**Public Health, Migrant Workers and a Global Pandemic:**

**From a Social Crisis to a Crisis of the Social**

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On 23 May 2020, the Gujarat High Court has admonished the state government in a remarkably harsh language by comparing the condition of one of its largest public hospitals with that of a dungeon facing the COVID-19 outbreak.[1]It has also invoked the metaphor of the Titanic – the large ship, which famously sunk in 1912 – in the context of the rising number of positive cases in the state and the government's ineffectiveness in containing the disease and has appealed to the private hospitals to admit as many patients as possible without any profiteering intention: "The foremost reason for their (private hospitals) existence is to treat sick patients and it would be utterly shameful on their part to shy away from this responsibility at this point in time, when the country and its people need them the most. Profiting off a poor man's health can be considered morally criminal."[2]

Although quite timely and necessary, the intervention by the judiciary in the matter of increasing privatisation of the Indian health sector is rare and could be interpreted by many as infringement of the right to do free business.However, it indicates a major crisis, to which the public health system has been heading over the last few decades. The government of India does not only recognise it but also endorses it in the latest National Health Policy (NHP) published in 2017 where it mentions quite casually four changes that have occurred since the last NHP in 2002: "First, the health priorities are changing. Although maternal and child mortality have rapidly declined, there is growing burden on account of non-communicable diseases and some infectious diseases. The second important change is the emergence of a robust health care industry estimated to be growing at double digit. The third change is the growing incidences of catastrophic expenditure due to health care costs, which are presently estimated to be one of the major contributors to poverty. Fourth, a rising economic growth enables enhanced fiscal capacity. Therefore, a new health policy responsive to these contextual changes is required."[3]Apart from the first point, which is probably themost undisputable observation once supported by medical data, and the third, which coldly presents a depressing fact that affects almost everybody in the country, the second and fourth pointsare connected to each other and present the crux of the neoliberal orientation of the present dispensation. In an ironic twist, the catastrophic increase in the cost of health care is argued to be taken care of by the emergent, rapidly growing(and seemingly private) 'robust health care industry' in the presence of an 'enhanced fiscal capacity.' This clarion call for privatisation does not take account of the majority of the population who will barely have access to this robustly industrialised health care sector and it does not acknowledge poverty itself as one of the causes of the depleted medical infrastructure and poor average health condition.

A farther reading of the NHP 2017 shows how far we have come from the Report of the Health Survey and Development Committee published in 1946.Constituted by the British government and chaired by Joseph Bhore, a senior civil servant, the Committee went on to recommend establishment of a 'progressive health service' that aimed to accommodate "all citizens,

[1]https://www.thehindubusinessline.com/news/national/covid-19-in-gujarat-high-court-uses-titanic-metaphor-to-stress-on-need-for-collective-response/article31663998.ece#; accessed on 25 May 2020.
[2] Ibid.
[3] Ministry of Health and Family Welfare, Government of India, National Health Policy, 2017, 1. https://www.nhp.gov.in/nhpfiles/national_health_policy_2017.pdf; accessed on 25 May 2020.

irrespective of their abilities to pay for it" with "all the facilities required for the treatment and prevention of disease as well as for the promotion of positive health."[4]It also introduced the idea of 'social medicine,' which would study the disease "as a community problem" incorporating "social and economic factors such as housing, nutrition, poverty and ignorance of the hygienic mode of life."[5]Evidently, the Bhore Committee was trying to infuse the postcolonial imagination of a 'healthy' nation with a specific biopolitical infrastructure sustained by a wide variety of governmental techniques, institutions and knowledge practices. The 'social' in social medicine, therefore, was a dynamic process, which would evolve out of an experimental modality of nation-building where surveys and "controlled experiments directed towards influencing the life of selected communities through the provision of improved health services, better nutrition, a cleaner environment and health education"[6] would also create the 'public' of the public health system. It took the government of India a long time after independence to formulate its first National Health Policy in 1983, but even there one may find the reverberation of the Bhore Committee's imagination mixed with the socialist rhetoric of the Indira Gandhi regime: "The Constitution of India envisages the establishment of a new social order based on equality, freedom, justice, and the dignity of the individual.It aims at the elimination of poverty, ignorance and ill-health and directs the State to regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties, securing the health and strength of workers, men and women, specially ensuring that children are given opportunities and facilities to develop in a healthy manner."[7]By making public health a constitutional responsibility of the state along with eradication of poverty and enhancement of knowledge, the NHP 1983 tried to give the 'social' a firm definition, which the later NHPs would try to dismantle.

It was the second NHP in 2002, which brought the private sector into the discourse of public health infrastructure. Dismissing the 'spirit of optimistic empathy' of NHP 1983, which promised universal health care by 2000, the new NHP set out 'realistic' parameters for a policy framework corresponding to the existing financial and administrative capacities.[8] One such realistic consideration was to welcome "participation of the private sector in all areas of health activities" and conceive a combination of "social health insurance scheme funded by the Government" and "service delivery through the private sector"for "an appropriate solution" to the problem of scarcity of public resources.[9]The involvement of the NGOs and other civil society organisations in delivering health services was also encouraged and the need for simplification of the procedures of government-civil society interfacing was emphasised.[10] The public-private partnership model thus envisaged relieved the government of its 'social' responsibilities of reaching out to the greater public and re-inscribed 'service' in the private domain of corporate healthcare and NGO-based community development. The apparent de-socialisation of the governmental stateactually initiated a reconceptualization of the social in terms of a series of risk management activities within the global networks of finance capital and prepared the ground for complete privatisation of the health sector.

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[4]*Report of the Health Survey and Development Committee, Vol 2: Recommendations* (Delhi: Government of India Press, 1946), 6.
[5]*Ibid*, 7.
[6]*Ibid.*
[7] Ministry of Health and Family Welfare, Government of India, National Health Policy, 1983, 1.
[8] Ministry of Health and Family Welfare, Government of India, National Health Policy, 2002, 5.
[9] Ibid, 31.
[10] Ibid.

In this context, the Gujarat case shows how, even when facing as big a crisis as a global pandemic, the governmental agencies have little or no control over the private sector: "It was noticed that 23 private hospitals had inked memoranda of understanding (MoU) with the Ahmedabad Municipal Corporation (AMC) to treat Covid-19 patients, but several corporate hospitals such as Apollo Hospital at two locations, Zydus Hospital, KD Hospital, Asia Columbia, Global Hospital, UN Mehta Hospital remained out of the list."[11] Whether the High Court's intervention would lead to a stronger policy regarding the handling of the private sector at a time of need is a separate question, but the whole fiasco points to two possible lines of enquiry. First, how deeply entrenched is the Indian public health system in the networks of global capital and what is the postcolonial trajectory of its privatisation? This question needs our special attention also to understand the neoliberal agenda upheld by the present government and its attitude to the federal structure of the Indian nation-state, since health as a concurrent subject is often a matter of contention between the central and state governments. A brief look at the history of public health planning in India is also required to highlight the contradictions that permeated the medical gaze of the nation-state. As ImranaQadeer points out, the shifts between various NHPs in the last forty years need to be contextualised within the shifts in the paradigms of planning since India's independence. "By the end of the 1970s," she argues, "the contradictions between comprehensive health care planning through social sector growth and integrated disease control strategies, and techno-centric approach to disease control through vertical programmes, and the requirements for primary health care and tertiary care became evident."[12] This draws our attention to a distinct genealogy of the liberalisation and re-conceptualisation of the health sector as a service industry through a model of technocratic interventions of control and a speculative mode of capital formation from a time much before the actual liberalisation of the economy took place. The history of neoliberalism in India is often mired in a narrative of rupture where the post-Washington-Consensus deliberations of the government in the early 1990s were prioritised against a seemingly unperturbed discourse of state-led growth. Once we start to read the history of public health vis-à-vis the politics of development funding and a financialised modality of infrastructural capitalism, we can see a highly technologized version of the 'social' emerging in the nation-state's imagination that patterns the crisis of public health in a language of insurance, risk management, diversification of investment portfolios and extraction. The project of alleviating 'social crisis' (poverty alleviation and population control), therefore, takes the form of one of managing a 'crisis of the social' where the boundary between public and private seems to dissipate. Whereas in social crisis, it is the crisis that is conceptualised and approached as a social phenomenon, which would have repercussions in the constitution of the public, in the crisis of the social, the social itself – the collective that is supposed to exist as a reminder and as a site of the state's responsibility towards its public – is reconceptualised and relegated to the domain of crisis management.Even with the apparently socialist rhetoric of the NHP 1983, the Indian nation-state was already on a journey to internalise the contradictions of a postcolonial capitalism that would only become more visceral in the present time. It seems that the history of public health provides a perfect site to re-examine the moments of this shift from a social crisis to a crisis of the social under the rubric of neoliberalism as a theory of the state and its relation with its public.

The second line of enquiry deals with the precariousness of the migrant workers at the time of the COVID-19 outbreak, as it exposes the contradictions between the social crisis and the crisis

[11]https://www.thehindubusinessline.com/news/national/covid-19-in-gujarat-high-court-uses-titanic-metaphor-to-stress-on-need-for-collective-response/article31663998.ece#; accessed on 25 May 2020.
[12]ImranaQadeer, 'Health Planning in India: Some Lessons from the Past', *Social Scientist*, Vol. 36, No. 5/6 (2008), 57.

of the social more poignantly than ever. One does not need to be an expert to realise how callously the issues of movement and survival of the workers stuck at their work towns were dealt with by the various authorities over the last few months. Rather than looking at it as an exceptional situation, one needs to consider whether there is any structural inequality implicit in the formulation of the National Health Policies and the overall imagination of public health in India as regards the migrant population. How does the migrant worker fare in the discursive as well as political terrains of risk management, which insures against the aforementioned crisis of the social? What are the elements of risk in the free movement of labour vis-à-vis the free movement of capital? Coupled with these questions is the issue of the risks faced by the workers in the public health sector whose lives and labours are entangled in the time of the pandemic in such a way that it presents a critical point of disintegration of the state of technocratic control. The proposed study will attempt to explore these moments of crisis by taking up the intersecting historical trajectories – the histories of privatisation of the health sector in India and the absence of the migrant worker in the public health discourses – against the backdrop of a global crisis of capital. The purpose of the study, therefore, is not only to describe the precarious conditions in which the migrant workers find themselves during the spread of a global pandemic, but also to elucidate on the discriminatory politics of production of an authentic 'public' in postcolonial India.