HEALTHCARE IN INDIA: GEOPOLITICAL ANALYSIS FROM THE PERSPECTIVE OF ANTI-GEOPOLITICS

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Abstract

This paper is an attempt to describe the Geopolitics of health in India - from the perspective of 'Anti-Geopolitics' or 'Resistant Geopolitics'. Geopolitics of Health refers to the analysis and political interventions that addresses the unequal and hegemonic relationships among states, transnational institutions, communities and individuals based on real or perceived differences in access to healthcare and healthcare policy formulation by different states. Healthcare in India is a complex scenario, which is designed by colonial and post-colonial history and geopolitics. This resulted in the presence of a robust medical pluralism, i.e. along with the state sponsored biomedical system, traditional medicines and faith-based healing systems are also very popular among the masses of India. One of the reasons for popularity of indigenous medicines in India, is the presence of a growing sense of resistance towards using biomedicine, which is perceived by the masses as imposition of western medicine. This phenomenon of mass resistance is intricated with geopolitical underpinnings. This study has attempted to understand such geopolitical phenomenon from theoretical perspective of 'Anti-Geopolitics as Cultures of Critique: A case of Faith Healing in India'.

Key Words: Geopolitics, anti-geopolitics, faith healing, medical pluralism, indigenous medicine

INTRODUCTION

In the domain of epidemiology and especially, public health, one has understood over years the centrality of politics to health. At the same time geography and health are closely tied-up. The place of our birth and stay shapes our health experiences, i.e. the food we eat, the air we breathe, the virus to which we are exposed to and the health services which are accessible to us. The social, economic and geographic factors impact our health outcomes in manners, which are quite relevant for our health policy. Therefore, territorial location plays an important part in creation of environmental risks and other health impacts. For example, location of healthcare facilities, targeting public health strategies and monitoring disease outbreaks all have a geographic context. (Dummer, 2008)

International matters, such as, environmental change, the international character of health service organization, and demographic transition have geographic dimensions that overtly influence health policy. (Asthana S, 2002) This is prominent from the very founding of the World Health Organization (WHO), right from the first Sanitary Conference held in Paris in 1851, through a series of meetings which took place over the next century, nations understood the geopolitical importance of health and the vital need to come together, to work together and to improve health.

The colonial history of the 19th-20th century aided in the establishment of the predominance of the biomedicine across the globe, in lieu of the Indigenous/traditional medicine. During the era of decolonization, the contemporary geopolitical forces, established biomedical system as the state medical system of most decolonised countries. During the early years of decolonization, there emerged various resistance movements from Indigenous peoples towards acceptance of biomedicine/western medical system, and a demand for traditional medical system was built. But over the years, due to the aggressive imposition of biomedicine by the

native dispensations, the intensity of the resistance movements decreased. This was true for India as well. (Bhattacharya S.)

But after the end of cold war, a new geopolitical scenario emerged. Since late 1980s, the World Bank (WB) has become the most influential donor in the arena of international health, actively promoting ambitious policy reforms and changing international health policy by becoming single largest external financer of health activities in low and middle-income countries. (Zwi, 2000) This the WB is doing as part of the Structural Adjustment Program (SAP). This intervention of WB had negative impacts on the health outcomes among vulnerable sections of the countries who were part of SAP. This result was staunchly criticised by international agencies like UNICEF, WHO and NORAD. Thus, lending to the health sector by the WB in the nineties had been tied to reforms, both structural and financial. The blanket policy prescriptions of the WB were not embedded in the specific history, experiences and problems of any particular country. This is due to the reason, that the loans forwarded by the bank were tied to the macro-economic adjustment policies, which most countries were unable to negotiate as equal partners of the bank. (Rama Baru, 2000)

In the context of India, it was apparent that the Bank's policy has resulted in distortion of priorities, esp. in regards to the communicable disease programs. Too much importance was once again laid on the vertical approach, which had demonstratively failed in the past. During the early nineties, more funds were provided for AIDS and TB than malaria and other diseases. (Rama Baru, 2000) This along with Bank's insistence of privatisation of healthcare at the tertiary level had resulted in creating gaps in healthcare provisions for the masses. (Srinivasan, 1995) The geo-economics of healthcare of the WB, is the manifestation of the larger geopolitics of health. (Rama Baru, 2000)

Geopolitics in health is an approach to global and local issues with politics of health in mind. Geopolitics in healthcare thus refers to analysis and political interventions that addresses the unequal and hegemonic relationships among states, transnational institutions, communities and individuals based on real or perceived differences in access to healthcare and healthcare policy formulation by different states. (Hyndman, 2001)

These geopolitics of healthcare of WB through SAP had resulted in disillusionment among the Indian masses towards its Government's health policy and public health system in general. This antipathy towards the health sector reforms by Government as part of SAP and its resultant inconvenience of the masses in the form of lack of access to public health system and high out of pocket expenses by visiting private practitioners of biomedicine, led to the emergence of the sense of anti-geopolitics among the masses. This approach of anti-geopolitics was manifested through people's resistance to use western biomedicine to address their health issues in lieu of traditional forms of medications. Thus, this paper, aims to study the healthcare in India, through the perspective of anti-geopolitics of health.

METHODOLOGY

The methodology of anti-geopolitics – a strand of critical geopolitics - has been used to study the proposition of the paper. Critical geopolitics studies the geographical assumptions and designations which underlie the creation of world politics. It questions the statist concept of power in the field of social sciences, a conceptualization, which John Agnew has termed as "territorial trap". Therefore, in line of political geography, critical geopolitics argues that spatiality is not limited or confined to territoriality. A strand of critical geography, is anti-geopolitics, this is an inquiry into popular culture and regular life. It is a form of political and cultural force within civil society, that shapes forms of counter-hegemonic struggles. (Kuus, 2017)

The study analysis, is based on the review of the existing literature on the geopolitics, critical geopolitics, anti-geopolitics, feminist geopolitics, and healthcare in India (both western and traditional). The literatures reviewed were identified in an extensive search of academic search engines and cross-referencing of bibliographies. The arguments and the observations were tested against each other for ensuring the highest possible accuracy.

Geopolitical History of Healthcare in India

Healthcare in India is a complex scenario, which is designed by colonial and post-colonial history and geopolitics. This is augmented by a robust medical pluralism. Currently, multiple medical systems contribute to provide healthcare in India, like, biomedicine, ayurveda, unani, siddha, homeopathy, naturopathy, yoga and the practitioners of a variety of folk traditions. Among these medical systems, unani medicine is from west Asia,

which entered India some 800 years ago, while naturopathy, homeopathy and biomedicine came to India nearly 200 years ago from Europe, and subsequently, became part of the medical tradition of this country. (V Sujatha, 2009) Thus, the emergence and entry of different forms of medical systems, their acculturation into different communities, along with its synergy and contestations with the indigenous medical system, reflects the unique medico-cultural geopolitics of the time.

The above narrative shows that India has been home to different medical systems, but since 20th century the state-sponsored healthcare is based on biomedicine. This is a model in which, the 'other' systems of medicine, which have mass support in terms of usage, large number of practitioners and cultural consonance have been casted against biomedicine (official system of state medicine). (V Sujatha, 2009) Now the question arises, why biomedicine was declared as the state medicine? The answer to this date back to our colonial period. The colonialism in India was a quest to gain geopolitical control over the country. Therefore, colonialism was not only a process of imposition of political control but also a process of establishment of domination of western science, technology and medicine. (Jose, 2007)

The expansionist policy of the British East India Company and its consequent occupation of the Indian territories, led to the establishment of a permanent military presence in India. By the end of 18th century, this led to a corresponding expansion of military medical services in India, in the form of establishment of The Indian Medical Service (IMS). Since then, the Britishers, had started to colonise the body of Indians. This got further impetus, after the Great Mutiny in 1857, when the Company rule came to an end and the IMS became the responsibility of the British Government. In this manner, the IMS owed its institutional origins nor out of the metropolitan models neither to indigenous precedents but emerged out of the geopolitical requirement of the early colonial rule. Along with IMS, the role played by the missionaries in dispensing public health services in India was notable. They also helped to embed the use of biomedicine in India, against the other forms of medical systems. The Christian Missions, participated in creating health awareness and facilities, which supplemented the work of the colonial administration and filled the gap that existed in the facilities created by the Government. This shows that the colonial state was not the sole patron of biomedicine in India, the missionaries played a dominant role throughout the 19th century. (Jose, 2007). Along with them, the nationalist organizations of India also played a major role in establishing biomedicine as sate medicine post-independence, as many prominent leaders of Indian National Congress, etc were champions of biomedicine. (Bhattacharya S.) But since 1920s till mid-1940s, provincial governments and popular leaders like Gandhi, had made various efforts to reverse this trend. And in 1946, when India's first National Healthcare Policy was drafted by the Bhore Committee, indigenous practices were totally ignored. Thus, resulting in adoption of the western biomedicine as the state medicine of India post-independence. (Srinivasan, 1995)

Resistance towards Biomedicine in India

Popular resistance against state-based biomedicine is common among Indigenous population in most of the countries of the world. This is true more due to their shared history of colonial rule and its role in undermining of the traditional systems of medicine. Even in places like Europe and North America, where biomedicine is the official system of medicine in the state health services, a public demand for Complementary and Alternative Medicine (CAM) are at odds with the state efforts to provide a standardised system of healthcare. (V Sujatha, 2009)

During mid-1970s, the demand for indigenous system of medicine among the people of developing countries, were termed as 'medical pluralism', i.e. people explored multiple options for healthcare outside the government healthcare system, which was based on biomedicine. And by 1990s, CAM became popular in the West and started denoting the inclusion of CAM within the state health administration. The responses of state administration to social resistance varies, as per the type of resistance, and the character of the government involved. When faced with such challenges, governmental responses include repression, cooperation, co-option and accommodation. (Routledge, 2006) The Indian state has tried to respond towards this resistance towards use of biomedicine by the technique of co-option and accommodation. Because unlike in western countries, in India, neither the colonial administration nor the independent Indian state could strictly regulate the use of Indigenous Systems of Medicine (ISM) outside the domain of state regulated medical facilities. (V Sujatha, 2009) Therefore, this was done by incorporating the concept of medical pluralism in the state medical system, i.e. by including AYUSH in the formal medical system of India. In the month of March, 1995 the Department of Indian Systems of Medicine and Homeopathy (ISM&H) was created by Government of India, under the Ministry

of Health and Family Welfare and renamed as Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy (AYUSH) in November, 2003. (Department of Ayush - Government of Madhya Pradesh, 2017).

Still after incorporation of AYUSH, a large segment of Indian masses, visited traditional practitioners outside the state sponsored AYUSH clinics and state certified traditional practitioners. This phenomenon, can be looked at by understanding the Healthcare Seeking Behaviour (HSB) of the people of India. HSB refers to the decision of an individual to attain, maintain and regain good health and preventing illness. The decisions are to visit a health facility (which can be, public or private and modern or traditional), to do self-medication and to use home-based remedies or not to utilize the existing healthcare services. (Kumar, Kapinakadu, & Anil, 2019) The desired HSB is related to visiting of formally recognised healthcare centres. But due to people's resistance of visiting the state sponsored medical systems, which is characterised by low quality treatment, long waiting period, long distance, inconvenient location and inadequate facilities, they visit traditional medical practitioners (including faith-based healers for treatment of mental health) to seek treatment. Apart from public health facilities, people also resist visiting private healthcare facilities, due to high out-of-pocket expenditure. This poor quality of public health system and high cost of private biomedicine providers has become more acute post SAP. This means, mostly the marginalised population of developing countries, like India, has started resisting the state-based biomedicine, in lieu of the traditional medicines, which are generally cheap, and is easy to access. This shows that HSB is a result of a complex interaction of provider (both biomedicine and traditional), patient, illness, and household characteristics. This resistance of biomedicine is more apparent in the rural areas, as nearly 80% of the biomedical health facilities, both public and private are concentrated in the urban areas and are thus, mainly utilised by the urban communities. (R. C. Chauhan, 2015) Therefore, here we can see that along with cultural resistance to biomedicine, social structural factors also caused wide spread resistance to the use of western medical system. The aspect of cultural resistance has an anthropological interest, whereas, the social structural issues has been studied mostly by the sociologist. (V Sujatha, 2009) But when we study this phenomenon from a geopolitical perspective, we tend to acknowledge both the views of anthropologist and the sociologist and at the same time, we study the role of state and the International players in confronting the issue of popular geopolitics from below.

Anti-Geopolitics as Cultures of Critique: A case of Faith Healing in India
In the above discourse, two 'cultures of critique' can be seen. First, is the internal generation of the critique of culture's own principles, and the second, is when an outside critique is made. This gives rise to the two-dimensional nature of both forms of critique. The first form of critique, is marked by 'rootless universalism of west' and the second, is marked by 'clinging particularism of Indians'. (Bhattacharya K. C., 1954)
The first form of western universalism (rootless), is marked by current attempts to internationalise health which in turn pathologizes the developing nations. This is a part of a developmental discourse, that see the developing countries as 'lagging other' of the developed Western nations. This leads to the formation of a geopolitical discourse, i.e. a continuing means of colonial subject formation. This Ashis Nandy, refers as covert colonization of minds. This is also a part of the political economy of global health, where WHO, conceptualises health issues through an economic discourse, i.e. ill-health (both physical and mental) as a load and as wastage of working hours. During the same time, for the pharma sector, promising countries, such as, India are considered to be the abode of drug makers, because 'the sector's future now rest in the developing countries. (Mills, 2012) This discourse of WHO, has been carried forward by the World Trade Organization (WTO) and the IMF, through the SAP, which has been discussed earlier in this paper.
Then comes the 'clinging Indian particularism', which is an attempt to uphold the traditional health system, and to celebrate such processes which mark their particularity to the global south. This phenomenon, at times creates a risk of misdirected glorification of everything traditional and depreciation of practices of other cultures. (Bhattacharya K. C., 1954) And this Indian particularism, has seen a revival in the past two decades.
The phenomenon of Indian particularism, can be best illustrated with a case of 'Faith Healing in India'. In the field of mental health, Indians mostly prefer to avail faith healing for treatment of mental illness, instead of availing biomedical psychiatric treatment. Here faith healing introduces a form of service that is not clinical or institutional in a typical western sense. In other words, the concept of faith healing not only offers a form of gendered/subaltern criticality to the mainstream psychology, it offers a criticality, which borders on a passive

form of resistant differing. At the same time, it also offers to the traditional Indian treatment of mental health, a new form of uncertain situation. (Sabah Siddiqui, 2014)

This case of seeking of faith healing for psychological treatment is a classic illustration of resistance/popular geopolitics. Here people (Indians) are drawing a link between place (site of traditional faith healing), healing (the treatment provided) and spirituality (the mystic). This relationship is antagonistic to the relationship between place (psychiatric clinic), healing (biomedical psychiatric treatment) and rationality (modernity). The accessing of faith healing as a preferred mode of treatment shows that there is a strong relationship between place, spirituality and healing, as people, continues to seek healing of body, mind and spirit in similar sites, by bypassing the state sponsored western psychiatry. This is a clear sign of the popularity of the geographies of therapeutic landscapes among the Indian masses, and shunning of clinic based biomedical psychiatric treatment. (Perriam, 2015)

CONCLUSION

Social resistance movements shape anti-geopolitics on a number of interrelated factors within society, which includes, economic, cultural, political and geographical issues. Thus, this social resistance towards utilization of state backed biomedicine in India, is manifested through consumption of huge volume of traditional medicine in the country, which is based on interrelatedness of the above stated factors. This is evident from the fact that large number of traditional medicines used within India continue to be produced by the hundreds of cottage industries and small firms of traditional medical practitioners. This is indicated by the figure, that there are 6,965 small and very small manufacturing units for Ayurveda (this includes cottage industries at country sides), against existence of only 10 large manufacturing units. In total the pharmaceutical industry of traditional medicine in India is estimated to be worth of Rs. 4,200 crores, in which Ayurveda alone accounts for more than 80% of the share. (Bode, 2006) At the same time, there is presence of nearly 10,000 licensed private manufactures of traditional drugs in India, this includes 500 in Ayurveda, 300 in Unani and 200 in Siddha. This market estimate of traditional medicine in India, shows its demand among the masses.

Therefore, through this paper I have tried to open the scope to gain an insight into the interplay of socio-economic, geographic, and politico-cultural dimensions of healthcare in the contemporary Indian society, from the perspective of anti-geopolitics, which is a strand of the field of critical geopolitics.

REFERENCES

[1] Asthana S, C. S. (2002). Themes in British health geography at the end of the century: A review of published research 1998-2000. *Social Science & Medicine, 55*(1), 167-173. Retrieved February 25, 2018

[2] Bhattacharya, K. C. (1954). Swaraj in Ideas. *Visvabharati Quarterly, 20*, pp. 103-114.

[3] Bhattacharya, S. (n.d.). *The introduction of western medicine in India.* Retrieved February 26, 2018, from The UCL Centre for the History of Medicine:
http://www.ucl.ac.uk/histmed/downloads/ma_teaching/lo/c123_9b.pdf

[4] Bode, M. (2006, December). Taking Traditional Knowledge' to the market: The commoditization of Indian medicine. *Anthropology & Medicine, 13*(3), 225-36. doi:10.1080/13648470600863555

[5] *Department of Ayush - Government of Madhya Pradesh*. (2017, February 6). Retrieved March 5, 2018, from http://www.ayush.mp.gov.in/en/brief-history

[6] Dummer, T. J. (2008, April 22). Health geography: supporting public health policy and planning. *CMAJ, 178*(9), 1177-1180. Retrieved February 25, 2018, from
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2292766/pdf/20080422s00022p1177.pdf

[7] Hyndman, J. (2001). Towards a Feminist Geopolitics. *The Canadian Geographer, 45*(2), 210-222.

[8] Jose, N. (2007, January 31). *Introduction and expansion of western medical system and health services in colonial India.* Retrieved February 26, 2018, from Shodhganga:
http://shodhganga.inflibnet.ac.in/bitstream/10603/132146/11/11_chapter%202.pdf

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https://www.gapinterdisciplinarities.org/

[9] Kumar, H., Kapinakadu, S., & Anil, M. (2019). Health seeking behaviour and its determinants among rural population - a cross sectional study in South India. *International Journal of Community Medicine and Public Health, 6*(11). doi:http://dx.doi.org/10.18203/2394-6040.ijcmph20195085

[10] Kuus, M. (2017, March). Critical Geopolitics. *Oxford Research Encyclopedia of International Studies*, 1-24. doi:10.1093/acrefore/9780190846626.013.137

[11] Mills, C. (2012). Live and let die: Global mental health and critical disability studies. In J. A. B. Sapey (Ed.), *Distress or Disability: Proceedings of a Symposium Held at Lancaster University* (pp. 57-61). Centre for Disability Research (CeDR), Lancaster University.

[12] Perriam, G. (2015). Sacred spaces, healing places: Therapeutic landscapes of spiritual significance. *Journal of Medical Humanities, 36*, 19-33. doi:DOI 10.1007/s10912-014-9318-0

[13] R. C. Chauhan, M. A. (2015, June). Determinants of health care seeking behaviour among rural population of a coastal area in South India. *International Journal of Scientific Reports, 1*(2), 118-122.

[14] Rama Baru, A. J. (2000). The role of the World Bank in international health: Renewed commitment and partnership. *Social Science & Medicine, 50*, 183-184.

[15] Routledge, P. (2006). Anti-Geopolitics. In K. M. John Agnew (Ed.), *A Companion to Political Geography* (pp. 236-248). Blackwell Publishing Ltd.

[16] Sabah Siddiqui, K. L. (2014). Faith healing in India: The cultural quotient of the critical. *Disability and the Global South, 1*(2), 285-310.

[17] Srinivasan, P. (1995). National health policy for traditional medicine in India. *World Health Forum, 16*(2), 190-193.

[18] V Sujatha, L. A. (2009, April 18). Medicine, State and Society. *Economic and Political Weekly, 44*(16), 35-43. Retrieved February 25, 2018, from http://www.jstor.org/stable/40279154

[19] Zwi, A. (2000). Policy Forum: The World Bank and International Health. *Social Science & Medicine, 50*, 167-168.