MTP Bill's proposal for a bureaucracy to vet abortions is ill-judged and impractical

Requiring pregnant persons to navigate a bureaucratic web of authorisation will inevitably lead to delays and thereby impede access to safe and legal abortion services.

Written by **Dipika Jain** |February 11, 2021

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The Medical Termination of Pregnancy (Amendment) Bill ('MTP Bill') passed in the Lok Sabha without much debate or deliberation in March last year, is scheduled to be tabled for consideration in Rajya Sabha. The Act prescribes the setting up of draconian medical boards in every state and Union territory (UT), consisting of a gynaecologist, paediatrician, radiologist or sonologist and any other members as proposed by that state or UT. Each board will be responsible for diagnosing substantial foetal "abnormalities" that necessitate termination of pregnancy after a 24-week gestation period. Medical boards are a form of third-party authorisation and were not envisaged in the MTP Act, 1971. In the context of the current healthcare budgetary challenges, this proposal to set up infrastructure across the country to regulate medical termination of pregnancies is both financially unsound and practically impossible.

India's healthcare system has neither the financial investment nor the infrastructure to sustain the operation and functioning of medical boards in every state and UT. Due to the weak healthcare infrastructure in the country, it would be practically impossible to constitute these boards with the requisite specialists. Even where they are set up, the accessibility of such boards for pregnant persons, especially those living in rural areas, remains a major challenge. More importantly, subjecting people to multiple invasive examinations in order to determine whether they can terminate their pregnancy is a grave violation of their rights to privacy and dignity. Requiring pregnant

persons to navigate a bureaucratic web of authorisation will inevitably lead to delays and thereby impede access to safe and legal abortion services.

India's current level of public financing of health is one of the lowest in the world (at 1.6 per cent of GDP in 2019-20) and does not even cover basic facilities for all. This has meant that most health expenditure in the country is out of pocket (OOP) — borne by patients themselves — with OOP expenditure on healthcare recorded at 58.7 per cent as per the National Health Accounts in 2016-17. About 17.4 per cent of the women from the lowest quintile in Mumbai slums financed their maternal care expenditure by borrowing money. OOP expenditure abandons the poor in the country to "distress financing" of medical care by selling off personal or ancestral assets like land and livestock, borrowing from predatory moneylenders, etc, and is a major cause of impoverishment in India, affecting those in rural and conflict zones the most.

The agenda of privatisation of healthcare, spearheaded by the central government, aims to turn hospitals into an "industry" and the state into a "strategic purchaser" of healthcare, as a consumer good. The central government has preferred to incentivise private players to set up or offer services, instead of building infrastructural and professional capacity. Privatisation drives up costs of care and the handing over of public facilities to the private sector can have catastrophic consequences, as private institutions prioritise profit over health and have no reason to cater to the vulnerable or marginalised. They additionally remain non-accountable to state authorities in terms of affordability or transparency (for instance, through Right to Information enquiries), or to uphold fundamental rights like non-discrimination in treatment or employment, or even the fundamental right to health. The National Sample Survey Organisation (NSSO)'s 75th report shows that less than 20 per cent of the population is covered by health insurance in India.

India's healthcare system is sorely inadequate in terms of the reach of medical facilities and the presence of adequate numbers of qualified healthcare professionals. According to the National Health Profile 2017, India has only one doctor for roughly 10,200 people in the public sector. A recent study by Centre for Justice, Law and Society at Jindal Global Law School highlights the acute shortage of nearly 80 per cent of specialist doctors at Community Health Centres, which are equipped to perform abortions. In certain states, such as Gujarat and Tamil Nadu, there is a near-complete absence in the availability of certain specialists in rural areas. In places like Arunachal Pradesh, Meghalaya, Mizoram and Sikkim, there is a glaring 100 per cent shortfall in the availability of paediatricians — one of the specialists required to constitute the board. These findings demonstrate the failure of governments to ensure public health availability, and strongly warn against instituting medical boards for abortion approval.

Poor public health infrastructure and absence of specialists across the country have meant that most abortions do not happen in the public sector, but at private centres or at home. With overwhelming shortfalls in specialist availability, especially in rural and scheduled areas, it would be impossible to constitute boards with requisite specialist representation as contemplated under the MTP Bill.

This article first appeared in the print edition on February 11, 2021, under the title "A misconceived approach". The writer is professor of law and director, Centre for Justice, Law and Society, Jindal Global Law School