social reproduction” (Blane et al., 2001; Bezanson & Luxton, 2006, p. 3). Women’s reproductive ability was (and still is in many cultures) considered to be “incompatible with paid work” (Messing et al., 2000, p. 36). This type of work involves, in part, reproducing people on a daily and generational basis (e.g. passing on cultural beliefs and practices, biologically giving birth, caring for a dependent, etc.). Conversely, men traditionally performed compensated work primarily in the public domain of the market. This work is often referred to as “paid work” or “productive work” (Doyal & Pennell, 1979). Now many decades later, as more women enter the paid workforce as a means to liberation and due to increasing financial constraints on the lower classes there is a tangible difference in the perceptions and expectations of women’s work (Moghadam, 1999). Globally, the majority of women hold jobs in informal, precarious, and unsafe work conditions characterized by the qualities of repetition and care. This partition of work based on gender roles and sex characteristics is called the “sexual division of labour”

(Armstrong & Armstrong, 1983). This article considers the sexual division of labour in India and the unequal distribution of health care resources. The strain of feminist political economy that I draw on primarily for this paper is labeled “feminist intersectional theorizing” (Vosko, 2002, p. 57). This literature does not treat social divisions such as gender, race, and sexuality as “epiphenomenal or of secondary importance” to class (Creese & Stasiulis, 1996, p. 6). It is my view that, in India, the social regulation of poor women based on class and gender is integral to the process of production and capital accumulation, and thus the experiences of poor women are important considerations for a feminist political economy framework used to understand health. What is also important about this debate is it highlights that capitalism is dependent on workers’ production outside of the productive domain. Namely, it requires a “social reproduction” that is often dependent on the unpaid work of women (Bezanson & Luxton, 2006, p. 3). Although there are many other crosscutting determinants that construct the inequitable health of poor women in India (such as race, sexuality, caste, culture, religion, etc.), this article focuses on the dualism of gender and class, as these are shown to be the most important relations through which these women face oppression. For this paper, a narrative literature review was conducted that focused on finding interrelations between neoliberal reforms in healthcare and labour markets, classism, sexism, and health outcomes. The findings of this review are analyzed using a feminist political economy framework.

## **FINDINGS**

### **History of Neoliberalism in India and the Structural Adjustment Program**

To understand the current gendered inequities in India’s health care and labour practices, I first reviewed the changes that have led to the country’s current mode of development. In 1947, after the exhausted triumph of the Indian Independence Movement, the country emerged

from under the reach of an Imperialist arm. Having been ripped apart into the contemporary India and Pakistan, India's experience of colonial rule lent for a socialist democratic government with a protectionist approach to public policy and trade (Aghion et al., 2008). Private business output was determined not by free market demand, but through strict licenses set in place by the government as an effort to regulate/advance industrialization across the country. This was called the License Raj (Aghion et al. 2008). However, by use of these policies India saw a drop in growth, an increase in economic instability, and a closure to trade and investment, which led to a balance of payments crisis by 1989 (Besley and Burgess, 2004). The progression into a post-colonial economic crisis was being iterated in many other developing countries. This was the opportunistic tipping point during which contemporary neoliberal globalization was incorporated into the Global South (Gore, 2000). At this critical juncture, it became apparent that an institutional arrangement had "come to define the rules of world trade", and whether or not the economy of a developing country flourished (Harvey, 2005, pp. 72). Via the direction of the World Bank and International Monetary Fund and guided by the United States, development in the late twentieth century focused on economic growth and productivity of the lesser developed nation state. The structure of neoliberal policies emphasizes the importance of market deregulation, state retrenchment, and the advent of privatization: i.e., a country will be driven to economic prosperity by maximizing markets and exposure to goods and services, not through legislature of the state. Development and policy decisions under these practices are modeled on a high yield of income that will benefit the population in a "trickle-down" effect, whereby the rich benefit first, followed by the poor (Aghion and Bolton, 1997). This model states two things: firstly, that the economy will reach a steady-state distribution over time given a high initial rate of income, secondly, that redistribution of this income via the empowerment of consumers will

lead to greater equity among the population (Aghion and Bolton, 1997). With guidance from the IMF and World Bank, India began a Structural Adjustment Program in the 1990s to remedy its external debt and foreign exchange crisis that shifted away from its previous socialist policies. The upheaval into neoliberal policies opened the way for an enormous venture into the globalization of India (Aghion et al., 2008). However, there were several negative effects from the reduction of the role of the state in the name of economic efficiency. In a country where government rule works in a federalist dimension, the transition from government-led to privately controlled industry contributed to differential growth across the states. The benefits of free market development accumulated at the top in urban centers and the poorest groups of the Indian population, particularly poor women, witnessed adverse impacts in two significant sectors: the labour market and health care.

## **EFFECTS OF NEOLIBERAL IDEOLOGY ON HEALTH CARE AND LABOUR POLICIES IN INDIA**

### **Broad effects of neoliberal ideology on health care policies in India.**

Neoliberal economics criticizes the inefficiency of government: it looks to more cost-effective consumer-friendly private markets for the optimization of social welfare and distribution of resources (Harvey, 2005). In this model, patient becomes synonymous with consumer; individuals shape their way of living through unfettered access to goods and services. However, the choices of consumers do not always translate into the power to control markets. Often the pursuit for profits lends to negligence of the poorer sectors, which is further legitimized through vertical legal structures and political mechanisms (Varman & Vikas, 2007). The neoliberal Structural Adjustment Programs of the 1990s diminished access to health care for

economically marginalized populations by largely privatizing delivery. This section situates the effects of neoliberal SAP on health care policies in India in the context of social reproduction and health. Good health must be present in order for social reproduction to occur at its most favorable level. And thus, in a quite literal sense, women's access to reproductive health services dictates the regeneration of the labouring population, whereby control of a woman's reproductive role becomes the key to the upbringing of the labour that they reproduce, and is thus considered necessary for both economic and social reasons. This is particularly salient in India where concerns about over-population and strongly rooted patriarchy govern the parameters in which women are allowed to give birth. There were prolific effects on health care provision in India as a result of the SAP, especially with respect to reproductive health services. The two most significant effects were the linking of income and gender inequity in health care, and a further reduction of women's health issues to their reproductive body (Sen, 2002; Inhorn, 2006). I find that the neoliberal ideal of privatization is a gendered determinant of two major factors that influence poor women's health in India: cost of care and access to health services. Privatization is seen to be an important reason for why households in India are falling into poverty (Iyer et al., 2007). Currently, 60 percent of rural households and 40 percent of urban households must borrow, sell household assets, and/or use contributions from relatives/friends to deal with the costs of hospitalizations (William, 2014). As such, whether or not a household is able to afford health care in combination with existing biased gender values functions to limit treatment for poor women. Usually, gender bias takes the form of rationing health care differently for women and men due to a decrease in the amount of household income that can be spent on healthcare (Iyer et al., 2007). Often, poor women only receive treatment when it relates to reproductive health. In this way, privatization has changed the discourse of how the Indian government

approaches women's health. Most health interventions directed at women after the SAP focused solely on women as reproducers and mothers of the next labour force. The almost complete privatization of health care resulted in the essentialization of women's health, whereby reproductive health became the contextual stand in for women's health. For women, particularly poor women, one of the only points of contact for health care delivery is reproductive health services.

As I have noted, by the late 1980s the country had fallen into a debt trap. Under these conditions, the creation of a complex and comprehensive system of primary health care was impossible. Instead, through acceptance of the SAP, India's health care system adopted a "World-bank driven, narrow, techno-centric intervention strategies in the area of population control, reproductive and child health, and treatment of communicable diseases" (Qadeer et al., 2001, pp. 120). The SAP forced medical care into the private sector and led to the collapse of the public sector. In the period of development after the Structural Adjustment Program, the Indian government introduced two national policies that, together, dictate the boundaries of poor women's current access to health care: the 2002 Indian National Health Policy and the 2000 Indian National Population Policy.

The most significant change to health care after the 2002 Indian National Health Policy was the expansion of the private sector. Evidence from national household surveys shows that the private sector in the previous two decades has become the main provider of inpatient care (Balajaran et al., 2011). India now ranks as one of the top 20 of the world's countries in its proportion of private versus public spending on health care (World Health Organization, 2012). This accounts for India having one of the highest percentages of household out of pocket health expenditures in the world: 71.1 percent in 2004-2005 (Balajaran et al., 2011). The growth of the

private sector comes at a time in India when the public health care spending as a percent of gross domestic product (GDP) is among the lowest in the world (World Health Organization, 2012). India ranks as 148 out of 194 countries. The public health proportion has fallen to a low of 1.2 percent in 2011 from 1.3 percent of GDP in 1991 when the neoliberal economic reform began (World Bank, n.d.). We can see the outcome of this in the extent to which there is unequal access to health care between rich and poor. Given the lack of government subsidy, health accounts for 12 percent of total household consumption in impoverished areas, and the cost of episodic medical treatment has risen from US\$22 dollars to US\$37 dollars (Varman & Vikas, 2007). Moreover, healthcare expenditure is the second major cause of debt among the rural poor with 80 percent of it coming through out-of-pocket payments by patients (Balarajan et al., 2011). Rich individuals are also more likely to be admitted to a hospital than are the poor and have longer inpatient stays in hospitals in the public sector (Sengupta, 2005). However, the poorest 40 percent of hospitalized patients in Indian must now borrow money or sell their assets to cover the rising cost of medical expenses (Varman & Vikas, 2007). There is also a bias in the private sector towards tertiary level curative services, which tend to be provided in wealthy urban areas (Balajaran et al., 2011). These inequalities showcase the limits and economic bias of private and technological intervention. Antony (2014) finds in his review of the primary health care system that the public system has continued to be dysfunctional and not geared to suit the needs of the population. This is primarily due to the amount of spending that has been allocated to the private over public system. By encouraging the privatization of health care delivery, the 2002 Indian National Health Policy subjected the poor to exclusion by ignoring the social causes of morbidity and mortality.

The 2000 Indian National Population Policy (NPP) broke the links between general

health and reproductive health for women. The immediate objective of the NPP 2000 was to “address unmet needs in the areas of contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care” (Government of India, 2000, pp. 1). Although, the intent of the NPP package of responses by the Government of India was to embrace the consensus of the 1994 Cairo Conference which called for a shift in discourse on population and development from “population control” to “women’s empowerment,” a repeated theme in the policy was the greater role given to individuals with an emphasis on outsourcing and privatization of health care (Halfon, 2007, pp. 4; Rao and Jain, 2003). By subdividing maternal health from the goals of the National Health Policy, the NPP redefined women’s health as the health of the womb. The ethnographic literature refers to this as the “reproductive essentialization of women’s lives” wherein women’s most essential characteristic is seen as their ability to reproduce the generations (Inhorn, 2006, pp. 347).

Review of these main policy changes to healthcare that occurred indicate that the advent of a techno-centric approach to health care has lent for reductionist policies that have increased the gap in gendered health equity between the rich and the poor and had no significant effect on addressing health care concerns. Moreover, the perception of population growth as the main cause of poverty is still the driving factor behind the expansions of reproductive health services. The policies identify women as the central focus of intervention to reduce population and, thereby, poverty.

### **Broad Effects of Neoliberal Ideology on Labour Policies in India**

In the context of labour practices and neoliberalism, the costs of social reproduction have shifted from the paid to the unpaid economy. Although social reproduction is a necessary

component of a capitalist system, the responsibility and cost of its components such as education, health care, and socialization has been put on households and communities, and within those, primarily on women (Bezanson & Luxton, 2006). The 1995 World Development Report showed that 11 trillion dollars are missing from the global economy each year, representing the invisible role of women in development and social reproduction (World Bank, 1995). This, in combination with the increase in the feminization of labour, has caused women's work burden to intensify, whereby, they must now assume roles in both the productive and reproductive realms. Women's paid work can therefore not be viewed in isolation from their social reproductive roles. In this section I define the changes in labour policies that have led to a feminization of poor labour in India, and then relate this to women's roles in social reproduction. The patriarchal and gendered beliefs that were pervasive in the changes to health care during the SAP also manifested themselves in India's labour practices.

The characteristic features of neoliberal labour markets are "flexible specialization" and "export-oriented industrialization (EOI)" (Harvey, 2005, p. 76; Mills, 2003, p. 49). Flexible specialization is based on decentralized small units of production, as opposed to the Fordist model of mass production of a single product. The outcome is lower wages, and increase in job insecurity, and loss of benefits (Harvey, 2005). Labour is put at a disadvantage under the guise of flexible specialization. This is due to the assailing of labour organization and labour rights. "Internally, the neoliberal state is necessarily hostile to all forms of social solidarity that put restraints on capital accumulation" (Harvey, 2005, p. 75). EOI stresses that the world market, through exports, is the reference point for any economic unit. It emphasizes export-oriented production by manufacturers to maximize the efficient allocation of production goods (Harvey, 2005). As such, in order for manufacturers to garner the most return on their investments, they

must employ cheap labourers. In this model of labour and industrialization, as in health care, the private sector is the engine for future development wherein the main goals are free trade, complete openness of the economy, and a minimalist state.

As stated above, a principle component of EOI is the provision of cheap labour. The imposition of SAP by the IMF and World Bank on developing countries meant that other neoliberal states would be able to rely on their immense, but disorganized, labour reserves in order to gather these cheap labourers. From the perspective of EOI, India, in particular, provides empirical evidence to support the links between the performance of exporting and economic growth (Srinivasan, 1985). After the SAP, India's percentage share in world exports increased steadily and the country reached unprecedented economic growth peaking at nine percent in 2007 (Datt & Ravallion, 2008). This economic growth was achieved by directing the domestic economy toward producing products for wealthy countries. However, the cost of a booming economy was a dismantling of labour rights. Part of this dismantling involved the establishment of special economic zones (SEZ). To attract foreign direct investment, the Government of India currently ensures the labour force in these zones is not covered by protective labour laws or social securities (Carr and Chen, 2004). As such, labour in these zones is referred to as "informal" work (Carr and Chen, 2004, p.1).

The "feminization of labour" is a term used to describe emerging gendered labour relations born out of the rise of neoliberal globalization (Moghadam, 1999, p. 370). As export-oriented industrialization became an important component of development in India, women began to claim an increasing proportion of industrial jobs, especially in the informal sector (Ghosh, 2002). Scholars have argued that the feminization of industrial work is the inevitable result of the combination of patriarchy, which keeps women's wages low, and EOI, which has

resulted in a decline of household incomes, and therefore leads to an increase in the number of job seeking women (Moghadam, 1999). From 1983 to 1993, the percent of women in the total labour force increased from 40 percent to 46.5 percent (Bhalla & Kaur, 2011). Rustaji et al (2013) find that this has fallen to a low of 34 percent in 2010. This could be explained in part to the high level of informal work that most poor women are now performing, such as that in the SEZs. The process of feminization is most marked in SEZs, where the share of female employment typically exceeds 70 percent (Ghosh, 2002). Again, exporters were drawn to female labour because they must employ the cheapest labour in order to compete in global markets. In 2007, the wage ratio (average women's wages to men's wages) was only 58 percent in India (Bhalla & Kaur, 2011). This perpetuates the belief that women should accept lower wages, no benefits, job insecurity, and work longer hours. Caraway (2005) argues that in addition to the issue of low wages, gendered discourses of work, the ideas and practices about men and women providing distinct forms of labour, play a critical role in the feminization process.

An evident example of the permutation of feminization, EOI, and discrimination of women in labour is the agricultural industry in India. The agriculture industry still remains the number one resource in India; ranked as the second largest farming resource worldwide. The country produces over eight percent of the world's agriculture, yet still retains some of the highest rates of severe undernourishment (Balarajan et al., 2011). Upon adoption of the SAP, there was a rapid export of primary resources, namely agricultural products, which led to declining prices of these commodities (Kothari, 1997). As a result, in 2003 agrarian practices accounted for only 19 percent of the GDP, but employed over 59 percent of the Indian workforce (Ghose, 2004). In 2004, 72 percent of rural women in the paid labour force worked in the agricultural sector (Bhalla & Kaur, 2011).

The process of feminization of labour directly relates to neoliberal social reproduction. Neoliberalism is chiefly concerned with how women can be useful for development. Finding income to replace social security benefits has increased the pressure on the household, which has, in turn, extracted women from the domestic domain into the public labour domain. This exacerbates the notion of the “double burden” (Doyal & Pennell, 1979, p. 526), whereby, women are still expected to be the principle proponents of social reproduction, and also participate in the paid labour force, but as such are perceived to be less efficient at both. As a result of this perception, Nadasen (2012) concludes that an almost complete reduction of benefits and social services for women has led to “a crisis of social reproduction and a corresponding increase in women’s workloads.”

#### **Analysis: Gender and Class Inequity in Neoliberal Health care and Labour Reforms**

This discussion analyses the intersection of changes in two sectors that relate to women’s health in India: health sector reforms and labour policies and practices. This choice of sectors reflects that there are critical linkages between them that affect their collective impact on gender equity in health. These linkages, as we will see, can be synergistic. A repeated theme in changes to health care delivery and labour practices is perpetuated patriarchy through a neoliberal model of development pivoting on the growth of the economy, whereby the measure of the country’s success lies in the gross national product per head. In this mode of patriarchy, we see gender and class, which in a neoliberal context is equal to income, as mutually inclusive processes (Gottfried, 1998). The findings of this article illustrate this concept at the level of health; we see that there are certain marked features of a neoliberal approach to health care and labour that perpetuate gendered dimensions of health inequity. In particular, patriarchal beliefs on one hand reduce public expenditure on health care leading to the feminization of labour and poverty, and

on the other hand push women into the informal sector to supplement family incomes with no accompaniment of a redistribution of social reproductive responsibilities. The patriarchal structural dynamics of the policy environment in the two sectors of labour and health care have had an emergent effect on gender and class as determinants of health for poor women in India.

The literature shows that key dimensions that determine the extent of gender equity in health care are access and cost of services available to different economic classes and between genders. A characteristic feature of the neoliberal mode of health care delivery is privatization, which we see creates a significant divide between the rich and poor, and disproportionately affects women. Market forces have had a devastating impact on the administration of health care in socially marginalized communities (McPake and Mills, 2000). Coburn (2000) asserts that income inequality is a far greater determinant of a country's health than the *average* income. Even if a country experiences high economic growth, the overall quality of life of the population will not increase if the capital is left undistributed. The findings suggest that commodity based social systems not only drive the gap between the rich and the poor, but also contribute to unequal health status among the population. Moreover, Pollert (1996) states that the process of gendering takes place inside class relations and that these relations are empirically inseparable. The results of this article support this claim. If we look both across and between classes, there is a divide between the provision of services to men and women, with women's health being largely thought of as providing for mothers of the next labour force. In India, gender differences in health are observed in all economic classes, but are larger in poorer households due to the effect of rationing (Sen and Ostlin, 2010). Moreover, sex ratios, which are considered as measurement of the valuation of women in a society, have declined from 927 to 914 between 2001 and 2011 (Registrar General of India, 2011). In this way, gender and class inequities lead to

multilayered discrimination, especially for poor women. Therefore, in a neoliberal approach to policy, the impact on health of gender inequity is further confounded by income inequality.

Public health interventions for women that are based on neoliberal ideology of a techno-centric approach do not sufficiently address gender and income as determinants of health, and instead essentialize women's health. Moreover, these interventions assume that through target-based approaches to health care, the human rights of women will be met and gender inequities will be overcome.

Being thought of only as a mother has limitations: other aspects of women's lives, such as work, are ignored and women's capabilities in these various realms are unrecognized (Inhorn, 2006). Gender inequity in labour is juxtaposed with the concept that biological reproduction of labour power is crucial to capitalism. Even though women will be the ones reproducing the next workforce, a neoliberal policy arena does not value this essential role. Neoliberalism has, as such, constructed a "gender regime" built upon pre-existing sexual divisions of labour wherein the paid work that is primarily done by women is increasingly undermined and devalued; women's unpaid work (which reproduces the next labouring population) is unsupported by the state; and, women who wish to do well under these conditions must be "willing or able to live like men" (Braedley & Luxton, 2010, p. 12 - 15). Melinda Vandebeld Giles (2014) states that although there has been a global push towards reducing maternal and child poverty and mortality through economic empowerment, there have not been similar acknowledgments of the inequities in health related to women's essential and invisible role in unpaid social reproduction. Thus, neoliberalism reproduces, and is reproduced by, patriarchal relations. In this article we find that the changes in labour practices in India as a result of the Structural Adjustment program have led to a massive influx of women into the labour force. The combination of a devaluation of social

reproductive roles and the production of special economic zones of informal work, where gender and class exploitation occurs, tells us that there is a depreciation of women's work that is institutionally legitimized by a neoliberal state. Standing (1999) argues that "gender outcomes in labour markets do not reflect natural or objective differences between men and women, but rather reflect the outcome of discrimination and disadvantage, and the behavioural reactions by workers and employers." Women have been gaining an increasing share of jobs, but only due to growing unemployment and a decline in the valuation of labour. Moreover, women are still disadvantaged in the new labour markets, in terms of wages, training, and occupational segregation. They are also disproportionately involved in forms of employment increasingly used to maximize profits such as informal work.

Furthermore our findings illustrate that women in the informal sector tend to be those same women marginalized by the changes to health care reform. In the special economic zones, the majority of women are "young, unmarried, and have to work under almost-forced labour conditions, without unions, without the protection of labour laws and often threatened by direct violence. These women are usually fired when they get married, because their employers do not want to pay any maternity benefits" (Mies, 1998, pp. x). Often the employers and supervisors at the managerial rank who make these decisions are men (Mills, 2003). Neoliberal ideologies of labour control are able to construct the worth of the women's labour and what kinds of labour specific groups of women are best suited for. Since labour practices and health care are interwoven sectors of the market, the effects of this labour control ripple into their ability to access health care. We see this in the example of the agriculture industry in India, whereby the shift in economy did not boost the market value of beans, fish, sugarcane, or textiles – all products that are farmed and cultivated by the rural working class. Instead, it saw the

deregulation of drug prices, rising cost of health care services, and crumble of the public health care sector (Kothari, 1997). Most of the farming population lives in rural villages, with limited access to medicines, adequate infrastructure, and government money (Fan et al., 2008). Thus, gendered inequities in health care provision and labour practices compound one another.

Poverty and women's health outcomes are defined by the cross-section of their position in both health care services and labour.

### **Conclusion**

The impacts of neoliberalism in India on gender equity in health are complex and manifest at many levels and dimensions. The intersection of access to health care and women's position in labour practices is of particular importance when looking the articulation of gendered divisions of poverty. In India, these processes underwent significant changes during the early twenty first century. First, the Structural Adjustment Programs and the roll back of the state, which is associated with the shrinking of funds for health care and a targeted approach to health, adversely affected working, poor mothers. And secondly, there were alterations in labour practices that allowed many poor women to find industrial employment, making them susceptible to new forms of capitalist control, and also devalued their role in social reproduction. Through the explorations of policy changes in these areas we see that gender and class inequity are socially governed and therefore actionable. We have come to another critical juncture where the literature shows that there is a need for the integration social approach, rather than a market-based approach in development and public policy. There is a gap in the policy agenda, which needs to draw on feminist epistemological advances to address and alleviate gendered health inequity in India. The review of literature in this articles suggests that poor Indian women's relations to work, healthcare, and reproduction are inhabited by the intersecting

oppressions of gender and class; and that these relations, which are structurally decided by the discursive power of neoliberalism, ultimately affect their material health outcomes.

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