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The Care Diamond: State Social Policy and the Market

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In this chapter, we examine the interface of state social policy, the market and 'community' organisations in making care practices within and without households and the labour/care regime, focussing on child care. Much of the discussion centres on one point of the care diamond - the state.[2] There is both a theoretical and heuristic purpose to this. The reach and financial clout of the state continues to make it a critical actor in modulating gender relations and care practices, whether it is through direct welfare measures or through purposive withdrawal/regulation in employment and the economy. Governments in India have had to appear, to varying degrees, responsive to both local constituencies and international pressures. Social and political movements have addressed themselves simultaneously to mobilisation of people and demanding action from governments and the state. Thus state policy, despite the labyrinthine and often obfuscating nature of its articulation, becomes a fruitful entry point in understanding the care regime in India. In taking this path, we follow measures of state policy that may have indirect implications for care and not just those which are explicitly tied to the issue. We find that state policy and the care diamond are differentiated in design and outcome, but focus more on the implications for and practices of the poor and the middle classes. Lastly, our attempt is to draw out the dynamic and changing aspects of the care regime as well as the continuities.

After a brief outline of the framework of government and development history, we examine the welfare regime in terms of both programmes in different areas of social policy and in terms of analytical-descriptive features. After a brief summary of our findings on time spent on paid and unpaid work, we turn to the care regime. We look at measures for workers in the formal and informal sectors as well as measures for citizens. We outline the contours of a growing market in care. Both in examining the welfare regime and in mapping the care regime, the links between state policy, the market, and political processes are drawn out.

1. The framework of governmental action and development policy

The welfare regime and social policy in India today have to be viewed in the context of the overall orientation of and shifts in state policy and government since 1947. With Independence, an interventionist and developmental state was seen as essential to achieve the stated aims of the 'Directive Principles' of State Policy[3] - the removal of poverty, social justice, self-reliance, and growth. Different recipes and structures were debated and concretised in successive Five-Year Plans. The principles formulated included free and compulsory education to children, a public health care system and higher education system, economic and social rights to women, as well as Scheduled Castes, Scheduled Tribes, and Other Backward Classes and religious minorities along with adequate means of livelihood for all citizens linked to industrialisation and agrarian reform, equal pay for equal work for men and women, proper working conditions, protection against exploitation, reduction of the concentration of wealth and means of production and economic inequality.

The model of working conditions and social security that the new state annunciated for its employees was to act as a standard as well as to ensure the loyalty of the emerging middle class to the new state. Not only were these regulations rarely implemented beyond the public and for white collar workers

[2] On the care diamond and the labour/care regime, Razavi 2007; 2006.
[3] These were formulated by the Constituent Assembly as guidelines for governance which should aim to give substance to the fundamental rights given in the Constitution.

in large-scale private enterprises, the proportion of citizen-workers who were able to avail of this model remained relatively small and gendered. The organised-formal sector, predominantly male, never grew beyond 10% of the employed. The paucity of benefits directed to women workers such as maternity leave, crèches, and other facilities in particular reiterated the tacit and overt distinction between male paid workers/employees and female family carers. That this distinction was a problem was overshadowed by the continuing high levels of unemployment and underemployment, which were simultaneous with high levels of overwork, child labour, poverty, and rural indebtedness and very low wages and labour productivity.

By the 1980s, the entrepreneurial classes no longer needed the infrastructural support of the state and saw the labour relations model as an obstacle to their further advancement, including that of limiting the labour supply. Since then, a neo-liberal economic strategy narrowly focussed on the market and growth continues to be advocated and the urban, middle and upper classes, who had palpably experienced the state in their everyday lives are a major constituency in favour of the policy. Social welfare now receives recognition in terms of the idea of a safety net against poverty rather than a means to social transformation and reduction of inequality.

The nature of Indian federalism is also important in understanding the welfare regime. The division of powers between the central government and the states/provinces was in favour of the centre, particularly in financial areas and through a central bureaucratic service controlled by the central government. While many areas of policy considered within the realm of social policy have fallen within the purview of provincial governments, the main instruments available to the state for accruing resources have been retained at the centre. In the early decades, the dynamics of centralisation were reinforced by the fact of the same political party being in power in the centre and most of the states. This last feature changed dramatically in the late seventies. Since then, not only are a large number of states ruled by parties which are in the opposition at the centre, many are ruled by regional parties. They may be part of the ruling or opposition alliances at the centre or remain outside of both. With this, one sees increasing differences in social policy between provinces, a result of differential resources as well as varying politics, ideologies, and party alliances.

The continuing and overwhelming agrarian nature of the Indian economy and society, based on family enterprises is also critical here, with growth in agriculture declining in the post-reform period. Provinces differ in average farm size, agrarian incomes and inequality and the extent of dependence on agriculture. In both the provinces chosen for closer study, Haryana and Tamil Nadu, agricultural productivity and agrarian incomes among large landowners had risen dramatically in the decades of the Green Revolution - the 1970s-80s. The rise in incomes among some of the agricultural classes and regions contrasts with the lack of food/work among others. Ups and down in agricultural development are paralleled by trends in migration and pressures on urban employment and a vast and growing informal sector. Social policy, including child welfare, education, and health has not touched more than the surface of the rural and informal sectors.

Whether there has been a real or relative decline in poverty in the decades of liberalisation is the centre of debate, with official figures and projections being contested. It is clear, however, that there has been simultaneously a rise in average per capita income with an expansion of the middle classes and of disposable income among them, a deceleration in wages of casual and regular workers, rural and urban, male and female and at all levels of education, and a slowing in the rate of decline of inequality even to the point of increasing inequality between regions, castes, genders, and classes. The impact of growth on poverty is reduced by adverse distribution in 13 states, including Haryana and TN (Dev 2008: 89).

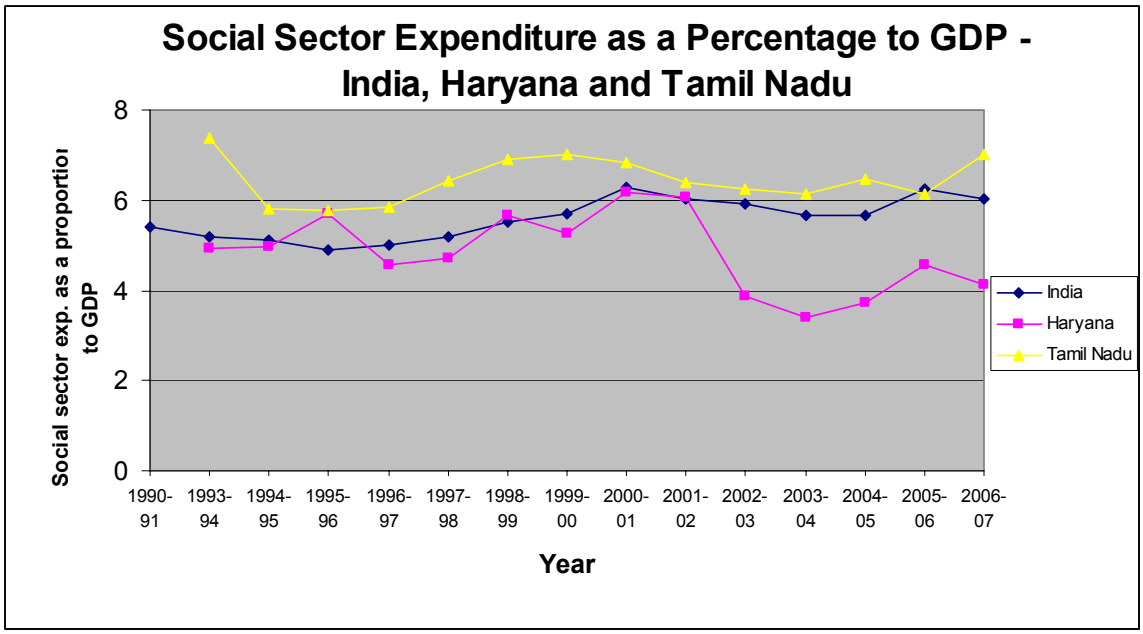
2. The welfare regime

India has a history of very detailed and diverse social policy programmes. This detailing in the policy discourse and the rhetoric may, at times, obscure the applicability of Titmuss' notion (1958) of a residual welfare state to the Indian case. Some scholars suggest that while the Second Plan (1956-61) had the least to say in terms of welfare it went further in laying out a social policy. On the other hand, while the rhetoric increased from the late sixties-early seventies Garibi Hatao ("Remove Poverty") slogan, it is from the Fourth Plan (1969-74) that the content of welfare policy has become fuzzy.[4] The welfare regime became the patchwork of programmes described below, furthering its residual character and in line with Gough's description of the process as piecemeal, haphazard and reactive. The programmes through which stated intentions were to be translated were clearly meant to react to market or family "failures" and limit assistance to marginal or especially "deserving" social groups. They were not designed or funded, however, so as to provide assistance to even all members of any "deserving" group, allowing for political and bureaucratic patronage and corruption. This was especially true of the range of social services, including those under the head of "social welfare and nutrition". After the neo-liberal reforms begun at the end of the 1980s, there was a further and clear shift in advocating private sector expansion in health, education, and (other) "social services" and denial of state responsibility in these areas even for the "needy/poor" groups with the levying of user fees. The possibility and probability of simultaneous market and family "failures" have also been played down. The gradual withdrawal of the state (with a slight upturn in the last few years) and its ad hoc treatment of the social sector are reflected in the trends in social sector expenditure (Figure 1).[5]

[4] Interview with Dr. Abhijit Sen, Member, Planning Commission.

[5] Source for the social sector expenditure data graphs is the Reserve Bank of India: State Finances: A Study of Budgets of 2007-08 & Budget documents of various states.

Figure 1

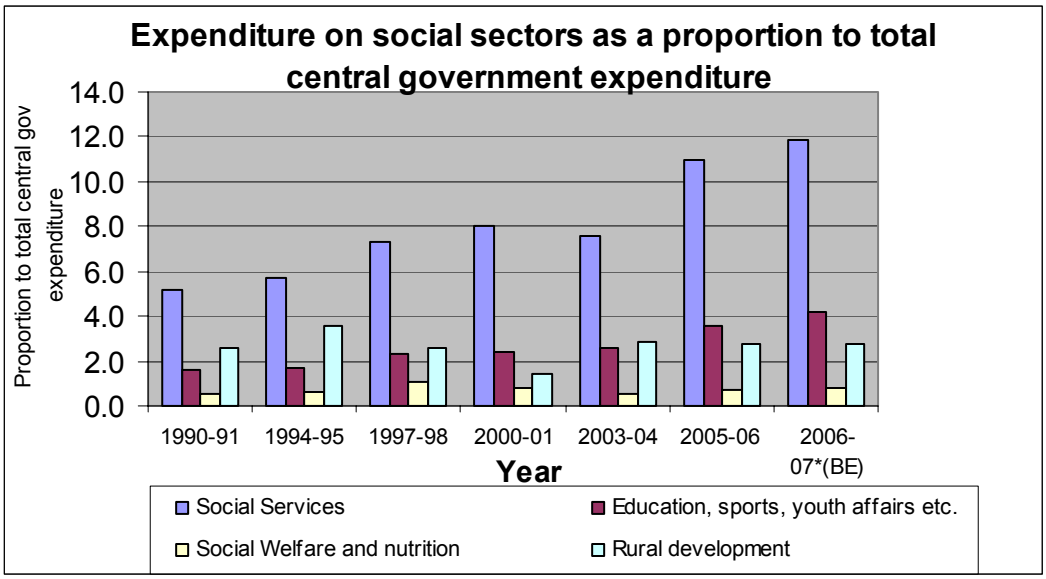


The above graph has to be read with two other sets of information. Tamil Nadu is much ahead of Haryana in the composite index of industrial development and GDP, but has a lower per capita income. Further, not only does Tamil Nadu have a higher poverty ratio over the last decade, the percentage growth of GDP between 1999 and 2005 has been approximately two thirds that of Haryana. However, as is clear from above there is a much greater attention to and development of a welfare regime policy in Tamil Nadu, which is seen in nutrition, pre-school and school programmes. We discuss this later.

The bias against agriculture in the terms of trade, the rural-urban income gap as well as rural-urban gap in public infrastructure - the urban bias- had been diagnosed as the problem in various studies. 'Rural development' has been an important component of social sector expenditure and a range of direct anti-poverty schemes and programmes directed to rural India had been initiated fairly early on, but funding and implementation were low and fluctuating. In order to cushion the worst effects of liberalisation on the poor, targeted "safety net" measures were advocated. From the mid-1990s, the emphasis shifted to human development and physical infrastructure, such that budget allocations to anti-poverty programmes declined (Dev 2008: 134). This decline in relative expenditure and importance was partly corrected from 2003-04.

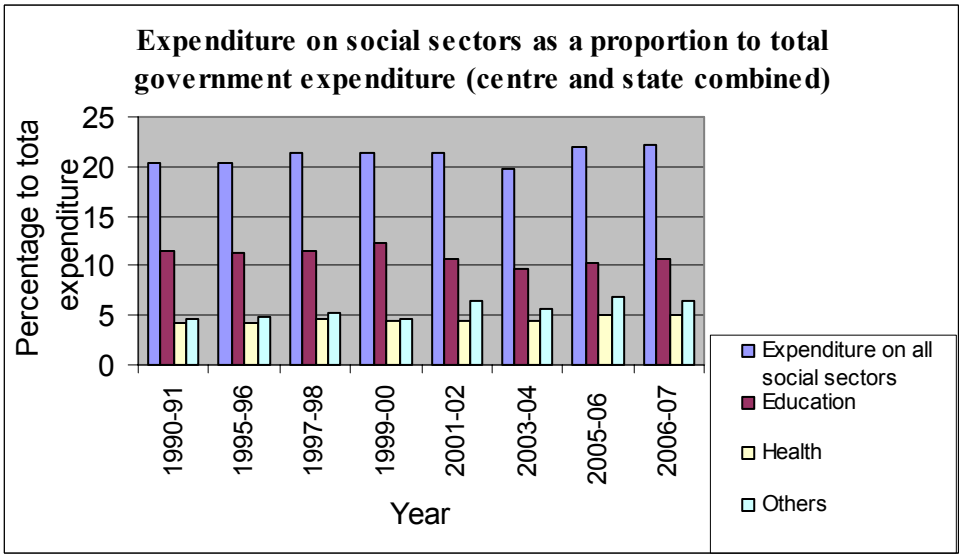
While the categories used in the following two graphs are not the same, they give an idea of the division of expenditure between various components forming the social sector and between the central and state governments. One feature which emerges starkly is that increases in central government expenditure have not meant an increase of total expenditure. State governments have argued that they are unable to increase their expenditure in the social sector - their main of area of responsibility - due to the division and allocation of fiscal resources between the central and state governments. The category of social services which receives the highest allocation as seen in the first graph includes the range of non-universal, discretionary schemes for 'deserving sections' as well as the Integrated Child Development Scheme (ICDS) discussed later.

Figure 2



Note: Total expenditure on social sector includes expenditures on Social services and Rural Development. Education, sports, youth affairs etc and social welfare and nutrition are components of social services.

Figure 3



In the following sub-sections, India's welfare regime is discussed through certain defining features of its social policy programmes. Despite various shifts in language, they remain pervasive. The filtering of social programmes through the absolute of privatisation seems to have both aided and been aided by some of these features, as will be indicated. Some features of social policy, such as those pertaining to primary schooling and health, directly relate to care. Others have an indirect impact on or implication for care, though their effect on the possibilities of acquiring the means for care, on the cost of care, the likelihood that people will choose to give care and to whom. While discussing them, we draw out their implications for care practices, which we turn to more centrally in a later section.

2.1 Limiting universality

There were very few 'universal' components in the Indian welfare regime. The few that were in place, as in health and education, were *differentially, unevenly and minimally available* or not accessed by those who had the means to avail of private facilities. Claims at striving for universal availability and access were not matched by allocated resources, leading to both a paucity of facilities and poor quality in services. This has been accentuated since the end of the 1980s with the push for privatisation and targeting of universal programmes. The poor often could/did not access public-funded facilities due to their non-availability or the immediate loss of wages or of family workers that accessing the facility (as with schooling) entailed. Unlike in Europe, where other than the elite, all sections accessed public health and education institutions, in India even the middle classes turned to private facilities, except in higher education and schools (Central and Army Schools) and hospitals (eg. All India Institute of Medical Sciences) designed for or available to public sector employees. Thus, those who run the government have had little stake in ensuring and improving government facilities or are able to access the 'islands of excellence' within them. Often they have familial links with those who set up private facilities.

2.1.1 Public Health

Health needs and care - of children, of the old, of the ill - and the responsibilities of giving care are issues for the practice of care which cuts across all sections of a society. The health system is critical to an understanding of the social and political economy of care in any national context and from the time of the Beveridge Plan became a standard measure for understanding and evaluating a welfare regime. In India, a public health system consisting of public facilities and health insurance for employees was to be one of the centre-pieces of its "socialist" orientation. However, from the start, the public health system was marked by all the characteristics noted for the schooling system: low funding, poor spread into rural areas, sub-standard infrastructure with islands of excellence, and paucity of staff. Again, the universality of the programme was denied in practice by non-availability, by the middle and upper classes opting for private health facilities and practitioners, and by doctors trained in government institutions opting for the private sector, preferably in another country. In addition, as population control became a principal 'development' strategy of the Indian state, allocations for health, especially of women and children were increasingly invested in family planning programmes - 'family welfare' being the euphemism. This made even the poor wary of public facilities. The neo-liberal advised institution of user fees and the rising costs of medicine within public institutions following market deregulation have further meant that for the poor there is often little difference in cost between public and private health institutions.