Public Health, Migrant Workers and a Global Pandemic: From a Social Crisis to a Crisis of the Social

Summary:

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.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."

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."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, 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."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."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" 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."By making public health a constitutional responsibility of the state along with eradication of poverty and enhancement of

knowledge, the NHP 1983 gave 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. 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.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. 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.

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." 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. The other important question deals with the precariousness of the migrant workers at the time of the COVID-19 outbreak. 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 two 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. In the last couple of months, the horrible indifference (or severity) with which the migrant workers were treated has exposed a deepening social crisis in India. However, this social crisis needs to be studied in conjunction with the crisis of the social that the consecutive health policies have engendered after the liberalisation of the Indian economy. 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