

**NEW REPRODUCTIVE TECHNOLOGIES AND
HEALTH CARE IN NEO-LIBERAL INDIA:
ESSAYS**

Imrana Qadeer

Monograph

(November 2010)



CENTRE FOR WOMEN'S DEVELOPMENT STUDIES
25, BHAI VIR SINGH MARG, NEW DELHI-110001.

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Contents

Preface.....	ii
I. Technology in Society: Case of ART/Surrogacy in India.....	01
II. New Reproductive Technologies and India's Transitional Health System.....	09
III. Social and Ethical Basis of Regulatory Legislation on Surrogacy: Need for Debate.....	27
IV. The ART of Marketing Babies.....	37
V. The Neo-liberal interpretation of Health as a Fundamental Right: Draft National Health Bill- India and the Affordable Health Care for Americans Act in 2009.....	52
VI. Benefits and Threats of international trade in health: A case of Surrogacy in India.....	67

Preface

In the nineteen seventies J.P. Naik initiated a move to bring together ICMR and ICSSR to develop a blueprint for Comprehensive Primary Health Care for India within his interdisciplinary vision of an equitable welfare sector. I had the privilege of meeting him when this report was being debated at the Centre of Social Medicine, JNU, and was impressed by his capacity to cross boundaries across disciplines and age groups and his passion for change. So when CWDS offered me the J.P. Naik Senior Fellowship for 2008-2010, I not only felt humbled for the privilege of being associated with a Fellowship in the name of a distinguished scholar, but it also brought back the memory of a generation that had believed in the possibility of an equitable society. The Fellowship also gave me an answer to the sympathetic, irrepressible, "Oh, you have retired!" I am therefore, doubly grateful to the CWDS and its faculty. They offered me an academic space and stimulating interaction, they shared their facilities (and food) generously, as well as their warmth and friendship. The library staff is an amazing lot at CWDS and I am grateful to each one of them for their help and support.

The freedom of doing only that which I wanted to do was new to me and I hope I have not squandered the opportunity. I did get deeply involved in many activities because of the space provided by CWDS - be it the standing Committee of the UGC for Women's Studies Centres or the project on traditional knowledge systems called JEEVA that focuses on the value of Traditional Birth Attendants and is now housed in CWDS. Egged on by Veenad's enormous enthusiasm, I had started working on Technology and Women's Health which has now become a part of my research agenda. These two years I focused on the ethics and legislation of New Reproductive Technologies. The papers here are the assembled product of my work during the two years of my association with CWDS. I see this time as a beginning of new learning, association, and explorations for myself. I look forward to comments and criticism from colleagues.

November 2010

Imrana Qadeer

Technology in Society: A Case of ART/Surrogacy in India

Imrana Qadeer*

The present faith of the middle class in technology to deliver the planned goals of economic, social and environmental justice has provided a shield of absolutism to the ever growing domination of technologies. This is particularly so in the field of health where the so-called beneficiaries are the least knowledgeable as well as physically and emotionally vulnerable and rarely in a position to make the final choice – either for themselves or for their dependents – once the outcomes of non-use are placed before them by professional practitioners. This absolute dependence on technology is largely rooted in an understanding of development that assumes the legitimacy of mechanical control, both of nature and people, in a manner that supposedly increases the overall efficiency of social systems. Added to this is the notion of autonomy of technology itself, and its conception as an entity which is almost like second nature to mankind, and therefore unquestionable. The dominant perspective on technology therefore remains deterministic and technologies have remained the propelling force behind market-oriented developmental processes in societies. Starting from manufacturing, transportation, communication, education, and medicine, technological control has penetrated almost every arena of life including the creation of cyborgs – the partial mechanisation of human beings themselves. Though the critics of technology point out its dehumanising effects, its manmade nature, and the need for human will and spirit to dominate, these ideas have only very slowly influenced the mainstream processes due to reasons embedded in the histories of class societies. According to Andrew Feenberg, there has been a surfeit of the essentialist philosophy of technology and we need to question concepts like technological imperative, instrumental rationality, efficiency etc. Technological essentialism, he believes, is born out of a loss of distinction between analytical

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and ontological categories in the study of technology and society that has led to technology acquiring its independent existence and being seen as a distinct thing or practice interacting at its boundaries with society- what is generally referred to as interphase between technology and society. In the process, another disconnect occurs between technical rationality and its experiential meaning – which may be different for managers and users, but that distinction is subsumed by the managerial interpretation based on a rationality that gives technology a unilateral face. This, in fact, is the terrain of struggle, according to Feenberg, for the different actors involved in technology. “Liberation from technological fetishism will follow the course of liberation from economic fetishism. The same story will be told about machines that we tell today about markets”. He foresees that, “Real change will come not when we turn away from technology but when we recognise the nature of our subordinate position in the technical system that enrolls us, and begin to intervene in the design process in the defence of the conditions for a meaningful life and a liveable environment” (Feenberg, A., 1999). Not going into the details of this domination or the criticism of technology, we are here trying to understand the other side of the coin. What holds us back from intervening in the design process?

Growth of technology is no doubt a reflection of human creativity; it has helped generations to survive and improve the quality of their lives through the control of nature. This control, no doubt, often meant destruction and domination of other species but it has also helped save other species at times. Technology has on the one hand been the instrument of the ruling classes to dominate, and on the other technological innovations have constantly challenged the social organisation of work, or of other spheres of civil society. In doing so it offers human societies a chance to re-examine their own humanity and create a better, more inclusive and egalitarian society. Why is the potential of technology subdued today? Why has this manmade asset been so trapped in the wheels of commercialisation and free markets, that its progressive potentials have been obfuscated? The reasons we believe are as much rooted in social processes as the origin of technology itself.

The history of medical technology in fact shows how innovations were initially tested by individual doctors to assess benefits for their patients. How alternative technologies competed not through the profits they created but through the benefits that accrued in diagnostics and therapeutics. Over time, with the recognition of its profitability and market value (both in diagnostics and therapeutics), and the growing complexities of production of technologies that required heavy investments, control shifted from the hands of the inventors into the hands of the investors who could produce and sell. Once in the hands of

entrepreneurs, the logic behind the use of technology acquires dimensions other than benefitting the patient; it becomes a means of earning profits and thus decides who is going to use it – rich or poor? The number of people affected acquires a new significance as it determines the scale of production conducive to profits. The role of the State as a client paying for the large scale use of technology among the poor becomes crucial in markets operating in democratic countries. Social perceptions of needs and acceptance or non-acceptance of a technology, as well as the State's readiness to invest in purchase and supply or its willingness to act as a steward for the private sector, are other key factors that the entrepreneurs take into account. The cost of technology determines the play between needs/demands and feasibility – both for individuals and the State. In other words, technology is selectively embedded in its context which determines its value at a given point and time. What is important is that the epidemiological relevance of technologies – its relation to the size and extent of the problem and its social determinants – have not received the attention that was due to them till the negative impact of the technology itself started raising issues of iatrogenesis, high costs, limited impact, and the exclusion of large populations.

One area of medical science where technological growth has been phenomenal is the discipline of obstetrics and gynaecology. It evolved from witchcraft to wisdom and technological development within it was rapid during the late nineteenth and early twentieth centuries. The earlier history of this discipline is primarily linked to complicated births. The technology that evolved ranges from manual techniques to Caesarean section, forceps, and foetoscope to electronic foetal detector, amniocentesis, and intrauterine surgery that came with the science of embryology. Use of 'burking' – murdering to order, usually for medical research (Campbell, D., 2010) – was not unknown in the 18th century and has been an issue in the twentieth century as well (Illich Ivan, 1975). Thus the scientific discipline grew with its associated destruction that was inevitable given its reductionist and inductive methodology. By the middle of the 20th century's decline in mortality rates, maternal mortality no more remained the only concern; the desire of infertile couples to have children became another area of research in the west. In the United States of America, Asians and Latin Americans constituting 85 percent of the migrants, became an important group accessing these services (Mittman, I. et al, 1998). Gradually the technology came to several developing countries with strong patriarchal structures where motherhood and a male child continue to be strong social values. The progress of biological research around pregnancy led to the first extraction of fertilised ova in 1973, and a successful IVF pregnancy in 1977 leading to the birth of baby Louise Brown in Britain in 1978. The evolution of reproductive endocrinology contributed to the success of

in-vitro fertilisation techniques as they elaborated the role of key pituitary, ovarian, and placental hormones in the sustenance of pregnancy. With this Dr. Steptoe – the scientist behind Britain's first IVF baby – was able to achieve his success. Though eugenics was shunned by 1950s due to its disreputable use against the Jews in Nazi Germany, its supporters strove for its survival within disciplines such as socio-biology, evolutionary biology, and genetics. With the evolution of science it got a new lease of life in the name of positive eugenics; which became a part of the growing field of genetic engineering in the 1970s and 80s when some of the eminent scientists, who were also supporters of the theory of biological determinism, eugenic sterilisation, and anti-Semitic research, backed it through their work (Qadeer, I., 2005). While genetic engineering brought in the benefits of a new breed of plants with increased production of grains and pest resistant varieties in agriculture; healthier and more productive cattle and improved animal husbandry; and drugs for use in medicine (production of insulin); it's coming together with embryology and obstetrics and the human Genome project of the 1990s led to a whole range of experiments that exploded with possibilities. It led to development of techniques of sex selection, prenatal diagnosis, prenatal treatment, as well as enhancement of future generations and the notion of a 'designer baby' in the first decade of the twenty first century, where artificially selected genetic makeup becomes a possibility through IVF and embryonic implants to achieve the desirable features in the newborn. Research on gonadal stem cells and germ line gene therapy has opened up a huge potential in genetic engineering even though their actual translation into diagnosis and therapeutic technologies has as yet remained limited.

These technologies were mostly developed in the west where philosophical and ethical debates were rooted in socio-cultural, political, economic, and epidemiological settings very different from the Asian countries. While the focus of the debate there is within the human rights frame with a focus on the individual's right to reproduce, the entry of these technologies in India is justified on the basis of increasing need due to high infertility. The reality is that it has more to do with the trans-border trade and transfer of technology, cheap medical markets that attract medical tourists, and availability of cheap organs for loan and transplant (as of kidneys). In this context then, what happens to creativity or the possibilities of change that new technologies bring to societies? The practice of surrogacy/assisted reproductive technology (ART) in India is an important area to examine this question as they have implications for socio-economic life and are in turn influenced by its ethical basis, epidemiological characteristics, and limitations of health service infrastructure, legislation and state policy.

Surrogacy and ART offer several turning points. For example, first and foremost they question the essentialism of genetic parentage, bring to the fore the importance of gestational and social parenting, make family a right of all non-heterosexual couples, question patriarchal values of paternal control, open up the family to new possibilities of human relations, underline the need to do away with secrecy, and consolidate child rights. However, given the nature of society, most of the time these possibilities are sabotaged. For instance, some of the simple forms of ART like artificial insemination and IVF do offer solutions to infertility but the markets that primarily control them have restricted access to only those who can mobilise resources. Absence of simple services in the public sector makes its access to the poor impossible and the legislation is being so articulated that simple technologies are debarred. The existing demand (more by professionals and the middle class) for these services distorts priorities in the organisation of health care services as pressure is built to set up hi-tech within open markets and public sector service infrastructure without building the basic facilities that help prevent infertility. The poor then have to either sell their assets to access the facilities, or use the opportunity to earn by selling their own reproductive potential – the women that are pushed into this process carry the maximum risks to their health. Even the limited scope of changing social norms, created first by the practice of adoption and now through surrogacy, has not opened the world of family for scrutiny. Those who use the new technology to create their families continue to do so in secrecy within the prevailing norms of a patriarchal family where genetic ownership of the baby has the highest value. ART has in fact, undermined the spreading movement for adoption as an alternative by selling the dream of owning your own baby. The fact that only one partner contributes the genetic material in most cases and that there are unknown genes of the donor, and therefore the problem of 'ownership' still persists, is completely sidelined even when there are reports from the West of mutual resentments and intra-familial tensions between children and parents. The prevailing social structures thus appear to succeed in dominating the new technology and throttling the challenges it throws open to society. New Reproductive Technology thus becomes the means of propagating the old and traditional family norms. The State also exercises its restraining power to keep the status quo by introducing legislation that promotes markets for reproductive tourism, reinforces traditional values that help market proliferation, and protects the interests of the foreign clients and the growth of research in genetic engineering with its huge monetary promises. Often this legislation undermines the policies that were put forward to promote universality and equity. Above all it underplays the experimental nature of many of the techniques of assisted reproduction and shows little concern about the use of women as guinea pigs and of the risks that

they are made to accept due to their sheer economic vulnerability and lack of safety measures built into the legislation itself.

The papers presented here elaborate on some of these issues and reflect the social dynamics that surrounds the introduction of New Reproductive Technologies. The first paper, "NRT and India's Transitional Public Health System" (Qadeer, I., 2010) , looks at the existing load of the infertility problem, its social dimensions, and the value of ART given its technical limitations, harmful effects, and high costs. It essentially attempts to locate NRTs within India's primary health care system with a public health perspective. The second paper on "Social and Ethical Basis of Legislation for Surrogacy: a Need for Debate" (Qadeer, I., 2009), looks at the existing social norms, the conflicts emerging from the practice of ART, and the extent to which the proposed legislation is able to contain them by reasserting ethical principles. The third paper is a critique of the Draft ART Regulation Bill, 2008, to point out its unscientific and pro-market position that lies totally against the interests of the poor women who offer to act as surrogate mothers. It illustrates the role of a State which is more of a steward for the private sector wishing to enter the medical care market (Qadeer, I., 2010). The fourth paper critiques the Draft National Health Bill, 2009 which in one stroke, in the name of universalisation of health care and right to health services, resolves all the problems for the State by shifting its responsibility from 'provisioning of services' to 'access to services' and is no more weighed down by the burden of providing comprehensive care and can opt for the private partnership model (Qadeer, I. & Chakravarty, I., 2010). This legislation, if passed, will undo all previous policies for provisioning comprehensive Primary Health Care within the Alma Ata framework. The handing over of the ART facilities to the open medical market is totally justified within the legal framework of this Draft Bill and, when put together, these two drafts, ART Regulation Bill, 2008 and National Health Bill, 2009, make a lethal combination for the most marginalised – the women who have no bargaining power and fall within their purview. The fifth paper is a conceptual overview of the benefits and threats of International Trade in Surrogacy. It argues for the need to evolve some universal international norms for the practice of surrogacy (Qadeer, I. 2010), and the 6th and last paper, "Medical Tourism: Progress or Predicament" (Reddy, S. & Qadeer, I., 2010) explore the new world of medical tourism to show how keen the State is to invest directly and indirectly to promote this form of private enterprise while ignoring the marginalisation of those in India who need the services most, both reproductive as well as medical.

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New Reproductive Technologies and India's Transitional Health System

Health and health services are dynamic outcomes of changing socio-economic, political, cultural, environmental and biological conditions and levels of technology and its organisation. The term public health refers to this dynamics of population. It invokes different meanings for different people according to the perspectives they carry. Once it meant hygiene, sanitation and health education within the sanitary perspective. Today, the techno-centric perspective (that ignores all socio-economic determinants of health)_dominates where experts and providers call the shots, as health services are primarily concerned with extensive application of medical technologies for preventing and controlling diseases. Yet another is the holistic perspective, where the social context of health and health services is given weight and prevention extends beyond technological and educational interventions into developmental and welfare activities to meet basic needs. It recognises the importance of inter-linkages of health with food availability, drinking water, sanitation and livelihood and also the constraints that power structures impose on access and availability of technology. In other words, this perspective shows the limitations of a techno-centric perspective- in achieving public health goals and shows that to reach the less privileged the level of equality and equity (structural and distributive potentials) must be addressed within a context. Its outlines emerged in the 19th Century with the public health movement in Britain, and it was widely accepted after 1950s when plurality of causes of disease became evident and social democracies promoted welfare.

In countries where the governments have failed to achieve equity in welfare, more and more of the societal problems are being labeled as 'technical problems' and pushed into the medical domain. For example, population planning, child abuse and now infertility are seen as purely medical issues. This is primarily because the links between production, reproduction, structure of labour, poverty, caste class stratification and patriarchy are neglected in planning. Their exclusion from the domain of social planning leads to a shift away from the holistic perspective of public health and the social roots of these problems remains un-tackled. For example, treating RTIs, STDs, providing better maternity care, safe contraceptives, abortion services and assisted reproduction may, to some extent,

control infertility in certain sections but, cannot reduce it to the extent possible, as infertility is rooted in the social situation that breeds infections, under-nutrition, values that undermine women and inequity of access to services.

Purely technological solutions are often too costly; combined with social alternatives they become more feasible, effective and humane. Yet, even within the techno-centric perspective, currently there is a clear shift from a systemic to a disintegrated institutional strategy that promotes tertiary care through competing, discrete institutions within the expanding medical market. A grasp over these shifts of perspective in public health in independent India makes it easier to understand why Assisted Reproductive Technologies (ARTs)¹ have become a part of the private medical market, and how- infertility could be tackled in the holistic perspective. Shifts of perspective determine the relative priority of infertility in service provisioning, technological strategies to deal with it, its linkages with welfare services, and the spaces for public to access service facilities.

The Context of Public Health in India

The health planning exercise taken up by the National Planning Committee of the Indian National Congress (1938), the Health Survey and Development Committee (1946), the National Health survey and Planning Committee, the Five Year Plans and the inputs given by the WHO in systems planning² had laid down concrete principles for prioritisation and problem selection when the resources are limited. According to these principles, public health must address the problems of the entire population. Secondly, among a large number of medical problems, those that caused maximum mortality and morbidity had to be addressed first. Thirdly, since technology was a key factor, its availability, indigenous production and costs had to be keyed in when setting priorities. Fourthly, building and maintaining infrastructure necessary for providing the services was an important priority. Right from 1930s, poor socio-economic conditions (lack of sanitation, clean drinking water, nutrition and housing) were considered a major factor in the production of disease and in limiting access. Therefore, tackling them through overall development was accepted as an important step in health planning³.

Despite accumulation of sufficient knowledge regarding comprehensive health planning, the health system slowly started restricting itself to provision of medical care for specific problems and health and welfare sectors were dealt with separately. It is evident that the principles of planning though strongly rooted in the Indian experience were not sufficient to direct the planning process that was caught between the contradictions of the objective reality and different ideological approaches of changing governments and national politics. Its shift away from

the holistic perspective was not only due to the undue dependence of the second generation public health planners on technology, their inability to see the close inter-relationship between living conditions and health, but, also the larger constraints of the social and economic system that bred rural urban disparity in the health care provisioning, undue emphasis on curative services catering to the elite, overemphasis on training medical doctors rather than paramedical and nursing staff and domination of professionals and foreign experts. As a result several distortions developed in the health service system. There was over emphasis on population control, verticalisation of national programmes and a techno-centric focus⁴, along with a decline in health sector investments even before the Structural Adjustment Programme (SAP) was formally accepted.

Though in 1978 the Indian government signed the WHO's Alma Ata declaration that defined comprehensive primary health care as the basic health service that constituted the core of an affordable and need based development of communities. In its actual implementation, the government let the bureaucracy put together the already existing programmes on paper as primary health care without any major innovation. In time even this was reduced to selective primary health care (based entirely on specifically chosen programmes) and later with SAP and Health Sector Reforms beginning 1990s, into primary level care focusing only on grass root services⁵. Thus health planning in India that was inspired by the social experiments of Europe and the USSR continued to be shaped by international influences. By the end of 1970s the western economies were slowing down while the USSR had collapsed. Welfare economies were under severe stress and it became easier for the United States to push neo-liberal strategies. Growing neo-liberalism found many allies globally as well as within the national governments and the local elite of the Third world including India. Dumping its own experiments in building a welfare state, the Indian government accepted the Structural Adjustment policies and Health Sector reforms (cut backs, privatization, opening up of the public sector to private investments and casualisation of personnel) that allowed international capital to penetrate its markets and capture new areas of investments like health⁶.

With reforms a critical shift in the techno-centric perspective of public health occurred as it moved from an organized systemic application of technology to a fragmented institutional approach. This was projected as a strength that brought in global finance to modernize and remodel the structure of health system. The earlier conception of public health- based on epidemiological needs and the principle of self sufficiency- was replaced by the new mantra of globalization, and its homogenising international public health. The ground rules were, problem selection based on available technologies, protecting corporate and donor interests

and generating dependence on experts in public health in the Third World rather than self sufficiency. The implications of these were far and wide and reflected in (a) a new alliance between the international elite and, (b) a new set of principles guiding public health.

The alliance of the global capital and the local elite is based on a shared understanding of advantages. With the help of GATS and TRIPR, global capital seeks to liberalise medical markets, privatize public sector services, promote technology transfer, access to cheap manpower, use of population for research and access to natural resources⁷. The local elite look forward to receiving hi-tech services (at the cost of comprehensive public health) since they already captured the welfare benefits (land and housing, water supply, sanitation, education etc.) from the state. Expansion of medical market, unplanned growth of private and corporate tertiary medical sector and promotion of medical tourism increases if not welfare of the common man. The growing number of medical students abroad⁸ and in the mushrooming private medical colleges, shows the attraction of the expanding medical markets for the middle class professionals.

In the market framework, the new set of guiding principles for public health are, that the international financiers and MNCs- by deciding the availability of future technologies- determine priorities as reflected in the narrow health focus of the millennium development goals⁹. Secondly, individual needs of a small paying minority are now considered equally important, specially, because they are able to articulate these as demand. Thirdly, the previous conception of state's primary responsibility for public health is now transformed into a public private mix in the name of "plurality of services" and "decentralisation". Private, public and NGO services are all projected as components of one health service system though they neither share objectives nor operational principles. The government has become a steward and a purchaser for the private capital so, it smoothen the process of privatisation through good governance! Thus, by taking over the non-profitable health services and infrastructure development, it saves private capital from getting locked up. Also, the private and NGO sectors get the privileges of being service sector but none of its accountability. Fourthly, cut backs in resources leads to a neglect of the tertiary and secondary public institutions that remain untended and incapable of providing supportive facilities. Last but not the least is the fragmentation of a complex integrated system where in, the service institutions are now forced to use the operational principles of institutional economics and loose the systemic perspective.

These guide lines of a disintegrated, techno-centric perspective lead to commodification of, and increasing inequity in services. Autonomy given to

institutions led them to strive for survival through investing in services that enhanced profits (orthopaedic, cardio-vascular and obstetric). Thus, priorities were distorted and easy access for the poor became less feasible. The National Sample Survey 1998-99, shows that 40 percent of the hospitalized persons are forced into indebtedness and 26 percent of the poorest deciles do not seek any service when sick¹⁰. Even the current effort of the National Rural Health Mission (NRHM) to reach out to the poor is guided by the same principles despite its claim of an integrated and systemic approach¹¹. It focuses on RCH leaving the rest of the programs as vertical, it depends heavily on private involvement and it neglects tertiary care for the poor. Where will such a system locate the high cost ARTs? What should be the contours of infertility services as a component of the Family Welfare Programme based on the RCH strategy? These are the questions that the following sections address.

ART in the Indian Health Services

Deaths and morbidities due to many preventable diseases have stagnated or risen, Infant Mortality Rate decline has slowed down over 1990-2004, anemia in the vulnerable population remains high¹² and serious questions are being asked about the performance of Polio¹³, Leprosy¹⁴ and Tuberculosis Control Programmes¹⁵. Yet, India is boasting of the quality of its tertiary sector that can now compete with international institutions and contribute to economic growth¹⁶. The celebration ignores the implications of this contradiction for the health of the common people. It is in this context that we have to look at the introduction of ARTs in India.

The first test tube baby was born in a public private partnership, at the initiation of ART research at the National Institute of Reproductive Research. Since then, its slow expansion has been a gradual but steadily increasing phenomenon. In the 80s biotechnology had acquired the reputation of the cutting edge of applied sciences and well meaning scientists, committed to biotechnology, were keen to put it to use for the benefit of the people. One of them argued that through ART, "A woman can give birth to a child from her husband even after the husband is dead. In surrogate motherhood, a couple who is otherwise normally fertile *but the wife does not want to go through the nine month pregnancy that would confine her for a substantial period, can have—another woman who would then give birth to a child totally unrelated to her*"¹⁷ (emphasis added). He also pointed out that over the past 10 years or so, our country has seen a mushrooming of fertility clinics. The grasp of patriarchal influence on social and economic conditions, and cultural values within which women live and his faith in technology is self evident. It was this same faith in technology that inspired the

ICMR to support National Institute of Reproductive Research to take up ART research and later to bring it in the Family Welfare Programme and tertiary care service institutions in the Ninth Five year Plan. It was said that couples wanting re-canalisation could use ART as a simpler, less invasive method of conceiving. This would make acceptance of sterilisation easier for them and would be a boon for the Family Planning Programme¹⁸. The ICPD declaration at Cairo on reproductive rights and choices emphasised expanding the scope of reproductive health and thus promoted ARTs in the name of women's choices and rights.

This vision of ART brought together both- promoters of medical market interested in generating profits through the sale of ARTs and the pro population control lobby of professionals and policy makers. The MNCs, interested in businesses that can be scaled up, soon realized the limitations of this set of highly individualised technologies. Their interest shifted to research on stem cells that have the potential to open up a much bigger market. ARTs for them became the source of obtaining ova and the embryos for research. For the private professionals however, given the son preference and social stigma against infertility, the present set of ARTs opened up a new opportunity to expand profits. Hence it was argued that higher rates of infections and ensuing complications in absence of adequate gynaecological and obstetric services contributed to high infertility in India. The socio-cultural 'need' of women suffering from harassment and social rejection was also used by providers to give ARTs the image of a gender sensitive technology. Finally, India's Ninth Five Year Plan introduced management of sterility in its comprehensive RCH Programme but not in the "Essential" package of RCH. It was said that given an estimate of 5-10 percent sterility, it is essential that couples who do not have children get access to essential clinical examination, investigation, management and counseling. It was proposed that while the expertise would be made available at the tertiary hospitals, basic services to detect causes and carry out preliminary investigations like sperm count, diagnostic curettage, and tubal patency tests will be done at the CHC to screen cases and refer them to appropriate institutions¹⁹. ICMR guidelines also mention that the scope of providing infertility services in the public sector needs to be explored. It is interesting that, while the Five year Plans committed to ARTs, the National Public Health Standards evolved for CHC²⁰ under the NRHM did not included the simple test facilities. This commitment was repeated almost verbatim in the Tenth Five Year Plan yet, the Broad framework for Implementation of the NRHM, while enumerating guaranteed services, talked only of treating RTI and ignored the simple tests for infertility at the CHC level²¹. Thus, in the public sector these services are confined to the tertiary sector and therefore not accessible to the majority.

We see then, that ARTs are a part of the glamour technologies projected by India to establish its international standards. It is however confined primarily to the private sector and tertiary public sector institutions accessible to a select few. The basic services have no strategy to deal with infertility. The intent of this neglect can be gauged only when we examine the prevalence of infertility and its causes.

Prevalence and causality of Infertility

Infertility/infecundity is mostly defined as failure of a sexually active couple to have a baby within one year of marriage without the use of contraceptives. It includes the term sterility²² yet the diagnosis of infertility does not necessarily mean sterility. Infertility could be primary or secondary when there is inability to have babies after one or more initial births. This is the more common cause of infertility in the Third World. In the US, according to the National Survey of Family Growth, 12 percent women in reproductive age group had impaired fecundity in 2002²³. In 2005, 134,242 ART cycles were performed in 422 clinics. Of these 38,910 were live births and 52,041 were infant births²⁴ indicating high level of success. Boivin et al analysed 25 population surveys on 172413 women in 2007 and found a 12 month prevalence rate of infertility ranging from 3.5-16.7 percent in developed countries and 6.9- 9.3 percent in the developing world. Of these on an average 56 and 51 percent respectively sought treatment and the range of these percentages was 42-76 and 27-74 percent²⁵. Interestingly, according to this review, infertility in the developing world is not higher as expected. According to earlier national assessment done over 1980s, the infertility rates in India varied between 4-8 percent²⁶. However, another study of rural Uttar Pradesh, Himachal and Maharashtra in 1986, where a total of 7,000 couples were surveyed (3000 in UP and 2000 each in Maharashtra and Himachal), gave very different results. Primary infertility was found in 3.7 percent couples but the prevalence of secondary infertility was much higher compared to the previously reported percentages giving higher rates for total sterility that came to 29 percent in Himachal Pradesh, and 24 percent in the other two states²⁷. NFHS 52nd round reports 3.8 percent childlessness in 40-44 year olds and 3.5 percent in currently married women²⁸.

The WHO's estimates of infertility in India using a two year period of failure to conceive as a definition through studies prior to ICPD, gave a prevalence rate of 3 to 8 percent for India²⁹. The Demographic and Health Survey (DHS) of 47 developing countries however, using studies over 1995-2000 and a definition of five years of failure to conceive, brings the total infertility levels in women aged

40-44 years and 25-49 years respectively down to 2.0 and 2.5 percent³⁰. This difference shows that the way infertility is defined itself is an issue. Most of the Indian assessments used to label a married woman infertile, are based on a period of one year of infertility after marriage, while the longer periods get comparatively lower prevalence. A study from rural Bangladesh shows that people from different sections perceive two year as the waiting period not one³¹. Infertility on the basis of a one year period is at least double that of the two year period estimates as it pushes up the prevalence by including women who would normally give birth in the second year. Instead of using relevant socially perceived definition based on two year period of failure to conceive, the Indian experts have stuck to the one year period. Thus, instead of helping to change social perceptions on scientific basis, they fall in the trap of using the least sensitive cultural norms that contribute to women's anxieties, medicalisation of her life and professional control of her reproduction, and commercialisation of infertility.

Talwar also found that combined sterility was 8.9 percent in scheduled tribes and 29.7 percent in scheduled castes, while primary sterility remained low in both- 3.4 and 4.4 respectively. When seen across income groups, the prevalence in the middle and higher income groups were above average (31 and 35 percent). As expected, the prevalence of gynaecological problems were much higher in the infertile group (20%) as against the fertile groups (7.4%) indicating the importance of gynaecological morbidities³². It still needs to be investigated why prevalence is higher in some social groups. Is it due to higher prevalence of infection and under-nutrition or higher use of unsafe contraceptives? Usha Ram³³ also found these differences in distribution in the NFHS surveys and the Rapid Household surveys at the district level over 1998-99 and 2002-04. Her analysis has shown that Southern states with lower fertility rates have higher childlessness. In Tamil Nadu over the years 1981 to 2001 Childlessness rose from 6.4 to 11 percent. She argues therefore, about the need for a disaggregated analysis of the context within which childlessness is to be studied.

Given the lower levels of primary sterility in the Indian context, the causes of secondary infertility become critical. The common obstetric and gynaecological morbidities that may lead to infertility are complications of delivery, pelvic infections, STD, RTIs and endometriosis, repeated pregnancies associated with high infant mortality, inadequate facilities for dealing with difficult labour, lack of pre and post partum care and the poor state of general health due to high rates of infectious diseases³⁴. Additional factors such as under-nutrition, pollution, environmental degeneration, the stress of migration³⁵ and complications born out of contraceptive use without proper guidance and care also contribute to secondary sterility as with quinacrine, IUD etc. Most of these are preventable

causes of infertility that call for social mobilisation for changing the context of deprivation, poverty and lack of access to comprehensive primary health care rather than only specialised services for infertility.

The social implications of infertility such as, isolation, denial of social status, contempt and abandonment, are well known in patriarchal societies³⁶ and demand attention towards the social context of the problem³⁷. The desire for male children combined with the economic dependence of women and lack of social support systems for those who wish to opt out of the cultural groove compels women to conform. It is this social reality that becomes easy to manipulate for the commercial forces that take advantage of women's disadvantage. They are often treated even if it is their partners who need to be examined.

ARTs in India's Private Sector

Within public sector, the tertiary level public institutions are developing their genetic, reproductive and stem cell research units under the ICMR guidelines however limited they might be. These facilities at present are not sufficient to meet the expanding societal demands. Enamored and unquestioning attitude of the middle class towards hi-tech medical care: makes over use and even misuse of technology easy for its practitioners who have confidence that no questions would be asked. Little change in doctor patient relationship, where the latter continues to be dependent rather than an informed partner, contributes to callousness among practitioners. It is under these conditions that ARTs have entered the Indian medical market fully supported by the medical bureaucracy. The Indian Society for Assisted Reproduction has a membership of more than 600. Though the number of experts competent to perform advanced procedures is still small, there are over 250 IVF clinics in India. In addition, smaller towns and rural areas have infertility centers that work with ART Centers located in the tertiary care institutions of cities where specialists are available to perform IVF and ICSI (Intra-Cytoplasm Sperm Injection) procedures³⁸.

Many of the private clinics are now easily accessible on internet where they advertise their activities. Medical tourism has added ART to its list of attraction, as couples from abroad come seeking easy access to surrogate mothers, eggs and sperms to have their "own" babies. According to these private providers, first world comforts and quality is available at these Indian Institutions at the Third World prices. Often this is achieved by reducing to the bare minimum, the necessary tests and safety procedures. Also, the surrogate mothers are paid lesser here than in western countries. To prevent misuse of pre-natal diagnostic techniques, the Pre- Natal Diagnostic Techniques Act-1994, was passed and

amended as Pre Conception and Pre Natal Diagnostic Techniques Act- 2002. Yet the monitoring of these clinics leaves much to be desired as the office of the drug controller, apart from being overburdened is also ineffective. This lacuna in view of the high rates of complications, poor success rates and poor implementation of ART Regulatory Guidelines- 2005³⁹ raises several issues about the suitability of ARTs in the present context.

Complications, Cost and Success Rates of ARTs

Even without going through the issues of surrogacy, ova sale and ethical problems around these, if we simply look at the complications reported due to ART procedures, the range is alarming. It is reported that even in the so called take home babies, mortality is four times higher. Risk of ectopic pregnancy in ART is five times higher, miscarriage is 2-3 times higher than normal pregnancies and the rate of Cesarean section is 43.9 percent ⁴⁰. Complications range from major congenital malformations, prematurity, multiple pregnancies⁴¹ to gestational complications such as 1st trimester bleeding, abortion, induced hypertension, diabetes, and premature deaths⁴². In addition to these are the less reported problems even though these are so common that they are treated as “normal” for the procedure by doctors and “safe’ for the women. These are strong emotional upheavals considered violative of the integrity of the body, depression and grieving caused by the poking and prodding of the body and the drugs injected. These side effects are now getting known in the western countries because women are beginning to talk and complain that they are given no feed backs⁴³. Drugs like Letrozol and clomiphene citrate are used for harvesting oocytes. These can cause hyper-stimulation syndrome that other than releasing large number of ova also causes ovarian rupture, vaginal bleeding, kidney and lung failure⁴⁴.

It is not surprising then that even the most generously defined success rates are not very impressive. It is also critical how success is defined! For example, live births or ‘take home baby rates’ are relatively the lowest reported compared to infants born or pregnancy rates. The other key factors that affect reported outcomes are the quality of the clinic, the period of infertility, age of the woman, and the population used for calculating rates. It is possible to show high rates by using suitable population for the denominator and selecting only ART done on younger women for calculating rates. According to the Advanced Fertility Centre of Chicago, success rates are higher when more eggs are retrieved to get at least two good ova and the women are in the younger age group. Their results were reasonable, fair and good only when more than five eggs were retrieved in women over 40, 35-39 and under 35 years of age. With seven or more eggs the

results improved further. The reported live birth rates by this study with 5-7 ova for the above age groups were 18.0, 37.0 and 46.3 percent and the highest reported rate among the younger women with over 7 ova was 59 percent⁴⁵. The harvesting of large number of eggs for repeating cycles is thus justified at the cost of the woman who bears the risk of higher rates of complications. Data from The Jones Institute for Reproductive Medicine in Eastern Virginia Medical School gives numerically similar success rates for all age groups but calls it pregnancy rate⁴⁶. This shows the wide variation in success in the well established institutions.

Against these when the private clinics in India claim success rates of 30-40 percent, it cannot but be taken with a pinch of salt. Dr Malpani of Bombay suggests three good embryos/eggs to get a pregnancy rate of 40 percent in their clinic (implant not live birth) and suggests that rates are poorer when the causal factors are male. Despite the unimpressive rates they advise their patients that if you don't go through the procedures you have no chance but if you succeed then you "have a 100 percent baby"⁴⁷. Other providers report success as implant with a wide range of rates varying between 10 -50 percent and 20-30 percent as take home babies. It was interesting however, that in the same study when the women undergoing treatment were asked about success they were given much lower success rates by the same providers. Also several women had gone through repeated cycles. The reported costs for IVF in western countries is around US \$, 5,000 and in India around Rs.20, 000 for each cycle and can go up as well. It takes on an average 2-3 cycles to get the reported success rates. In addition intra uterine implant costs additional 2,000-10,000⁴⁸. These costs no doubt make ART inaccessible for the poorest sections of the society.

The Political Economy of ARTs

The emergence of ARTs can actually be traced to the positive eugenics and the history of population control. After eugenics was rejected as non science, genetics made it possible to talk of improving the human race through population selection using counseling and genetic manipulation and now through genetic and pre-implantation diagnostics and gene therapy. These techniques also help sex selection, as a way to plan families at the cost of girls. The desirability of population control technologies for the prevailing order is evident in a state where the shrinking welfare sector is unable to cover the majority of the underprivileged. In 1994, in the name of choices, and women's empowerment, the ICPD at Cairo brought together the environmental and the population control lobbies to talk of acceptable ways to arrest population growth with the help of technologies. ARTs in fact were projected as corrective hi-tech interventions, an asset to family

planning programme and a satisfier of societal needs. It was a conquest of science over nature and also a way to take the Third World forward. At that time aggressive methods of population control were considered politically undesirable. So, a range of new contraceptives had to be tested and introduced in the market. Along with these, ARTs and pre-natal diagnostics came in as they contributed to population control through sex selection. Experience over time has also revealed that the facilities of ARTs have to tune in to individual specifications and therefore, scaling up for higher profits is not feasible. Yet, the commercialisation of this technology was critical in shifting the directions of corporate search for profitable scientific innovations such as- stem cell or germ line research.

Obtaining ova for research is not an easy task as it requires consent of women. India with its strong patriarchal structure, son preference and the practice of sex selection became suitable ground for introducing ARTs. Both ARTs and sale or business of harvested ova could be combined easily. The need for “good ova”, frozen not fresh, requires young female donors, and success of the ART procedures requires repeated implants and therefore unquestioning clients. On both these counts, India’s young population with its susceptible women make a good hunting ground as women are amenable to manipulation in their given socio-economic conditions. Explanations such as, the unused embryo’s should not be wasted or that it is a new area of science that India needs to take on, are propagated. Women are not only sought as clients and their body parts fragmented and commercialised, the very process of reproduction is being pushed out of the personal domain into the industrial. This shift of domain is suitable to the pursuit of stem cell research within the system’s prevailing logic of monetary efficiency.

When we put ARTs in the holistic perspective and the context is defined as above, it becomes easier to understand why the Indian state with its growth oriented model of SAP and Health Sector Reforms (sacrificing the welfare sector, opening up public sector to private investments and promoting privatisation) within it, has permitted ARTs, to flourish in the private sector. These risky, invasive and unregulated, “red technologies”⁴⁹, need open markets where freedom is boundless. This arrangement keeps costs of the public sector primary health care low and at the same time lets profits pour in to the private sector. That’s why despite the commitments made by the 9th and the 10th Five Year plans, ARTs has remained confined to the tertiary level public sector institutions. The policy of commercialisation of health sector and giving private medical care institutions the privileges due to an industrial units (exemption from import duty and retaining profits), for financial growth, is the key to this anomaly. ARTs make good medical business and good business needs a good market offered by the Indian middle and even lower middle classes. Both are in the bind of a historical juncture

where cultural norms embedded in patriarchal structures, and marketable ARTs, become instrumental in enhancing the profits of the entrepreneurs and at the same time create potential for ova and embryo sale and purchase. The recent announcement of a public private partnership between three European pharmaceuticals and the British government for using human stem cells for drug safety is talking of "ethically sourced stem cell"⁵⁰, can India afford to close its eyes to this issue in adopting these technologies and giving a free hand to private sector?

A Way Out

It is evident that inclusion of ARTs has been guided by the new frame of public health planning, guided by technological expansion for monetary gains. The question that we need to ask is, will pressing for more ARTs in the public sector medical care system at all levels in the name of sensitivity to the problems of infertile women (social ostracism, humiliation), be the way out? Or, do we treat infertility as a public health problem where intervention is clearly needed at three levels. (a) Strengthening primary health care services to ensure good ante-natal, post-natal, and child birth services, obstetric and gynaecological problems specially infections that cause infertility and provisioning of safe contraceptives. Health education and counseling with couples must also take up this issue in the services sector. This alone takes care of the bulk of the problem of infertility also, given the costs, complications, and the poor results of ARTs, it is important to keep in mind the limits of ARTs. (b) In the social domain the challenge that women's movements along with other social movements for reforms face, is the issue of women's status, her rights to making educational, economic and social choices. This alone will lead to redefining infertility socially and initiate processes that help acceptance of primary sterility not as a disease or an affliction but as a variant of biological existence and also make adoption a much more acceptable option than it is at present. Issues of infertility will require open debates on definition, causes, ART success rates and complications and the alternatives that women have. Inevitably, this calls for a change in public health perspective as well and an alternate vision of development. (c) Since ARTs have entered the scene without much action at these two levels, it is important to pay attention to a third set of interventions that are urgently needed. This concerns regulatory mechanisms for the fast mushrooming ART clinics and their quality, cost and safety and improvement in the guide lines and legislation as they exist today⁵¹. A reorientation of the ART services where women's integrity, dignity, and health is central and not peripheral to the procedural successes is called for. In addition, the regulatory procedures for procurement of ova for research also need to

come out in the open. It is an area that lacks clear guide lines, legislation, and informed public debate⁵² to avoid malpractices.

Simply because an experiment has a humane potential, such as the stem cell use, it does not become the scientists' prerogative to go ahead with that research without a public debate when the implications are as serious as in the case of ARTs that has raised innumerable scientific and ethical dilemmas⁵³. To put scientists above society will be a mistake because they too- like the society- never act as one group and are ideologically divided. Also, they operate today in a context where science is funded by corporate sector and where the market rarely hesitates to cut through humane perspectives if they come in the way of profits. So, even for the concerned scientists, it is important to find allies in public and move at a cautious pace in applying a set of knowledge that has implications far beyond her/his imagination.

(Endnotes)

¹ ARTs are new reproductive technologies that are used to treat infertility. Both the eggs and the sperms are handled, eggs are either fertilized in the laboratory environment or within the fallopian tubes. Thus the In-Vitro Fertilisation for example includes Assisted Hatching of oocytes, Intra Cellular Cytoplasmic Injection, Zygote Intra-fallopian Transfer, Cryopreservation, Pre Implant Diagnosis etc. The other set of ARTs is used for fertilization within the woman's body as in Gamete Intra-fallopian Transfer and artificial Insemination etc).

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Social and Ethical Basis of Regulatory Legislation on Surrogacy: Need for Debate

About 290 surrogacy cases were reported in India, in the year 2006 as against 50 in 2004¹. Most of the surrogates are from poor and lower middle class and the past 2 years have seen a 150 percent rise in surrogacy arrangements² The prevalence of infertility in India is about 10-15 percent, and not more than 2-3 percent of this is primary sterility amenable only to assisted reproductive technologies (ART). In the public health priority ART services therefore come much lower on the epidemiological scale. However, the suffering and social ostracisation that infertility creates, and the desire for children laced with the eugenic notion of exclusive genetic belonging in patriarchal societies where the tradition of continuity through 'blood' is strong is used by medical markets to promote ART. It is reported that of the total cases of IVF, only one percent require surrogate breeding in good ART clinics³, yet the numbers are rising. A factor in the rise is reproductive tourism for foreigners in India. Added to these are the economic compulsions of the not so well off that transform them into surrogates. The money power of foreigners coming for surrogate agreements, and the growing tribe of experts who see profits and fame in this art, has pushed surrogacy with ART beyond its legitimate place in priorities.

Every technology has an inherent bias depending upon the context in which it evolves, yet its impact outside that context depends upon the manner in which it is used: to nurture traditional values and curtail the potential to create new ethical practices or to question the prevailing retrograde practices and values. How do social forces shape use of ART and its progressive potentials if any? To answer this we explore the way these technologies are used and their social impact.

Social Processes and Introduction of ART and Surrogacy:

When societies change rapidly, their prevailing ethical norms are challenged both by the biases of new knowledge and the conflicts created by the new practices that threaten prevailing norms. Ethics is the notion of what is good and

right in society that guides human action. In periods of transition the emergence of new ethical practices is guided by it. This is not a linear process but a trajectory interspersed with conflicts of ideas and interests in various arenas of technology society inter-face. In medicine for example, the principles of beneficence, non-maleficence, consent, confidentiality and patient autonomy guided clinical practice. Public health added social responsibility and justice to ethics of medical practice and research. We explore now, the conflicts emerging out of the practice of ART and the extent to which the proposed regulatory legislation contains them by reasserting the ethical principles.

ART and the medical market

The IVF babies in the west constitute around 20% of the births and the total cost of a surrogate delivery there is about 50,000-80,000 US\$⁴. Reproductive tourism takes place within the states in the US and with some countries in Europe. However, the debate there is more on conflicting ethical views on surrogacy and the need to permit reproductive tourism in the interest of democracy and building an open society rather than economic advantage. India is seen as a hub of quality ART services that can be had for about 1/5th -1/4th of this price. This explains the rush of foreign couples seeking surrogacy (75 percent of the commissioning parents in India) and ART and a proliferating ART market⁵. In India not only surrogacy in ART remains low in the epidemiological priority, the social and economic backwardness of a significant proportion of the population in India allows the medical market to exploit the economically needy. Two processes are worrisome. First is the misuse of technology causing serious problems such as declining sex-ratio, rising caesarean sections, over diagnosis etc. The second is the commodification of body parts as in the clandestine trade in kidneys, placentas and aborted foetus. When combined- as in reproductive technologies- the results are disturbing. Harvesting of oocytes of ill-informed young girls, use of IVF by clinics not recognised for it, and surrogacy contracts for “servicing the foreign clients” through practicing specialists without ensuring the security and rights of the surrogate mother or baby are occurrences that are being reported⁶.

Most of the above is a result of totally unregulated private ART clinics- with varying costs, standards, and procedures- that give primacy to profits rather than epidemiological needs of the majority in India. The need to prevent secondary infertility due to poor obstetric services, reproductive tract infections, and poor nutritional status of women and provision of basic services to deal with treatment of infertility is thus ignored by the state and private sector is given full freedom to expand ART clinics This strategy fits the medical tourism approach meant to

earn foreign exchange rather than the health of the majority. . The business of ART here is said to be of \$ 445 million⁷. Also, the fact that this technology is not perfect, its out come as live births is between 25-45 percent⁸ <http://Ezinearticles.com/?High-Success-Rate-Of-Surrogacy-in-India-With-Low-Costsid=1196946>, it can physically harm the female donors as well as the surrogate as it can lead to hyper-ovulation syndrome, multiple pregnancies, complications due to techniques used (such as foetal reduction), low birth weights and high rates of abnormalities in the babies is not made public.

Unwilling to let go of the financial advantage, and pressured by demands for information on surrogacy and its regulation, the state has responded by hurriedly including some ill thought out clauses on surrogacy and put them under regulatory legislation for ART⁹, now waiting to be passed. It needs to be underlined that a legislation pertaining to one aspect of health is not only insufficient but subversive, as it has the capacity to distract from the main thrust of policy. Therefore, ART Bill can be analysed only within the social context that we propose to explore. The shift in state's vision is reflected in allowing commercialisation of surrogacy while organ donation continues to be non commercial.

Impact of technology on key definition

Changing technologies influence not only organisations around them but also definitions of problems. For example, surrogacy changed its nature and definition with the evolution of ART. From mythological stories of Rohini in Mahabharata who bore a child for Vasudev and Deveki, the technology of artificial insemination brought surrogacy into the domain of a more acceptable medical practice. Till then, the ova came from the surrogate mother and the integrity of genetic and gestational aspects was retained. She was the biological mother and she chose to part with her baby and give it to another. After the techniques of ova harvesting and IVF and embryo transplant became popular, using ova of the surrogate was no more necessary. Technology thus explicitly underlined the social and gestational value of mothers who may or may nor provide the genetic material now available through donors. It weakened the ideology of motherhood and the most commonly held ethical and legal position that a mother is the one who gives birth and parents alone provide identity.

Nurturing and bonding acquired a new meaning as knowledge of genetics and intrauterine and early development of the newborn helped give a nuanced understanding of foetal development where, for the genetic potential to unfold fully, it is important to be nurtured in a biologically optimum and socially environment. For the development of a well adjusted baby, the importance of

not separating it from the mother (surrogate) too early was thus laid by modern scientific knowledge. It established the need to practice a more inclusive and intimate form of surrogacy where the two families participate and separation is delayed for 3-6 months for the welfare of the baby.

The human organ donation was given a non-commercial status by the Human Organ Transplant Act- 1994, however, temporary lending of uterus on payment has not been objected to by the state. This irrational distinction between human body parts donated and rented, and equating of goods and living beings in commercial surrogacy, is undermining the sacrifice and autonomy of surrogates. The expert providers see it as an industry where cheap Indian “labour” of the surrogate makes it a profitable venture for them. Their logic obfuscates the distinction between the product of social human labour (consumable commodities) and the product of woman’s procreative labour (a human baby). This distortion is the product of market liberalisation pushing profit oriented techno-centric solutions for infertility at the cost of its social determinants.

In contrast to the area of child development, when we look at the medical definition of infertility (failure to conceive after one year of living together of a sexually active couple), we find it inadequate, as it is based on social perception unchecked with a body of knowledge of pathology or of epidemiology. At the same time, the definition does not take into account the variation in social perceptions and becomes undependable as different communities accept different time gap between marriage and conception-it is 2 years in rural Bangladesh¹⁰. So when do couples need reassurance and when medical intervention is necessary, needs to be medically defined. At present a lot of couples without any specific diagnosis are declared infertile by this definition and made vulnerable to the vices of the market.

By using other healthy women as means of reproduction for the infertile, on a commercial basis, the experts create the same inequality of power and control in ART clinics as in the patriarchal society. Even when the issue of surrogacy is seen in the market framework a key issue is the definition of compensation. To understand this, the irrationality of blurring the definitions of production and procreation needs to be underlined as there is no way to put a value on the product of the latter (a baby), except arbitrarily. Therefore, its value has to be the same as any where else in the world even if the Third world provides cheap human labour and technological services such as ART. In the US the lowest possible fee for surrogacy varies between 15- 25 thousand US \$ (Rs. 750, 000-1, 250, 000)! In addition, to the medical expenses related to the pregnancy, surrogates are given full health insurance for the period of involvement, medical insurance

for her family's as she is the care taker for them and expenses for travelling for maternity care and clothing. In addition all expenses for the independent lawyer that she would employ, is paid by the commissioning parents¹¹. In fact, a country claiming to have "international standards" and "world class" institutions, should strive for these norms and no less. The reality is that while in the US even up to 50% of the cost of ART with a surrogate arrangement goes to the surrogate, in India most of the money is appropriated by the Sperm Banks the clinics and the lawyers!

Social Context of Surrogacy/ART

New reproductive technologies claim to help human being through creative interventions to reduce suffering and a potential to transform society. Commercialisation of surrogacy however, creates several social conflicts rather than resolving some. It generates family pressure on poor women to oblige. Given the extreme vulnerability of almost one third of the Indian women due to poverty, exclusion from, and marginalization in labour and job markets, patriarchal social and family structures and low educational levels, the financial gain through surrogacy becomes a key push factor. This is substantiated by the fact that most surrogate mothers are from not so well-off sections and the motive primarily is monetary. This makes their economic exploitation easy for the agents working for commissioning parents.

Procreation and infertility are interpreted within constructs like patriarchy, social and economic inequalities and so is surrogacy. The use of ART to "help" infertile couples adds new conflicts. For example, the way ART is practiced reduces parents into objects of medical experiment and sanitises the mystique of biological evolution. The surrogates not only frankly accept monetary motives (treatment, education and housing for family members), they also talk of social dilemmas they face. Some claim death of the baby after it is given, lie about the parentage and often leave home for that period¹². In a meeting convened by the ministry of Women and Child Welfare on the 25th of June, the State Minister said that the fact that these women get amounts equalling 2-3 years of their wages can not be ignored. This is indicative of the mood in the government that sees surrogacy as a replacement for employment guarantee and adequate subsistence!

Another area of concern for disability and women's movement is around narrowing of choices for couples in the name of expanding choices. Gender, disability and infertility are social constructs. Yet, the PNDT Act has given full rights to parents to abort a disabled foetus. The use of PGD in ART helps to rout

out disability without defining any limits to this choice. Thus, selective exclusion of disabled, of girls and of infertility has become possible through ART¹³.

The refusal to part with the baby, inability to pay back the sum received and change of mind and opting for abortion are known occurrences that conflict with the interests of the commissioning parents and the reputation and profits of the providers. They therefore seek regulation through legislation India and their representatives made a significant proportion of its drafting committee.

Surrogacy can also affect the older children's perception of the values and integrity of their family, unless there is transparency and involvement of the social mother right through the pregnancy. Secrecy and anonymity creates a negative environment that affects human relations within and out side families.

Yet another social conflict that emerges is the Child's right to information about identity of parents which is at present linked to adulthood, even though the sense of belonging and socialisation begins very early. Global experience of adoption shows that the urge to know ones roots brings young adults back to unknown people. Why then fit surrogacy in the old patriarchal mould of secrecy and anonymity, instead of changing norms and making the process more transparent? For the commissioning mother, being involved with baby care right from the beginning while it is breast fed and knowing the surrogate through the pregnancy might be a step forward. It might make adaptation less difficult for all concerned. These questions need to be examined and not set aside, simply to push the surrogacy markets. Secrecy and anonymity is rooted in the social value of primacy of "blood relations" which in itself derives from notions of exclusivity and superiority the very essence of eugenics! The present practices, instead of openly questioning these values, harms children by letting them grow with false notions of belonging and then pushing them into a search for identity, sense of shame and anger against their social parents¹⁴. An open and frank environment could be much more conducive to accepting their status.

Again, the present restrictive policy towards the sexuality of same sex couples, denies them open access to ART despite sufficient scientific basis establishing the biological validity of their distinct sexualities. The legislation chooses to remain silent on their need for a family, reflecting a lack of initiative to question obsolete social mores.

Surrogacy as it is practiced is heavily biased against the baby. It compels the surrogate mother not to get too involved with the growing baby in her body. The baby has no say in the matter and has to live the consequences of the social process. His right to bonding and breast feeding for at least a minimum period of

3-6 months is denied. Also the very right to survival of all babies born out of ART- whether disabled or one of a multiple pregnancy is undermined as they are not treated at par with other babies but depend upon the whims of their commissioning parents for survival.

Of the estimated 8-10 percent infertility in Indian women 98 percent have secondary sterility requiring. Most of these can be avoided through an effective antenatal and natal care and not schemes of paid institutional delivery without basic facilities. In short, good primary health care with basic facilities to diagnose and treat infertility- without distorting priorities- is the answer for the majority who are being forced to access ART markets after developing secondary infertility only at their own cost.

These emerging social practices protect the interests of the market and negate almost all the principles of medical ethics enunciated earlier. Is the draft, Bill any different?

The Draft, ART Regulatory Bill-2008

A huge infrastructure is proposed for registration and standardisation of clinics and sperm banks with little effort to regularly monitor success rates of different techniques. Research and popularisation of ART is its focus rather than stopping misuse of technology and exploitation of donors and surrogates. We illustrate this with a few examples.

An extremely inadequate and open format for private contract between surrogates and commissioning parents permits continuation of exploitation of surrogates without addressing any of the concerns raised on issues of health, informed consent, compensation, legal assistance etc. This is despite the fact that the Bill recognises surrogacy as, "pregnancy achieved in furtherance of ART", and therefore acknowledges its imperfection. It propagates the patriarchal and eugenic values of exclusivity by giving primacy to genetic parenthood. Goes to the extent of denying the right of surrogate to be registered as birthing mother and directly transfers parentage to protect the right of the buyer at the cost of the baby. At the same time the interests of the clinics and sperm banks are fully protected and all risks transferred to the surrogate- be it her death, complication during foetal reduction or transfers of infections such as AIDS. The Bill denies the critical developmental needs of the baby and in order to make separation easy and quick for a commercial surrogate, ensures fast separation, bans the donation of ova by her. It goes to the extent of permitting three surrogate births to a woman and three cycles of ova transfer for a single couple with out any

reference to her health risks. At the same time the right to demand abortion and pregnancy reduction is given to the commissioning parents and she is bound to oblige. No attention is paid to the rights of the surrogate to keep the baby if she changes her mind early or due to death of her own child. Similarly, the same sex parents do not get any recognition by the draft though single parents can access the technology. The question of identity of parent is clouded by secrecy and anonymity not making any effort to bring in a degree of openness and co-operation between the two families to secure the welfare of the baby¹⁵.

The Bill therefore not only openly protects and promotes unregulated commercial surrogacy, it also contradict the existing national policies on health and family welfare. These contradictions are:

- a) The state has a two child policy to ensure stable populations and women's health. Those opting for surrogacy can not be exceptions.
- b) Maternal mortality which is a matter of great concern for the government will by no means decline if surrogacy practices permit nine possible cycles of transplant of ova (a maximum of three cycles for a single commissioning couple and three surrogate babies in a life time irrespective of her own children).
- c) The state's public policy is against gender exploitation, inbuilt into present surrogacy practice- both economic and social.
- d) Sale of children, human trafficking and sale of body parts are illegal activities as is evident in the laws for trafficking and human organ transplant, yet commercial surrogacy is being promoted.
- e) India is a party to the UN Convention on the rights of the child and committed to their protection before and after birth. Yet the present ART Regulation legislation does not ensure that child rights are fully protected.

The fact that the drafting committee was not concerned about these contradictions is reason enough to demand that these questions be thrown open to a public debate, to find how best the interests of the baby, the surrogate mother, or the adopting parents could be looked after within an ethical frame. This will help evolve a more widely accepted legislation, particularly so, as the social complexity in this country gives rise to many views regarding surrogacy. There are different attitudes towards infertility. Accordingly, there are those who are completely against surrogacy on ethical and ideological grounds, those who fully support it even as a commercial venture, those who accept it but oppose its

commercialisation and those who on the very basis of ideology say that commercial surrogacy- if well regulated- is a way to question patriarchal notions of family and society. It is interesting that within feminists, one set encourages adoption and questions eugenic tendencies of genetic manipulation that re-enforce patriarchal notions of paternity and the other uses genetic manipulation for attacking traditional family. These counter currents raise significant challenges for the law and policy makers genuinely interested in the regulation of ART and surrogacy. Therefore it would be in their interest to listen carefully.

(Endnotes)

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The ART of Marketing Babies

According to a report of the 18th Law Commission of India, “Law is an ardent defender of human liberty and an instrument of distribution of positive entitlements”¹. Nelson Mandela in his address to the academic community in India said, “Law must be broken when it becomes oppressive”. This wisdom coming from a lawyer with a difference highlights the role legislation plays in a society riddled with conflicts; liberating for some and simultaneously oppressive for others. Notwithstanding the Law Commission’s idealism, new legislation too could be oppressive for a significant population depending upon the politics of its drafters. The current upsurge of the surrogacy trade in India and the label of a “win- win” situation that it has acquired, points towards unfettered commercialisation of Assisted Reproductive Technology (ART) and the practice of surrogacy that is blinding both its middle class users and providers, policy and law makers, and charging an imagination that is already caught up in spiralling consumerism.

The aura of High-Tech has overshadowed the exploitation of less-privileged women. There was, thus, little public dissent to the several regressive proposals regarding surrogacy in the Draft Assisted Reproductive Technology Regulation Bill-2008², and it was proclaimed that women accepted it out of their own “free will”! Stories abound of this “free will”: economic pressures forcing women into surrogacy; a relative needing a kidney transplant; buying a taxi to run the household; or the decision to give schooling or a house to her children³. She is “fed up of her poverty”, becomes the rationale for the providers who argue that, just as medical technology is cheap in the Third World, so are surrogacy arrangements that help families to overcome financial constraints⁴. There are also stories of surrogates clinging on to the commissioning parents, demanding more and more and even refusing to part with the baby. This disturbs the clients and their providers whose business and reputation is at stake. These so called ‘dirty workers’ are then unable to fight discrimination, not only because they are dependent⁵, but also because the State itself is not concerned about exploitation, false promises, misuse of techniques, and above all the loss of ethical principles in the present practices as well as its proposed Draft Assisted Reproductive Technology (Regulation) Bill & Rules-2008 (ARTRB) that lacks even a preamble.

This paper identifies the interests of the affected, and examines the contradictions of the proposed Bill with their interests as well as the present health and population policies. The critique is confined to the handling of surrogacy, not the entire content of the Bill. The basic tenets of the analytical perspective⁶ used are the context of poverty and the health needs of the Indian population, the need to locate surrogacy services within the overall public health service context and its epidemiological basis⁷, the need to restrain direct human experimentation for the advancement of any technology and use of safer methods, the rights of surrogate mothers and their babies, in India, not the compulsion or dynamics of the medical market and reproductive tourism.

The practice of surrogacy can be ethical only if the interests of the baby, gestational mother, and commissioning parents, and science itself are located within this framework. The proposed Bill not only disregards these but, negates a number of important state policies. If legislated, it could make these policies irrelevant. The central issue, therefore, is what perspective must guide the practice of surrogacy?

The concerns of the affected

The Newborn Baby

The vulnerability of the baby can be enhanced if the surrogacy process is not sensitive to the issues of child rights. These basically are: i) the right to bonding, breast feeding for a minimum period of 3-6 months, and early psychological and immunological development while prescribing the time of separation, ii) right to survival like any other baby with disability or born of a multiple pregnancy should not be undermined by the whims of the commissioning parents, iii) right to a safe home as an obligation of a state that permits surrogacy in cases where both sets of parents refuse to accept the baby, iv) right to know her/his identity too needs to be respected as an early acceptance of their status helps their socialisation and acquiring a sense of belonging. Discovering parentage late or accidentally is more damaging than knowing the truth in an open and frank environment. Secrecy and misinformation is born out of the notion of priority of biological associations over socio-psychological ones.

The Surrogate Mother

Voluntary acceptance of surrogacy requires that women have self respect and social status born out of equal opportunities, adequate wages, and freedom of

decision making. It should not be an alternate employment generation scheme. It would be a mistake to evolve legislation on the basis of systemic weaknesses and failures or, for the law makers to assume that volunteerism under conditions of poverty is genuine. In the present context surrogacy is rarely voluntary, one needs to know what payments are for, and to articulate the difference between commercial and voluntary surrogacy.

In the best traditions of liberal thought, the concepts of minimum wage and compensation were understood separately. One was money payment during the period of employment that would provide a family unit a level of survival that is socially acceptable, and the other was payment for permanent or temporary disability and for death⁸. A third kind of money exchange, that is now included, is coverage of expenses for an altruistic act of humanism, as in organ transplants, where expenses of donors are born by the family receiving help. But normal pregnancy is neither a disease nor a disability, hence the issue of 'compensation' for pregnancy does not arise. The compensation can only be for the handing over of (separation from) the baby, for damages caused to the mother in case of complications and medical negligence, and in the event of the mother's death. This should include compensation to the family which is denied her care while contributing to mother and baby care during the period of surrogacy. Women are in fact being forced to become captives of clinics in the name of protection and care. In addition, for nurturing the baby, the surrogate should earn 'wages' for the time and energy invested in pregnancy and baby care. 'Coverage' of expenses for surrogacy would mean all services for the surrogate. Apart from all medical expenses it should include her life insurance, counselling and legal expenses, travel charges, psychological evaluation, adequate food, and health insurance for the family that is involved in caring while the baby is with them⁹. In voluntary surrogacy then, at most coverage of expenses and part of compensation could be paid, while in commercial surrogacy all of these are the surrogate's due.

We now examine the notion of 'wages' for, and 'products' of, surrogacy. The global market has made Third World labour a resource for its growth as it is cheap. This principle has been thoughtlessly transferred to surrogacy where the "procreative labour of the surrogate woman" is equated to "social labour" of human beings. The product is a commodity or a service in one case, and a human baby - the future of mankind - in the other. To compare these forms of labour and product is untenable as the latter is a biological process linked to human, biological, psychological, and emotional energies continuously invested over a period of time that affects the whole being. This can not be put at par with skill-based physical labour of the former. Similarly, while an Indian commodity may have lower value as a product of low-cost raw material, technology, and

human labour, the value of life of a surrogate baby can not be lower in India as its human potential - and the maternal energies that nurture it - are the same globally. The value of surrogate motherhood (as wages) and the surrogate baby (as compensation) is thus, universal. It can not be measured regionally. At best it can be given a universal arbitrary value as there is no way the human potential of a baby could be assessed at birth, nor can gestation be different in different countries.

This obfuscation of the difference between a commodity and a human baby, and between social and procreative labour, has provided the rationale for justifying two assumptions. First, the priority of the rights of owners of genetic material over the surrogate's gestational rights in the true eugenic tradition; second, undermining surrogate gestation as "services provided" and labelling it as cheap labour. This logic is unacceptable and unethical as it denies the universal value of life for all babies, and the value of gestation, which is 'labour extraordinaire'.

While NRTs have transformed genetic material- so critical within the eugenic perspective of parenthood- into an acquirable commodity, the key dimensions of motherhood remain gestational and social mothering. The modern understanding of foetal and infant growth has also shown the importance of early bonding¹⁰ that in fact begins in the uterus, and of breast feeding¹¹, both critical for emotional and physical development and immunological protection of the baby. This need for biological continuity in baby care places responsibility not only on the mother but, more so, on the doctors who advise her.

It is the state's ethical responsibility then to come clear about definitions, valuations and payments if it is promoting commercial surrogacy. To use the language of voluntarism and hence deny payments is to cover up its own business interests and its neo-liberal paradigm.

The Infertile and Same Sex Couples

If one of the sexual partners is infertile, that couple is called infertile. However, this malaise is generally assumed to inflict women alone even though in India, according to the president of Indian society of ART, it is estimated that 30-40 percent infertility is due to male causes and about 15 percent remains unexplained¹². The problem of female infertility in India is primarily of poor health and health services as of the estimated 8-10% infertile women, 98% have secondary sterility caused by infections such as post-partum infections, tubercular infections, RTIs, complications of delivery, and poor nutritional status of women. Most of these can be avoided through an effective primary health care with basic

services for diagnosing and treating conditions causing infertility. Reproductive tourism distorts these priorities.

Women requiring help of a surrogate mother should have the right as well as the responsibility of participating in the care of the surrogate mother and the custody of the baby to ensure smooth transfer and socio-psychological preparedness of the second mother. The veil of secrecy and separation of the two mothers will be antithetical to this desirable mode of transition. Also, the right of couples of the same sex needs to be protected.

Couples of the same sex- despite their fertility- need donors or surrogates; their primary problem therefore is to be legally recognised as couples to seek ART /surrogacy services. To force them to lie by calling themselves single parents is to treat them differently, a travesty of their constitutional rights to equality and justice.

Last but not the least, the adoption laws need to be improved and streamlined to encourage adoption. Access to adoption services for all religious groups should be made possible.

Surrogacy and the proposed ARTB-2008

The Draft ARTB-2008 is reviewed in the light of the above understanding of ethical and social concerns. Its Drafting Committee was constituted by three lawyers from Public Interest Legal Support and Research Centre (PILSARC) including its trustee, four representatives of the service providers including the famous ART clinic Rotunda, three government representatives, an eminent molecular biologist as its Chairman, and an Indian Council of Medical Research officer as the member-secretary. Representatives of women's organisations, consumers' groups, public sector obstetric and paediatric service providers, and experts in ethics, child development and child psychology, were conspicuous by their absence.

The Draft Bill helps the state abdicate its responsibilities and protect and promote provider and commissioning parents interests in the free market by giving extraordinary powers to the private sperm banks and clinics as against the surrogate mother. It does not ensure that all social groups within the country have equal access to this service and is actually geared to promote reproductive tourism and further open medical markets. Even the role of the proposed State Boards in providing the necessary counselling and legal assistance to surrogate women for a fair deal is not defined. As a consequence, The Draft bill neglects the interest of the baby and the surrogate mother and shrouds the challenge that

ART poses to archaic social structures by conforming to traditional norms of a patriarchal society, promotes and pushes ART as a desirable intervention, rather than trying to effectively regulate and monitor it. Its discrepancies, contradictions and directions can be gauged by the following observations around these two sets of issues.

Receding state and expanding markets

1. The regulatory authorities are the National and State Advisory Boards. The former is more focused on developing the field of ART, popularising it, and counselling the patients, rather than setting up regulatory mechanisms. The State Boards are the registering, monitoring, and enforcing authorities but, strangely enough, the clinics and the semen banks are to keep the records for ten years only, after which these will be transferred to a central data base of ICMR! How, without regular annual data supply, monitoring of success rates of different technologies would be possible is anybody's guess. In developed countries this data is collected on a continuous basis and published annually as a national report for ART performance, assessment, and monitoring - as in the USA¹³. The National Advisory Board, instead of focusing on data monitoring, analysing for trends and publishing for open public debate, is to promote training and research in ART. Systematic data needs to be collected annually and published by the National/State Boards to report on 'type of sterility', number of surrogacy arrangements and reasons, success and complications for each type of ART used, profile of the surrogate volunteer, the contract conditions with the commissioning couple, the clinic and the sperm bank, medical check-ups, site and nature of registration of births, any complications and their management, sex of the baby, its follow up, and the papers for nationality and migration in cases of foreign parents. Like the Drafting Committee, the Boards too are heavily composed of experts in ART and private ART providers, with a lack of representation of the other relevant experts and concerned sections of society.
2. The Bill prescribes a legally enforceable surrogacy agreement between the parties where the State plays no role after preparing the rules and the forms for the same. By providing a vague and open template for rules and contracts for a private undertaking, it leaves huge gaps for the commissioning parents and providers to take advantage of the surrogate mother who is given no legal help by the State. The commissioning couple has the right to demand abortion and pregnancy reduction in congenital anomalies (not specified) and multiple pregnancies, if they so desire according to the surrogacy contract (Form J). This condition however is not stated in the contract between the

provider and the surrogate (Form U). Hence, nobody has any responsibility towards any risks (even death) to the surrogate mother arising out of these interventions, including the clinic.

3. The Bill ensures that both the private institutions (sperm banks and clinics) exploit the two parties and donors to their advantage and do not suffer monetarily. Both institutions have the right to full information on the surrogate's private contract with the commissioning couple, on the outcome of her pregnancy, and have control over her actions during pregnancy, but have no financial or medical obligations. The sperm bank alone gives the green signal to the surrogate after the tests are done. Yet, they are not responsible for any damages, even though the contract form forces the surrogate to sign that the choice of clinics and doctors will not be hers but of the commissioning couple. Also, no monetary benefit is given to the surrogate for remaining on the bank's waiting list.
4. The clinic even acts as her legal representative with the bank (Form R (2) of Rule 1.5). This is illegal as the clinic is not supposed to be a party to the identification of the surrogates at all. Its counselling too will be biased given the conflict of interest! While the surrogate signs a form that she has fully understood what was explained (without any specific details of it), the doctor only signs that she has explained everything to the 'extent humanly possible'! There is no way to assess from these Forms if the effects of the drugs and procedures used and their risks are adequately explained. The agreement with the surrogate and the clinic (Form J) puts in all the safety clauses for the clinic which is not held responsible for its failures. The "implications of surrogacy" (social, psychological, emotional) and risks (to surrogate mother and baby) have not been listed adequately. The statements use clinical language with assurances that are likely to escape the woman's attention. For example, she is informed of the drug administration necessary but not of the side effects. Similarly, she signs on the dotted lines, "I have been assured that the genetic mother and father have been screened for—. However I have also been informed that there is a small risk of the mother or/and father becoming seropositive for HIV during the window period". Thus, instead of testing the donors twice, this simple transfer of risk burden reduces the cost for the dominant controlling parties. What is said to the surrogate remains unrecorded. The agreement for surrogacy (Form J) makes the woman accept that she would agree to foetal reduction if asked for by the party seeking surrogacy without any mention of the risks involved!

5. When it comes to monetary transactions, the Draft Bill ignores available legal definitions and mixes up compensation with wages by stating that, “the surrogate may receive monetary compensation ... for agreeing to act as a surrogate” (Clauses 34.3) or for “services provided” (Clause 34.17). Damage to the surrogate’s health or her possible death is simply ignored. The Draft proposes that the surrogate’s expenses for insurance, “related to a pregnancy achieved in furtherance of ART ... and after delivery ... till the child is ready to be delivered ... to the biological parents shall be borne by ...” the commissioning parents. It is thus able to skirt the complexity of the issue of wages, compensation, and coverage of expenses altogether! All of it is transformed into, “payment for pregnancy achieved in furtherance of ART”, as if the surrogate is being awarded for her contribution to science! Thus, the draft twists and turns terminologies and language to circumvent the issues of definitional clarity, and appropriation is artfully woven into the legislation. It is noteworthy that, while the legal definition of surrogacy that the Draft Bill sets for itself makes no mention of payment, the legal practice of surrogacy proposed makes payments necessary: laying the basis for commercialisation without actually pronouncing it. It clouds the ethical issues around compensation, wages and motherhood, rationalising it all by giving genetic material priority over gestation and calling commissioning parents “biological” parents. By ignoring the eventuality of death no liabilities are fixed, leaving the children of the surrogate vulnerable. Even in terms of coverage for expenses, apart from counselling, legal expenses, travel and her dietary needs, payments even for medical coverage for a fixed period are not clearly spelt out. The lowest rates in the western market economies range are US\$13,000-25,000, so if Indian costs of labour and technology have to be lower, it should be through lowering the shares of clinics and gamete banks where the logic of low-cost labour and technology applies and the legislation must make state responsible for fixing the lower limits. Standard knowledge of obstetrics and paediatrics is also not used to define critical newborn care (up to 6 months of life), but leaves the time of separation to be individually decided by the clinic doctor! This also reveals the keenness of the drafters to make commercial surrogacy easy
6. The role of effective counselling to women and full information about the vulnerability of the baby, psychological, physical, and social consequences for her family cannot be over emphasised. Counselling must be done by independent agency, with the help of the State and not the clinics. Clause 20.6 makes ART clinics responsible for this and ignores the obvious clash of

interest. Even though single women are free to opt as surrogates their need for intensive counselling is ignored.

Patriarchal Biases and undermining of rights of surrogate mothers

1. This Draft Bill mixes up service with human experimentation for advancement of science! Through its confounding logic it kills more than two birds in one stone. According to experts, patients needing the help of a surrogate are too few if proper selection criteria are used¹⁴. The Draft sets up no criteria for the selection of 'patients' for surrogacy services. At the same time, it is well known that IVF results are better in healthy women as compared to women with problems in carrying a pregnancy to term and under stress (45 % against 30%). Lack of stringent selection criteria has the potential for over-use of surrogacy for better results. In the process surrogacy becomes a way to sustain a not-so-successful ART and the profits that ensue! Vulnerable women become live guinea pigs for promoting ART rather than dissuading them through conditions that only provide for very genuine surrogacy needs, such as full payments, stringent selection of patients, and meticulous monitoring. According to the Bill, not only is a woman permitted to undergo 3 surrogate births in her life time, she can also go in for repeated embryo transfers for a maximum of 3 times for a single contracting couple! Clause 34.9, in fact, says that if a transplant fails, the surrogate on mutually agreed financial terms prescribed in the contracts – as 50 % of the original agreement – can accept two more successful transplants! She is however, not to have more than two surrogate babies and three embryo transplants for the same couple. This means that a woman can attempt nine embryo transplants for three different couples! Her health and rational evidence, no doubt, is the last concern!
2. The Draft Act prefers to give the surrogate the responsibility of providing the names of those who "have availed of her services" to the hospital, where she registers for delivery, but not provide the hospital a copy of her private contract with them (Clause 34.8). The vague Clauses 34.2 and 34.3 of Chapter VII of the Bill as well as the contract between the commissioning parents and the surrogate mother (Form U) do not mention any details of the liabilities for which the commissioning couple would be responsible, except for the financial transactions for pregnancy and a mutually agreed upon compensation for 'services'!
3. Though punishment is envisaged (without any specification) for the commissioning couple if they refuse to accept the baby, in the case of foreigners

there is no compulsion for them to be in India at or before birth as they can appoint a guardian for the infant. In case they refuse to accept the baby, this guardian will be held legally responsible. Thus the legislation makes light of the punishment for the real culprits and makes no effort to hold them responsible. Even the handing over of the baby in such cases is mysterious as Form U gives two names of alternative persons without any surety that they will be held legally responsible for the full care and upbringing of the baby. Again the role of the State in this eventuality is left out of the legal domain. This is a matter of concern as the Draft is proposing laws within which it is not ensuring Constitutional propriety and its own responsibilities.

4. The surrogate woman is denied the right to be an oocyte donor to eliminate her genetic claim; in the process it does away with the use of intra-uterine insemination - a much simpler and safer technique. The gamete bank is given the nomenclature of 'sperm bank', creating an illusion of a virile male population with no infertility. This undermining of the surrogate mother at all levels makes her just a 'compensated surrogate worker' whose integrity, autonomy, and rights are an impediment to the profits of the medical industry. Her separation from the commissioning parents kills the potential of ART to create space for new social relations.
5. While the donors can refuse the use of their gametes before they are used and the surrogate has the right to abort and return the compensation, according to Clauses 34.4 and 34.10 of the Draft Bill the surrogate is required to "relinquish all parental rights" and permit the commissioning parents' name on the birth certificate itself. Only when a woman's integrity as a person and her status as a nurturer are recognised, will her right to the baby under given circumstances be respected and entered into the contract as in many other civilised countries¹⁵. Australia¹⁶, United States of America, and several European countries (United Kingdom, France, Netherlands) give the surrogate a right to change her mind and some extend it to even a week after the birth of the baby (Israel)¹⁷. The Indian Bill chooses to grant total security to the commissioning parents ignoring that the surrogate's name on the birth certificate is important for ensuring a surrogate child's right to parental identity. This responsibility/right was later identified by the Law Commission 2009¹⁸.
6. The Draft also does away with adoption of the surrogate baby. In the interest of the baby and the surrogate mother, transfer of parentage should be made easier but through fast-track courts as practiced in South Africa. This will make surrogacy accessible to those communities that are not permitted

adoption¹⁹. This process of transfer must be included in the contract between the surrogate and the commissioning couple (Form U, Rule 15.1, page 131-133) as it guards the right of the baby to breast feeding and healthy growth.

7. The Draft continues to operate within the patriarchal family framework wherein any form of family other than monogamous has to be confidential. Hence anonymity of the surrogate and the donor has to be maintained unless some life-threatening medical condition affects the child or, after 18 years of age, she/he demands this knowledge. This secrecy is contrary to the long term interests of the child and the future possibility of an open society and contrary to the spirit of justice and equality in the eyes of law. Similarly, A couple is defined as persons having a sexual relationship that is legal in the country of residence. This excludes same sex couples in most states and forces them to seek surrogacy as single parents.
8. The oocyte donor is also neglected. The contract she signs with the bank and the consent she gives to the clinic mention no side effects of ova retrieval procedures such as hyper-ovulation syndrome, harmful impact of six possible repeated retrievals at the interval of three months on her reproductive health, or compensation for any damage.

Conflicts with State policies

The principles of existing social and population policy²⁰ are negated by the Draft ART Regulation Bill. The key areas of this negation are:

- a) The State has a two-child policy to ensure stable population and the mother's health. It would be illogical to say that this is incumbent on all except for those who opt for surrogacy. This amounts to legally promoting ill-health of the surrogate women.
- b) Maternal mortality, which is a matter of great concern for the government, will by no means decline among the surrogates if surrogacy is promoted as a part of legalised reproductive tourism. High risks with commissioned abortions, pregnancy reduction, transplanting 3 or more embryos (fertilised in-vitro) in one cycle that increases the prevalence of multiple pregnancies are well known, and may add to mortality.
- c) The State's public policy is against gender exploitation. Surrogacy (commercial) on the other hand, is based on exploitation of needs – both economic and social.

- d) Sale of children, human trafficking, and sale of body parts are illegal activities as is evident in the laws for trafficking and human organ transplant, yet surrogacy with compensation is being promoted.
- e) India is a party to the UN Convention on the Rights of the Child and committed to their protection before and after birth. Yet the present ART Regulation legislation does not ensure that child rights are fully protected.

The fact that the bill ignores both-the ethical and conceptual issues raised in the earlier sections as well as the contradictions it generates visa-vi national policies, reflects its ideological moorings in the neo-liberal developmental shifts of the post 1980s era. It underlines the historical truth that legislations are not guided by ethical principles alone but are primarily a product of changing socio-political balance. The dominant interests use their own rationality to redefine concepts, reinterpret ethics, and deal with social conflicts. In the case of surrogacy itself, The Draft Bill defines it as, “a pregnancy achieved through ART, in which neither of the gametes belong to her or her husband” (page 3). Thus, a woman can now either donate eggs or be a surrogate but not both as was the case earlier. In this change of definition, the advanced technologies have replaced simpler pre-existing modes of surrogacy, and removed conflicts of interest around hi-tech ART! That surrogacy has been clubbed with ART in itself reveals that it is seen more as an instrument for advancement of hi-tech ART rather than for fulfilling the wishes of commissioning couples from all strata. We argue therefore that this draft is reflective of the dominant ideological push that thrives on the inequities of the social system. For the draft to be reworked in a way that it does not compromise the interests of the majority of Indians it requires an alternate ideological push from within its makers or a pressure from the civil society.

Coming into being of the Act

The Draft ART Regulation Bill 2008 was critiqued by women activists²¹ for its weaknesses, for not locating ART within the priorities of public health, and for using the suffering of infertile couples in India to expand surrogacy markets for international clients without addressing social and medical causes of infertility and its solution²². But there was no response from the authorities. This strange marriage of High-Tech medicine and legislation focused on exclusive tourists and clients, ignoring effective and safe technologies for widest possible coverage to prevent secondary sterility - a primary concern of the majority.

Inevitably, the Draft Bill does not realise the creative potential of surrogacy which opens new social spaces, such as the world of family for the surrogate

child which could be more than a pair of parents. It ignores the need for altered definitions and construction of family/ parentage and prefers anonymity and secrecy - pretending that nothing unusual is happening. Instead of celebrating her act of generosity and humanness, the surrogate is treated by this piece of legislation as a contract worker available for exploitation - both monetarily and psychologically - by denying the value of her gestational motherhood and giving weight to the commissioning parents as owners of the genetic material. This negation of the potential of a humane relationship between the two mothers and their families that can generate an open environment around surrogacy reflects the fears of a patriarchal society and its inability to address new challenges with a new vision.

The law makers are reluctant to accept that law in societies at the cross-roads has to respond to new situations and not contain and hide change - even if it is the notion of parentage, motherhood, fatherhood, or family itself.

The 18th Law Commission that reviewed this Bill had a mixed reaction. It pronounced infertility, "a huge impediment in the over all well being of couples", "a major problem", but without any objective assessment. Though prohibition of surrogacy was considered undesirable it was realised that the complexity of the issues called for a comprehensive legislation. It stated that the Draft prepared by the ICMR is full of lacunae and is incomplete, and proposed that, 'while all reasonable expenses should be met' by the contract, surrogacy must not be commercial. Secondly, the surrogate should be given life insurance and financial support for the surrogate baby should be ensured in case of death of the commissioning parents. Thirdly, it involved the husband and the family of surrogate in the consent process and accepted artificial insemination and therefore, donation of ova, by surrogate mothers. At the same time, the Law Commission accepted the contention that parentage is determined by genetic relationship. It proclaimed, "Love and affection with a child primarily emanates from biological relationship". The child, according to the Commission, should be registered as that of commissioning parents, as perhaps gestation is not sufficient to generate love and affection! Essentially then, the Commission's review is only a slightly amended version of the Draft Bill with which it shares an eugenic, patriarchal philosophical base.

PILSARC, in the mean time, has allowed one of its members to go public about its disagreements with the Draft Bill. Gayatri Sharma claims that the Bill was sent to them in 2006 for comments, and they reviewed and put in their bit in 2006. There have been many changes since then and the present Bill is different from the 2006 version. It is "conservative ... reinforces heterosexual and patriarchal

assumptions". There are, however, two problems with this dissent. Firstly, it bravely points out that though there is a criticism that surrogacy has been commercialised, "PILSARC and the Draft Bill are silent on commercial surrogacy"²³. As we have argued, it is the silence on ill-defined compensation and medical coverage that lends a hand in transforming surrogacy into a commercial contract! Secondly, the full PILSARC team might not have been a party to the outcome of the Drafting Committee but three of its members were.

After being on the ICMR and the Health Ministry's website for some time the Draft has not resurfaced. One hopes that in its new avatar, a preamble would make its perspective explicit. The law makers have the onerous task of retaining collective respect for life, equality, justice and humanness that must guide all sciences and legislation. Such a task calls for political conviction and strong ethical moorings, as yet feeble in the Draft. It needs to address the issues highlighted above, and not just provide for the right to access ART services in the market without ensuring responsive Primary Health Care Services by the state.

(Endnotes)

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The Neo-liberal interpretation of Health as a Fundamental Right: Draft National Health Bill- India and the Affordable Health Care for Americans Act in 2009

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ABSTRACT

A National Health Bill of the Indian Ministry of Health & Family Welfare is on the anvil since 2009. The preamble of the Bill is impressive and promises “protection and fulfillment of rights in relation to health and well-being, health equity and justice, including those related to all the underlying determinants of health and health care”. It also grants that health is a fundamental human right. One is so overawed by such acceptance of the wisdom that health is a basic right, that its social determinants are equally important, that it is easy to miss its real intent. This paper takes a critical look at the definitions put forth in the Bill and the obligations of the state. The analysis shows how the government has appropriated the idea of universal access to health services and health as a fundamental right, to suit its ideas of health as a right in terms of economic access. The Bill promotes the idea of shift in state obligations from one of providing services to ensuring economic access to affordable healthcare services. The paper also looks at the recently passed US Patient Protection and Affordable Care Act that moves towards increasing health insurance coverage for the Americans, even while rejecting the idea of a single system of national health insurance. Such legal measures in these two widely different contexts indicate how within the liberalization process there is a systemic convergence - of the state stepping in to ensure universal coverage through private insurance in one context, and the state moving away from universal provisioning towards privatization of services and ensuring economic access through health insurance, in the other. Overall, the draft National Health Bill expresses welfare concerns, but actually moves towards furthering private sector involvement, and the liberalization process.

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The neo-liberal wave starting in the 1970s affected most developing countries that were trying to build state led welfare services. Countries like South Africa and Brazil- with deep political commitment to welfare for the marginalized managed to keep their investments in health sector between 4-6 percent of their GDPs despite increased privatization that they could not contain. In contrast, India chose massive privatization of its medical care services. Today, it is amongst the most privatized health care systems along with Laos, Burundi, Pakistan, Myanmar etc. Over the past two decades of this experiment, sufficient evidence has emerged to show that privatization does not help the marginalized, it only furthers their marginalisation. Planning Commission of India, based on its studies, is reported to have estimated that over 2004 and 2005, an additional 39 million people were pushed into poverty (Times of India, January 10 2010, pp18, column 6-8). Similar trends have emerged in an analysis of National Sample Survey since the 1980s (Selvarajan and Karan 2009). And yet, when we look at the currently circulating Draft National Health Bill - 2009(NHB) (Government of India 2009), it is clear that while it broadens the scope of health care to include services other than those of medical and public health, it fails to hold the state responsible for the provisioning of Comprehensive Primary Health Care through a strong and integrated public sector health service at primary, secondary and tertiary level services (Qadeer 2002). The Draft ignores the challenge of creating either a system of health taxation, cess or a national health insurance system, a challenge recognized as early as 1961¹. This Bill therefore needs critical scrutiny.

The Draft National Health Bill (NHB) 2009

The preamble of the Bill is impressive to the extent that it promises “protection and fulfillment of rights in relation to health and well-being, health equity and justice, including those related to all the underlying determinants of health and health care”. It grants that health is a fundamental human right that requires an overarching legal framework for providing essential public health services and functions, including powers to respond to public health emergencies, and also a common set of standards, norms and values. However this is to facilitate the Governments’ stewardship of private health sector as a partner!

It acknowledges the existing clauses regarding health in the Constitution and India’s obligations as a signatory to several international treaties and agreements regarding right to health. Though all this sounds wonderful, it never acquires teeth as no rules are drawn to punish non implementation of welfare services. These basic problems are rooted in the very definitions that the Draft proposes or omits.

Definitions

Firstly, some definitions lack clarity; secondly, some key concepts used in the text are not defined. Thirdly, some key concepts are missing altogether, without which a Bill on health is incomplete. This makes interpretation of the text an open exercise due to lack of clarity or the fact that new meanings are imbued and old meanings ignored in a manner that the people's struggles are not able to use legislations to fight for their rights. There are several examples of these. While right to health is defined as, "a right of every one to a standard of physical and mental health conducive to living a life in dignity", neither this "standard" nor "life in dignity" is defined. In a society as stratified as ours such definitions can barely provide a basis for any meaningful legislation. Worse still, though the draft proposes to ensure this right to health through access to facilities, access itself remains undefined. In fact it is equated with "affordability", as stated later on page 19. Thus, access understood in common parlance as availability and free use is confused with what is understood as one's ability to purchase! "Indirect denial" of services (p 13) is thus prevented by ensuring economic access (p 19), and not by provision of free public services! This is nothing short of legalizing the right of private sector to be paid by the government through "Government subsidization or financing or other social security measures..." (p 8). The draft bill thus twists the meanings of commonly understood words to suit itself.

The "determinants of health" include (without being limited to), adequate quality and quantity of food, water, sanitation, and housing (p 12). Why adequate earning, which is basic to acquiring the above in a market oriented system, is excluded from this set is not clear. A core obligation to, "Ensure equitable distribution of and access to essential health facilities, goods, drugs, services and conditions to all..." (p 14) is proposed but "essential services" remains undefined. A third term used in the preamble, "Essential public health services and functions" (p 6) adds to this confusion as this too remains undefined. The Draft Bill seems to make no distinction between health system, health service system and medical care services. It reflects either conceptual confusion, or else an attempt to introduce conceptual distortions that simplify the complexity of health service system and reduce it to users, steward and the providers. The providers the bill is most concerned with are the private, ignoring the fact that the state has the major responsibility of providing not only Comprehensive Primary Health Care, but also for building an infrastructure through which major national health and disease control programmes are run and for manpower planning and training that can not be left to the private sector. The Draft Bill simply does away with the differences between public and private systems- one non- profit service the

other for profit service, one accountable to public and the other to individuals buyers. To integrate them into one health service system, where resolution of conflicts benefits the private medical industry (Qadeer 2009), is to confuse the very definition of a systems approach, which means managing a complex system which has a shared objective and where each component works towards achieving the stated objective. Public private partnership is thus taken as a given by the draft and the basic contradiction between public and private ignored. Consequently the rules of partnership and its clear definition find no space among the definitions.

Similarly, while the state obligation to provide, "Free and universal access to health care" is accepted, it is neither elaborated upon nor defined. Instead, a word included in definitions is "affordable", which is equated with direct or indirect provisioning through subsidies or financing or social security, "Specially for those who are unable to meet their basic needs" (p 8). Thus, 'free care' means that the state will be responsible for all monetary coverage. There is no time frame stated, what is said is that the governments have an immediate duty to prioritize the most vulnerable and marginalized unable to access means of care. This again brings back the target approach surreptitiously, without any sureties for universalisation. Actually nothing comes free and some one always pays. In this case it is the exchequer's money acquired through a taxation system- heavily biased towards the rich- out of which the state pays for direct or indirect costs of health services. It is not difficult to see then that, given the much higher cost of the private sector, it is more rational for the state to accept the obligation of ensuring comprehensive health care through its own cheaper service system. The evidence supports this in India (Qadeer and Dasgupta 2007) as well as the world over (Oxfam 2009), but the draft Bill ignores it. The need of the hour is to assess the monetary and technical efficiency of public and private sectors, and then define the least costly choice for the state.

Yet another problematic definition is the one for life style diseases. If it is, "Diseases associated with a way the person or group of people lives" (p11), then why should these be restricted to atherosclerosis, cardiovascular diseases, strokes, diabetes, hypertension, and not include hunger and under-nutrition, anaemia and occupational diseases, equally born out of choice arising from compulsions of poverty? This reveals unwillingness to seriously confront the structural roots of ill health.

The definition of government "stewardship" for private sector is also conspicuous by its absence. This term, coined by the proponents of privatization of health, denotes that the state must restrain itself from provisioning of health services and stick to promoting and smoothening the process of privatization (Nachuk 2009). The quiet entry of the term in the National Health Bill is therefore

very ominous (p 6), specially when the term is never defined. A steward is meant to serve and not to regulate. The latter is possible if one not only has the power to impose conditions but also the moral right to do so by providing a model system of provisioning. As a steward the state is being promoted to do neither. It is interesting that in the preamble, "a common set of standards, norms and values" are desired "to facilitate the Governments' stewardship of private health sector" rather than steward ship desired to enforce these standards for the benefit of the public! Also missing from the list of definitions is Comprehensive Primary Health Care. While control of communicable diseases, population stabilization and family planning is on the agenda, the need for the state to take responsibility for integrated and rational national disease control and health programmes, based on balanced strategies combining preventive and curative strategies, are missing.

A long-standing concern, that of regulation of health services, both public and private, in terms of quantum of basic care assessed epidemiologically, its quality, costs, internal links, and which sector provides what service, finds no place in definitions.

Obligations of the State

The omissions and distortions of the definitions undermine the statement of obligations as words acquire different meanings. The Bill commits the Government to five sets of obligations - general, core obligation regarding underlying determinants of health, obligations to provide access to quality care, specific public health obligations, and the obligation to respect protect and fulfill. In the first, the Government is to mobilise resources; take all steps for addressing bio-medical and socio- economic, cultural and environmental determinants; provide free and universal access to health care without any denials by any provider, private or public; set standards; ensure at least the minimum conditions of health care to the vulnerable, enable involvement of civil society, specially the marginalized, in decision making and planning at every level, ensure health impact assessment of all development projects. The universal service is thus transformed into a targeted obligation; and mechanisms for participation of the marginalized in decision-making are not defined. Nor is the practice of interdepartmental planning exercises given legal mandate.

The core obligations are identified in three areas. First are health facilities, now narrowed to essential health care facilities for vulnerable or marginalized (and universal access as in general obligations is left out as illustrated earlier). The second set of obligations include determinants of health such as food, safe

water, sanitation and housing including effective sewerage, waste disposal, control of pollution, carriers of infections, ecological degradation, eviction etc. The third core obligation of the state is towards periodic reviews of policies and adoption and implementation of the new strategy within a year when this Act would come into force. The Government is already bound to these obligations through the International Covenant on Economic, Social and Cultural rights and the Alma Ata Declaration. If it has not acted till now how does the Bill ensure that it would now?

Access to quality health care services with assured standards (Indian Public Health Standards – IPHS - to begin with) and norms for, “all aspects of health care including services, processes, treatment protocols, infrastructure, equipment, drugs, health care providers” in public, private and non-government sector are a part of core obligations. For this, all steps such as education, training, Health Information System, IEC will be taken up. Women’s and children’s health, prevention of major infectious diseases, occupational diseases and public health emergencies will be tackled. Unfortunately, given the confusion of definitions of health care, essential health care and essential public health services and the responsibilities of public and private sectors, no clarity emerges regarding some core obligations of the state.

Under the fourth set of obligation pertaining to public health, both the Centre and the State have the obligation to take appropriate legal steps, enact laws, amend or review existing public health laws, implement laws and through their powers issue rules, regulations, orders and by laws under this act. This increases the domain of control of the Central Governments to prevention and control of communicable diseases along with registration of births and deaths, safety and availability of drugs and their rational use, labour welfare, maternity benefits, population stabilization, Centre State co-ordination etc. The States have been prescribed certain specific areas to legislate other than those they are entitled to constitutionally. These areas are safe drinking water, sanitation, biomedical waste, occupational safety, hazardous substances, life style diseases and substance abuse, road safety, accidents and trauma case environmental disasters etc. The expansion of the Centre’s legislative rights is contrary to the spirit of decentralization propounded by the Bill and might lead to conflict of interest over common areas of legislative rights.

Collective and individual rights

These obligations of the government then get transformed into rights. Though it is stated that “every person has the right to a standard of physical and mental

health conducive to living life in dignity" no time plan is laid out for acquiring this universal right. Rights to health, range from right to food, sanitation, water, housing and appropriate health care to right to protection from disasters and hazardous substances as well as right to Health Impact Assessment of all new development projects. Following this is a reiteration of rights against discrimination, to dignity, justice, participation, and information, which already exist! User's rights are delineated as right to survival, integrity, security, right to seek service without discrimination and receive rational quality care, emergency treatment and reproductive and sexual health care. Choice of service, informed and assured referral facility, benefits of scientific and technological progress, access to information on medical records etc. are added rights. To many of these already accepted norms (which may not be practiced at large), is added right to participate in clinical research, to confidentiality and privacy etc. Users should be enabled to lodge complaints for investigation through judicial, quasi judicial or institutional mechanisms within service providing institutions. These rights could be curtailed if necessary, through least restrictive alternatives compatible with the prescribed law.

The Draft Bill then enumerates the rights of health care provider vis-à-vis user when they act to the best of their professional capability and judgment, and in the interest of the user. The responsibility to protect such a provider lies with the institution where s/he is employed. This leaves out a vast majority of the individual private providers. In the Draft Bill, all these rights hang without much support from the schedule, rules and by-laws.

Public Health Boards

To implement the obligations Central and State level Public Health Boards will negotiate revisions of Plans, expenditures, standards, and systemic improvements. It would also evolve rules and regulations for recruitment from open market, develop mechanisms for PPPs and empowering the decentralised monitoring committees at all levels. At the State level these boards will implement, monitor and provide financial, technical and human assistance. There will be nominated members representing different stake holders apart from the ex-officio members. For the State these will be public health experts, representatives of medical associations and NGOs! This is the vision of participation in decision making of the marginalized! The Draft document suggests, but does not ensure, that the planning at decentralised monitoring committees is incorporated into the state plans. The formation of additional boards to implement legislations is a trend that does not auger well for the existing State health directorates and district

head quarters, whose regulatory and supervisory functions instead of being strengthened, might get squeezed out in the name of monetary efficiency. Will this increase the administrative costs and raise the financial burden of the state or, is it being proposed to further cut down the public sector infrastructural costs by making these boards semi autonomous bodies with mainly ex-officio members not to be compensated (pp 30)? Or is it that these Boards will primarily function as regulatory bodies promoting the interests of the private sector medical institutions by treating them as equal or more than equal partners?

As the state is legally bound to its obligations, different levels of redressal mechanisms are proposed. These are Swasthya Jan Sunwais, In-house Complaint Forums at the institutional level and district courts. These however will be meaningful only if the essential services and their mandatory standards of quality are spelt out.

A major shift of emphasis

Reading this well crafted document of 56 pages, one is so overawed by the ultimate acceptance of the wisdom that health is a basic right and that its social determinants are equally important, that one easily misses its real intent. So far, all policy documents have accepted that the state is responsible for the provisioning of Primary Health Care (PHC) to all even though the definition of PHC has been changed from 'comprehensive' to 'selective' PHC then, 'primary level' and lastly 'essential' health care (Qadeer 2002) . However, now when it comes to state obligations the emphasis has shifted from providing service to ensuring economic access to services. The state takes on stewardship of the private sector - a role of overseeing the transition. Thus even though the scope (field level, out patient or indoor care), and the levels (primary, secondary and tertiary) of services are articulated, the division of responsibility between public and private providers is not. In other words there is no clarity on the state's provisioning obligations. Instead, the acceptance of public private partnership in the implementation of public health programmes (pp 6, 34) is being promoted despite its inefficiency and high cost (Pollock 2004) and well known conflicts of interest (Evans 1999).

The socio-economic determinants have not been not been defined in terms of their minimum standards despite enough available research based quantitative prescriptions for the same (Sanjha Manch and Hazards Centre 2001). By ignoring the existing recommendations and proposing further epidemiological research, the Draft Bill offers an excuse to delay any laying of rules, regulations, by-laws and legal orders to translate obligations into legislation.

Lastly, the way specific public health obligations are articulated in the Draft, the role of the Centre has certainly been expanded. Earlier, it was responsible for a very limited set of activities covering international health, central government services, and medical education, but this arena has now been expanded many fold. This is an infringement of the state's autonomy where the Centre has the prerogative to legally interfere with the working of the State in many more area of health and welfare. Earlier the Centre manipulated through resource control but now there is an explicit appropriation of the constitutional prerogatives of the State!

The US Patient Protection and Affordable Care Act - Convergence of strategies for health rights in the largest democracies

The US healthcare system is characterized by dominance of private insurance and private provision. The crisis in the US healthcare - in terms of increasing numbers of uninsured and underinsured persons, increasing numbers being rejected for insurance, decreasing percentage covered by employer based and government provided healthcare, and healthcare costs increasing faster than wages and inflation, poor outcomes despite high healthcare spending (Carey et al 2009) - re-opened the more than a decade-old healthcare reform debate during the 2008 Presidential election² (Oberlander 2008, Marmor et al 2009), and several reform bills were introduced in 2009. Among these were: America's Affordable Health Choices Act 2009 (Tri-committee Bill 3200), United States National Health Care Act or Expanded and Improved Medicare for all Act (Single Payer 676), Affordable Healthcare for America Act (House of Representatives Bill 3962), Patient Protection and Affordable Care Act (Senate Bill 3590). The last Bill – 3590- was passed by the US House of Representatives on the 20th of March 2010, with amendments to accommodate the interventions of the President³.

In the US the political struggle is openly between private and public insurance systems. The final piece of legislation in the US - despite succumbing to the private insurance lobby- has taken a step toward universalisation of health insurance. The original Bill, America's Affordable Health Choices Act of 2009 lost as the idea of universal coverage, health taxation as well as a national insurance system and of primary health care was too revolutionary for the American Congress. However, in voting for The Affordable Health Care for Americans Act [H.R. 3962] in November, the House members voted to increasing state intervention in the \$ 2.5 trillion health care system and to restrict its private sector. Even though the US medical industry won the right to make its profits, the three area

of progress were: (a) the expansion of insurance coverage (b) the controls proposed to contain private profits and (c) mobilization of resources for health care through taxation. The American Senate, however, passed the Patient Protection & Affordable Care Act [H.R 3590] in December 2009, which rejected a single national insurance, and accepted only individual state insurance, lowered the medical care payroll cut off for taxation to house holds earning over US \$ 250,000 annually (0.9% additional Tax). On 22nd February President Obama came out in favour of expanded coverage, better subsidies, lowering costs and provision of Community Health Centres, and offered a compromise between the two Bills, accepting the rejection of national insurance, and withdrawal of state subsidy for abortion services as demanded by the Republicans.

Moving towards the American model, India is veering towards dismantling its Primary Health Care, which is disastrous for its population mired in poverty. One showing the 'human face' in covering 30 million uncovered Americans, and the other undermining primary health care and opting for privatization, reflects a systemic convergence from opposite directions, in two widely different contexts. Thus we see within the liberalization process two tendencies - of moving towards universal coverage through private insurance, taxation to subsidize this coverage and some restrictions on insurance companies in one context, and the state moving away from universal provisioning at the cost of the poor towards privatization of services and by ensuring economic access through health insurance, in the other.

While the US Act is clear on where the money is coming from and how much, the Indian Draft Bill while putting the responsibility on the state, provides no clues on this key variable! Despite the presence of private insurers in health sector, the Indian draft Bill never clarifies the nature of insurance system that it repeatedly promotes. It retreats from universal provisioning and proposes 'economic access' (subsidy or direct payment to private sector and PPPs), and a targeted approach to begin with - for those who cannot pay for services.

These contrasts and similarities are historically rooted in the very different trajectories and socio-economic structures of the two countries. In the free market economy of the US, the private health services became so costly that the state had to intervene; whereas the strong role of the post independent welfare state in India- committed to providing services free of cost- had to be muted to promote medical markets after the acceptance of HSR. This has been done by the state firstly, by denying resources to the public sector and secondly, by initiating legislation that makes private sector an equal partner of public sector in an unequal social situation. The struggle for a different legislation in the US is rooted

in the needs of a much larger proportion of its middle class, affected by the high cost of medical care, and not just the poor who are outside its private insurance system. In India even though large in absolute numbers, the middle class- whose needs drive the markets in health- constitutes at best about 25 percent of the total population. A vast majority whose votes count in a democracy are denied health facilities.

The Indian draft NHB has not emerged out of a parliamentary debate reflecting different interest groups. It is a consequence of a series of public hearings organized by the National Human Rights Commission at the behest of the Jan Swasthya Abhiyan-the People's health movement of India- a collective of pro-people grass root activists and practitioners of public health that demanded universal access to health care at the National Health Assembly in 2000 (Jan Swasthya Abhiyan 2006). This process culminated in the recognition of denial of service and the importance of recognizing health as a basic right (National Human Rights Commission 2004). Recognizing the weight of the argument, the Government of India has appropriated the idea of universal access to health services and health as a fundamental right by putting forth the Draft NHB to suit its idea of health as a right. This Bill, as we have argued, promotes the expansion of a well regulated medical market and investing in health as conceptualized by the Commission of Macro-economics and Health which emphasized the role of health markets in economic growth (World Health Organization 2001). In economies where growth rates increase without a corresponding increase in employment, as in India, the increase in growth rate has little to do with improved health and productivity of labour, that remain under or unemployed. It is an outcome of subsidies and support to expanding private sector which makes its profits out of the burgeoning middle class.

Is the neo-liberal demand on the economy the only explanation for the shifting priorities? Or, is it an over kill of a political leadership too keen to oblige its mentors as well as its middle class base? The American Bill shows that within the neo-liberal paradigm there is space to accommodate some of the liberal ideas (not all). The Indian Bill demonstrates that behind the veil of 'health as a fundamental right', medicalisation and commodification of services, reduced provisioning and transformation of public health to poor quality primary level care can be pushed, ignoring that an efficient integrated public health system lowers costs of health care and even reduces state deficits, as shown by the US example. Attempts to provide Primary Health Care through Accredited Social Health Activists, Bachelors of Rural Health (proposed short courses for rural practitioners), monetary incentives of Janani Suraksha Yojana (scheme for

maternal safety) and National Health Insurance for those below poverty line mainly through registered private practitioners can barely hide the fact that the middle class is being favoured. Free medical education in state medical colleges without any responsibility towards state services, permitting growth of capitation fee-based private medical schools, supply of trained doctors from state run medical institutions as fodder for corporate hospitals and as part of technical labour supply to the international market are well known concessions to this class. On the other hand, fast changing definitions of poverty levels⁴, citizenship access⁵ and rights of the marginalized communities to basic services⁶ are indicative of the shrinking democratic spaces where only interests of the powerful matter.

In this milieu today, a draft National Health Bill, biased against a strong public sector is afloat with all the constituents of a recipe for liberalization - full of welfare concerns but lacking legal teeth - it confuses a casual reader. However, if it has to move beyond a restricted NRHM, it must address the challenge of providing, "Comprehensive Primary Health Care" for all as defined in the Alma Ata declaration, and of resource mobilisation for reviving state funded institutions. It will have to address these through a systemic perspective where in the shared objectives of the public and private sector, their specific roles, responsibilities and freedoms, if any will have to be specified or else, it will remain yet another legislative measure on the road to anti-people health sector reforms.

(Endnotes)

¹ According to the Health Survey and Planning Committee 1961 of the Government of India (Mudaliar Committee) the question of financing of medical care needed careful study, and the possibility of the levy of a health cess was worth exploring.

² During the 2008 US Presidential election, the New England Journal of Medicine asked the two candidates to describe their plans for reforming the US healthcare system. See 'Healthcare Reform and the Presidential candidates' in New England Journal of Medicine (2008) vol 359 no 15 pp 1537-1541 for the two statements.

³ The solutions proposed by these bills ranged from universal coverage through national insurance or national health service to expansion of private insurance. According to advocates of the single-payer system, such as Physicians for National Health Programme (PNHP) simply the potential savings on profits and administrative costs would be more than \$350 billion per year, enough to provide comprehensive coverage. Savings would also accrue from containing drug costs through means such as price negotiations. While there is lack of support from the mainstream corporate US media and other influential sections for this plan, numerous surveys have shown popular support for it, including support from physicians, and from the major health workers' and labour organizations (Bybee 2009). The single-payer proposal of Bill 676 that

would have provided a nonprofit healthcare system was rejected by the elected representatives and senators, including Obama himself who was for it before election. The ones that were accepted and were debated retained private insurance at the core of the health system, thus precluding any genuine reform of the health system that would control costs and ensure provision of the needed healthcare services to all.

⁴ Tendulkar Committee Report. <http://southasia.oneworld.net/todayshadlines/every-third-indian-below-poverty-line-says-report>

⁵ <http://lawmin.nic.in/coi/contents.htm> accessed on 15th Feb 2010

⁶ Citizens' Groups, 2009: 'Half Time or Time Out'. Citizens' Review Jawaharlal Nehru National Urban Renewal Mission: A Collective View from below, Hazards Centre, New Delhi.

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Benefits and Threats of international trade in health: A case of Surrogacy in India

To be child free, to want one's own baby with assistance of technology or a surrogate mother, or to adopt one is a matter of personal choice and these choices are socially influenced, depending upon the status of fertility rates, means, and mind set of the women concerned. Conflict arises in those countries that deny surrogacy, though none, however, stop reproductive tourism for cheaper commercial surrogacy services across borders. Fertility declines are not comparable between the South and the North, but countries like India, with a strong tertiary sector, estimate 100-150 annual surrogate births¹ with a tripling of fertility facilities², while infertility estimates remain at 8-10 percent, most of it being secondary and preventable. This spurt thus reflects no significant epidemiological shift in infertility prevalence, but only expanded assisted reproductive technology (ART) and surrogacy services within India's booming medical market. Matching the needs of the rich for children to the economic needs of those whose basic needs are unmet, these markets use reforms to encourage financing of hi-tech ART services, knowledge and technology transfer, and profits for professionals.

Any discussion on the benefits and problems of further development of global trade in hi-tech reproductive services for patients and health systems and the extent to which ethical and national health policy needs should or should not be taken into account as part of negotiation of global trade in services demands attention to two things. Firstly, enforced reforms and World Trade Organization agreements saw protective national policies as trade restrictive and tied member states to a trajectory that served the multinational corporations, undermining public services of health care, education, energy, water and sanitation³. Secondly, attention must be directed to the nature of the governments that willingly commercialise public resources to favour international and private actors.

A diversion of global reproductive tourists was thus inevitable and its profits contributed to economic growth. Successive national governments pursued this policy of growth without equity, camouflaged in phrases like "security net", "targeting the poor" and "inclusive development". With ambiguous health and population policy statements, the state actually drafted legislations such as the ART (Regulation) Bill-2008 and the National Health Bill-2009. The first ensures

surrogacy as a part of ART through free markets, and the other, right to health in terms of “free and universal access” through state subsidies but not state provisioning! In other words, support for medical industry for a few has priority over the welfare of the majority. The current controversy over the Civil Nuclear Liability Bill in the context of Bhopal, where the government is trying to absolve the US private suppliers of reactors of any liability in case of an accident leaves little doubt about where the government’s interests lie. It is futile to imagine a simplistic North-South divide on ethical national health needs, when the conflict is between those who decide the trade in health services and those who do not.

For instance, the perceived official “need” for making surrogacy legal in India has brought to the fore several ethical, social and public health issues. This led the government to come up with a Draft of ART Regulation Bill which contradicts the national policies of the two child norm and a Net Reproductive Rate of one, ensuring safe delivery and maternal health under the Millenium Development Goals and the UN Convention on the Rights of the Child - including breast feeding and bonding. By emphasising genetic parentage and an eugenic view of life, it undermines the importance of gestation and adoption, while promoting anonymity and secrecy around individual identities that are counterproductive in the healthy socialisation of babies.

This Draft Bill projects a surrogate pregnancy as “furtherance of ART”, and a “service” to commissioning parents. Should surrogacy be used to further ART is highly questionable but, to avoid the issue of wages for ‘services’ is no less unethical. The four sets of issues it raises are central to a global debate on the ethics of commercial cross border services: the basis of payment underlying economic exploitation of surrogate mothers in the developing countries; safe maternity care for surrogate mothers; ensuring universal rights of the newborns; and the illegitimate protection offered to providers. Should international regulations ensure minimum norms for these?

The notion of ‘cheap wage labour in developing world’ rooted in the concept of a variable skill based “productive social labour” (low in the developing world), is different from the universal value of women’s procreative labour, which is biological, not fixed for a number of hours a day, and with a product neither saleable nor a commodity but which is a priceless human baby. Hence any woman who agrees to be a commercial surrogate deserves her ‘wage’ for the energy (physical, emotional and psychological) invested in nine continuous months, plus the period of caring for the baby. Only the professional provider’s payment could be lower. The “compensation” can only be for the pain of separation from her unique product - the baby, and events such as physical damage due to negligence or her death.

The Draft Bill, firstly, confuses the issue of wages by terming it, “compensation for services”, and “coverage” of insurance and expenditure related to pregnancy until the baby is handed over; but medical care, legal contracts, counselling, travel, psychological assessment, and health insurance for the family for the period of surrogacy are excluded. The uniqueness of surrogate pregnancy demands that these components of payment are recognised internationally to undo the inbuilt exploitation of women who offer their services as a livelihood in absence of work and social security even if the labour of the professional service providers is considered cheap.

Secondly, the Draft Bill permits up to three embryo transfers for the same couple in case of failure of surrogate conception and three successful surrogate live births to a woman in her lifetime - nine embryo transfers in all. Reduction of pregnancy is mandatory if the commissioning couple wants it and most common risks are transferred to her (including her death) rather than the provider or the commissioning couple. She, on the contrary, has no rights to safety or to keep her gestational baby under any circumstance, have her name on its birth certificate, or demand any securities for her family. The state is given no responsibility to ensure that the commissioning parents and the providers are held liable for damages.

Thirdly, for making the process as smooth as possible for the commissioning parent, a strategy of early separation of the baby is promoted at the cost of breast feeding and bonding - the rights of the most vulnerable baby - even though India is a signatory to the UN Convention on Rights of the Child.

Can an international debate around these issues help evolve universally shared ethical guide lines for cross border surrogacy services or will such a consensus by raising levels of payment for the poor women in India, also become a means to regain business now going out of the developed countries due to medical/ reproductive tourism? Linking this search with the international opposition to Reforms seems to be the only way.

(Endnotes)

¹ <http://www.medicalnewstoday.com/articles/62462.php>

² <http://www.thestar.com/news/world/articles/800791>

³ Sarah Sexton: 2001, Trading Health Care Away? GATS, Public Services and Privatisation, Corner House Briefing, 23 July