Public Health, Migrant Workers, and a Global Pandemic: Towards a New Politics of Life

By

Iman Kumar Mitra*

On May 23, 2020, in the context of the COVID-19 outbreak, the Gujarat High Court admonished the state government in a remarkably harsh language by comparing the condition of one of its largest public hospitals to that of a dungeon.[1] It also invoked the metaphor of the Titanic— the celebrated ship which sank tragically in 1912— as it took note of the rising number of positive cases in the state and the government's seeming ineffectiveness in containing the disease, and 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, this intervention by the judiciary in the matter of increasing privatization of the Indian healthcare sector is rare and could be interpreted by many as an infringement of the right to do free business. However, it indicates a major crisis, towards which the public healthcare system has been heading over the last few decades. The government of India not only recognizes but also endorses it in the latest National Health Policy (henceforth, 'NHP'), published in 2017, where it mentions, quite casually, four changes that have occurred since the previous NHP of 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 [healthcare] industry estimated to be growing at double digit. The third change is the growing incidences of catastrophic expenditure due to [healthcare] costs, which are presently

* Iman Kumar Mitra, Assistant Professor, Shiv Nadar University. Delhi.
Email: imanmitra@gmail.com.
Refugee Watch, 57, June 2021.

estimated to be one of the major contributors to poverty. Fourth, a rising economic growth enables enhanced fiscal capacity. Therefore, a new health policy that is responsive to these contextual changes is required.'[3] Apart from the first point, which is probably the most undisputable observation supported by medical data, and the third, which coldly presents a depressing fact that affects a large portion of the country's population, the second and fourth points are connected and present the crux of the neoliberal orientation of the present dispensation. In an ironic twist, the catastrophic increase in the cost of healthcare is argued to be taken care of by the emergent, rapidly growing (and seemingly private) 'robust [healthcare] industry' in the presence of an 'enhanced fiscal capacity'. This clarion call for privatization does not take account of the majority of the population who will barely have access to this robustly industrialized healthcare sector and it does not acknowledge poverty itself as one of the causes of the depleted medical infrastructure and the poor average health condition.

The Bhore Committee Report and the Constitution of the 'Social'

It is curious to see how far we have come from the Report of the Health Survey and Development Committee (henceforth, 'Bhore Committee'), published in 1946. On October 18, 1943, a press communique was issued by the government of India announcing the appointment of a committee chaired by Joseph Bhore, a retired ICS official, 'to make a broad survey of the present position in regard to health conditions and health organisation in British India and to make recommendations for future development'.[4] The formation of the Bhore Committee, as the communique itself mentioned, took place 'in connection with post-war reconstruction plans'.[5] As we know, it was the same motive of reconstruction which initiated a similar overhaul of the existing social policies in Great Britain during World War II and gave birth to the idea of the British Welfare State with the publication of the Beveridge Report in November 1942[6]— about a year before the appointment of the Bhore Committee. The link between the two becomes even more prominent when we recall that it was the Beveridge Report which recommended a National Health Service for British citizens as part of its comprehensive framework of social insurance schemes. Authored by the noted economist William Beveridge, the report identified three guiding principles of its recommendations:

- The first principle is that any proposals for the future, while they should use to the full the experience gathered in the past, should not be restricted by consideration of sectional interests established in the obtaining of that experience. Now, when the war is abolishing landmarks of every kind, is an opportunity for using experience in a clear field. A revolutionary moment in the world's history is a time for revolutions, not for patching.
- The second principle is that organization of social insurance should be treated as one part only of a comprehensive policy of social progress. Social insurance fully developed may provide income security; it is an attack upon Want. But Want is one only of five giants on the road of

> reconstruction and in some ways the easiest to attack. The others are Disease, Ignorance, Squalor and Idleness.
>
> - The third principle is that social security must be achieved by co-operation between the State and the individual. The State should offer security for service and contribution. The State in organizing security should not stifle incentive, opportunity, responsibility; in establishing a national minimum, it should leave room and encouragement for voluntary action by each individual to provide more than that minimum for himself and his family.[7]

The Beveridge Plan, apart from everything else, was a call for breaking free from the conservative mores of the British society plagued by five obstacles in the way of progress: want, disease, ignorance, squalor and idleness. Needless to say, all five of them were interlinked where a comprehensive social policy must take cognizance of the grid of bureaucratic and intellectual apparatuses that could establish the links between public health and urbanization, unemployment benefits and education, job security and creation of effective demand. A mere patchwork would not do; what was needed was a complete reorganization of the 'system'— a call made popular in the years between the Wars by both the Left and the Right. What became important, therefore, was the question of agentive responsibility: who would lead this total overhaul? Maintaining distance— although not equal— from both the Soviet model of centralized planning and the Fascist programme of anti-individualistic totalitarianism, Beveridge argued for a scheme of co-operation between the state and the citizen where the individual's pursuit of maximum happiness would be bolstered by the 'national minimum' set by the state.

Over the years, this would become the most iconic model of the welfare state. A progressive tax system would ensure the redistribution of wealth and the availability of basic minimum services in the domains of education, health, and infrastructure. The 'insurance' part in the 'social insurance' of Beveridge was the guarantee of this basic minimum. But what constituted the 'social'? Daniel Defert, while giving us a genealogy of social insurance in France, lists the shifts that occurred when the 'old technique of life annuity' was replaced by the discourse of life insurance in the nineteenth century.[8] One of them was to find a 'way to manage populations which conceives them as homogeneous series, established in purely scientific terms rather than by way of empirical models of solidarity such as a trade, a family or a neighbourhood.'[9] When Beveridge said that social insurance 'should not be restricted by consideration of sectional interests established in the obtaining of [past] experience,' he was reiterating the same point. Thus, we see how he proposed to divide the British population into six classes in a section of the report, titled 'The People and Their Needs': 'I-Employees; II-Others gainfully occupied; III-Housewives; IV-Others of working age; V-Below working age; VI-Retired above working age.'[10] Organized around a strict definition of work ('gainful employment'), this mode of classification was thought to have disavowed the conservative class structure and initiated a

need-based scheme of assistance. The eight primary causes of need were: unemployment, disability, loss of livelihood, retirement, 'marriage needs' of women, including compensations for widowhood, separation, maternity etc., funeral, childhood, and physical disease. [11] Apart from those below working age (Class V) and above (Class VI), the 'other four classes all [had] different needs for which they [would] be insured by contributions made by or in respect of them.'[12] What is important to notice here is that the compensation was meant for any kind of interruption in the continuous flow of work— be it disability, age, disease or death— performed by different classes under the imagined identity between life and livelihood. The idea of interruption had most definitely arisen from the history of social insurance itself, which came to materialize when the state wanted to deal with industrial accidents by itself: 'What we today call social insurance was originally established in France by nationalizing the industrial accident departments of the private insurance company.'[13] The 'social' in 'social insurance' was, therefore, an outcome of making this interruption at work a matter of public action— a problem that could no longer be left to the individual's capacity for self-reparation.

When we read the Bhore Committee report today, we may find a semblance of the same argument advanced by Beveridge: only a comprehensive and interconnected approach to policy would yield a systemic reconstruction of the society. In its own way, the Bhore Committee tried to tackle the questions already raised by the Beveridge Plan: the links between life and livelihood, and the constitution of an ideal 'social' with an uninterrupted flow of work. It was quite candid in explaining how the early attempts at health administration in British India fell short of conceptualizing health as an indicator of social progress and focused mainly on disease-control through coercion and religious sanction. 'The idea of prevention came much later,' the report stated, 'partly as the result of the observation that diseases were often communicated from the patient to those in close association with him. Thus arose the conception of segregation of the sick and of the enforcement of quarantine against those who were in contact with patients.'[14] After noticing the inadequacy of such measures carried out 'many centuries before the causes for their incidence had become known,' the report concluded that, with the advancements in 'modern sciences, such as bacteriology, parasitology and pathology,' the need for 'active interference by man with the natural environment' was acknowledged and a 'coordinated application of curative and preventive measures' was recognized as the ideal strategy for controlling diseases.[15]

However, a significant point of departure for the Bhore Committee was the way it sought to define health: 'The term health implies more than an absence of sickness in the individual and indicates a state of harmonious functioning of the body and mind in relation to his physical and social environment, to enable him to enjoy life to the fullest possible extent and reach his maximum level of productive capacity.'[16] Three points need to be noted here: health is not the mere absence of sickness and, therefore, must not be conflated with disease-control only; harmony with the physical and social environment is of paramount importance; and the link between

fulfillment of life and maximization of productive capacity. These three elements of public health expanded its horizon beyond the narrow confines of standard curative practices and inaugurated a theory of the 'social', which was in dialogue with the schemes of social insurance and discourses of work that the Beveridge Plan flagged. In this connection, the first volume of the report named the prevalence of unsanitary conditions, low level of nutrition and inadequacy of medical infrastructure at the levels of both institutional care and pedagogy as the reasons for the poor health condition in India.[17] It also elucidated on 'the social background of ill-health', which included unemployment, poverty and social customs like purdah and early marriage.[18] At this point, it mentioned even the Beveridge Report to strengthen its case: "In a reaffirmation of the principles regarding health policy in connections with discussions on the Beveridge Report, the British Medical Association emphasized that 'the health of the people depends primarily upon the social and environmental conditions under which they live and work, upon security against fear and want, upon nutritional standards, upon educational facilities, and upon the facilities of exercise and leisure.'"[19]

The second volume of the report contained recommendations to the effect of the 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'.[20] It also introduced the idea of 'social medicine', which would study disease 'as a community problem' incorporating 'social and economic factors such as housing, nutrition, poverty and ignorance of the hygienic mode of life'.[21] 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'[22] would also create the 'public' of the 'public healthcare' system.

It took the government of India a long time after Independence to formulate its first NHP in 1983, but even there one may find the reverberation of the Bhore Committee's imagination combined with the seemingly 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.'[23] 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.

The Two NHPs and the Management of the 'Social'

It was the second NHP, 2002, which brought the private sector into the discourse of public health infrastructure. Dismissing the 'spirit of optimistic empathy' of the 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.[24] 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.[25] The involvement of NGOs and other civil society organizations in delivering health services was also encouraged and the need for simplification of the procedures of government-civil society interfacing was emphasized.[26] 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-socialization of the governmental state actually 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 privatization of the health sector.

The latest NHP, 2017, has already been severely criticized[27] for its lackadaisical attitude towards public health, in spite of making a call for strengthening the role of the government in 'shaping health systems in all its dimensions'.[28] If one takes stock of these dimensions, it becomes clear why public health activists and commentators find the policy as following the neoliberal stipulations that have been part of the political architecture of the Indian state for over the last three decades: 'investments in health, organization of healthcare services, prevention of diseases and promotion of good health through cross-sectoral actions, access to technologies, developing human resources, encouraging medical pluralism, building knowledge base, developing better financial protection strategies, strengthening regulation and health assurance.'[29] At a surface level, these objectives sound fair and spirited. Coupled with an overarching narrative of universal healthcare, which promises equity, affordability, accountability, inclusion and pluralism, it may look even more progressive than the previous NHP, 2002, which was much maligned for introducing the idea of 'alternative medicine' in the public health framework.[30] A crucial difference between the two policies is how the latest one deploys a particular language of decentralization that stands for deregulation and/or privatization. The previous NHP was framed in a matter-of-fact way, starting with a list of achievements in the health sector since 1951, showing rise in life expectancy, fall in epidemic outbreaks, and strengthening of infrastructure. 'While noting that the public health initiatives over the years

have contributed significantly to the improvement of these health indicators,' the Policy had said, 'it is to be acknowledged that public health indicators/disease-burden statistics are the outcome of several complementary initiatives under the wider umbrella of the developmental sector, covering Rural Development, Agriculture, Food Production, Sanitation, Drinking Water Supply, Education, etc.' By recognizing the role of what one may call the social sector in the ambit of health infrastructure, the NHP, 2002, followed the footsteps of the NHP, 1983, which linked the programme of poverty alleviation with the strategies of public health improvement and thus, prescribed a holistic approach that retained traces of the recommendations of the Bhore Committee. By 2017, however, the rhetoric shifted to that of a seemingly non-interventionist state, which is expected to suture the public and the private in a model of managing partnerships between communities, medical professionals, and corporations. One of the most interesting recommendations of NHP, 2017, is to create:

> [A] Public Health Management Cadre in all States based on public health or related disciplines, as an entry criteria [*sic*]. The policy also advocates an appropriate career structure and recruitment policy to attract young and talented multi-disciplinary professionals. Medical & health professionals would form a major part of this, but professionals coming in from diverse backgrounds such as sociology, economics, anthropology, nursing, hospital management, communications, etc. who have since undergone public health management training would also be considered. States could decide to locate these public health managers, with medical and non-medical qualifications, into same or different cadre streams belonging to Directorates of Health. Further, the policy recognizes the need to continuously nurture certain specialized skills like entomology, housekeeping, bio-medical waste management, bio-medical engineering, communication skills, management of call centres and even ambulance services.[31]

Apart from a very pronounced rhetoric of management and service-delivery mechanisms, what this idea tends to generate is an epistemic orientation that speaks to the framework of an interdisciplinary liberal education recently championed in the New Education Policy— another example of the neoliberal agenda of the present dispensation. The desires to privatize both health and education, therefore, converge in the figuration of a corporate-state complex that adheres to a logic of decentralization and plurality where the expansion of a choice set driven by the market is projected as the most significant expression of freedom and equality.

This is not very new. As Imrana Qadeer points out, the shifts between various NHPs in the last forty years need to be contextualized 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.'[32] This draws our attention to a distinct genealogy of the liberalization and re-conceptualization 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 liberalization of the economy took place. The history of neoliberalism in India is often mired in a narrative of rupture where the deliberations of the government in the early 1990s, after the Washington Consensus, are prioritized against a seemingly unperturbed discourse of state-led growth in the previous decades. When we read the history of public health along with the politics of development funding and a financialized 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 managing a 'crisis of the social' where the boundary between public and private seems to dissipate. Whereas in a 'social crisis', it is the crisis that is conceptualized 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 reconceptualized and relegated to the domain of crisis management, as exemplified in the figure of the public health manager. Even with the apparently socialist rhetoric of the NHP, 1983, the Indian nation-state was already on a journey to internalize the contradictions of postcolonial capitalism that would only become more visceral in the present time.

This story, however, gets a unique twist with the outbreak of COVID-19. In the rest of my article, I shall argue that the pandemic and the long march of the migrants have revealed the contradictions between the two 'socials' of 'social crisis' and 'crisis of the social' in such a way that will have a much larger implication in terms of a new politics of life and its capitalization, and reconstitution of a 'public' implicated therein. Talking about how the fight against the virus assumes a rhetoric of war, Ranabir Samaddar observes, '[t]he enemy— the virus— is not of public health, but is of life, which will therefore require and legitimize all kinds of governmental prohibitions and interventions. Humans are anxious.'[33] Taking a clue from this observation, I would like to emphasize three axes of the present predicament: life, governance, and the 'human'. It is probably unfashionable to emphasize the 'human' in this time of human–nonhuman interface when the inadequacies of all the humanist discourses have been exposed at the face of various levels of crises— political, economic, environmental— that define our individual and collective existence. But this is precisely the reason why one may think of venturing into a project of freeing the 'human' from humanism. In order to do so, we need to revisit the concept of biocapital and how that dehumanizes labour by channelizing a particular theory of life.

A New Politics of Life?

Kaushik Sunder Rajan, in his landmark study of the human genome project, explores the workings of biocapital around the exchanges and circulations that thrive on the epistemic centrality of life and life sciences in modern times.[34] The co-production of the knowledge about life and the techno-capitalist processes that make use of that knowledge is a unique feature of the modern episteme. As Michel Foucault shows in *The Order of Things*, by the end of the eighteenth century, a new discourse of biology made its appearance where the study of living beings was no longer dependent on the tabular modality of classification through interlinked grids of observable characteristics. Similar to developments in the field of political economy, where the invisible labour is delineated as prior to all visible exchanges, in the modern life sciences, the invisibility of life gets prioritized over the visibility of the signs or markers that distinguish one species from the other. The anatomical imaginary, therefore, is conceived in terms of systemic distribution of organic functionalities such as the nervous system, the respiratory system, the digestive system etc., all of which are working for preservation of life whose *a priori* existence gives meaning to them. This new epistemic order had two great implications: (1) in the political domain, it led to reconceptualization of the nation-state in terms of a biological entity whose life would be tied to the lives of the multitude not simply by a logic of territoriality but also by a unique chronology of growth and decadence, an organicist historicism; (2) in classical political economy, the new order of things cut through the circularity of the time of exchange and proclaimed the linear, continuous time of production. By the mid-nineteenth century, however, life was itself turned into a site of myriad calculations and speculative investments riding on the deployment of what Francois Ewald calls a technology of risk.[35] Insurance— especially life insurance and/or insurance against bodily damages— as a technology of risk transforms the incalculable— the loss of a dear one, for example— into an estimate based on statistical techniques and medical surveillance. But more importantly, by turning life into an investible asset, the technology of risk made way for a regime of exchange and circulation— namely biocapital— which was not simply a specific form of capital but a central motif of financial capitalism in the twentieth century. In fact, one may say that we have been trained to incorporate the same kind of rationalization of risk against a probable compensation or reparation in almost all of our everyday transactions.

The same appraisal and capitalization of risk have come to the forefront of the public health discourse in its deliberations on the current pandemic. The decisions regarding the length of the lockdown, the strictness of the social distancing protocols, and the durability of the medical infrastructure are all based on the statistical calculations that render life an asset and death an accident. The anxieties that fill our minds are often outcomes of the lack of information on the basis of which one can contemplate and assuage the risk of socializing— the burden of the neoliberal

subject. In this context, migrant workers have emerged as dangerous figures as they have exposed two fundamental contradictions in this biopolitics of risk management: between life and livelihood, and between the life of labour and the life of capital. As we may remember, it was the association between life and livelihood that marked the advent of social insurance and the welfare state. However, the neoliberal state is increasingly unwilling to accept this association. Although Article 21 of the Indian Constitution guarantees the right to life and personal liberty, and prohibits its deprivation 'except according to procedure established by law', there is no clear indication if it includes the right to livelihood as well. In various rulings, it has been observed that, even though, in a broader sense, the right to life can be interpreted as a right to live with human dignity and proper livelihood options, there is no absolute association between the two and, if proper legal procedures are followed, both the state and private entities can deprive others of livelihood— for example, acquisition of land in public interest or firing an employee citing actual reasons. In most cases, the merits of the claims and counter-claims are judged on procedural accuracy. It is, however, a different matter how the relationship between life and livelihood plays out during the time of a pandemic, when conducting one's livelihood activities may be perceived as a threat to others' lives. In each of these cases, life trumps livelihood with a disturbing realization that, without livelihood, life will cease anyway. Even though the opposition between life and livelihood has become everybody's reality, for most of the migrant workers belonging to the informal sector, without job security and social support, it becomes insurmountable. The discomfort with the figure of the migrant worker also gets more pronounced with the metaphorical association between them and the virus— both unwanted, foreign entities engendering a randomness that upsets the existing technologies of risk and warrants an overhaul of the regime of calculations, facing which most governments of the world look genuinely clueless.

The other contradiction exposed by the migrant worker is between the two lives of labour and capital respectively, a contradiction which has surfaced more concretely after a series of constraining interventions by the governmental state controlling the movement of the workers and forcing them to leave the host town even during the lockdown. The discourse of life that characterizes biocapital since the second half of the twentieth century conflates human labour and nonhuman capital in the concept of human capital where both labour and capital are assumed to generate identical streams of revenue over a period of reproduction and depreciation. Wage defined as revenue earned from the deployment of labour is, therefore, a surplus over the investments that one makes to acquire different skills; in other words, education loans. The labouring body as an assortment of skills— or as Foucault calls it, an ability-machine— is completely dehumanized where the life of labour does not have any privilege over the life of capital. At first glance, this does not look very different from the theory of abstraction of labour into labour power within the Marxist framework where the reduction into the socially necessary labour time results in a disappearance of the concrete bodily form of the individual labourer. However, as Marx has

pointed out many times, there is a special character of the labour congealed as social substance in every exchanged commodity— its essential humanity expressed in terms of an exclusive physiological fact that all productive activities 'are functions of the human organism, and that each such function, whatever may be its nature or form, is essentially the expenditure of human brain, nerves, muscles, &c'.[36] As Thomas Keenan puts it, '[a] spectre is haunting this analysis. The spectre of humanity'.[37] This spectral humanity is also the ethical basis of Marxian radical politics. What the discourse of human capital does is to de-essentialize the physiological aspect of the life of labour and de-prioritize its role in the production process. Thus, one of the fundamental contradictions of capitalism— the one between living labour and dead labour— is cancelled in favour of a symmetrical framework of organic assemblage made popular by post-humanist discourses.

The predicament of the migrant worker, however, reveals the implicit asymmetry in the conflation of the lives of labour and capital when in movement. During the pandemic, while the movement of labour was severely controlled, commodities were allowed to move freely. Not only that, delivery services like Amazon and Flipkart have been able to expand their businesses in an unprecedented manner, both in terms of volume and reach. Although it has been observed time and again that the virus survives on the non-living surface as well— even though the duration is disputed— it is the living labour which is projected as the principal mode of transmission. The lack of a symmetrical perception of threat certainly pertains to a fundamental asymmetry that is usually covered up in the neoliberal technologies of risk. Thanks to the pandemic and the coercive interventions, this asymmetry has once again reared its head and the present regime of biocapital must not be allowed to repudiate this moment of the return of the 'human'.

Coming back to the question of the 'human', as we can see, the pandemic indicates possibilities of a new politics of life— a politics which is critical of the anthropocentricism of liberal humanism but not averse to point out the asymmetries between the human and the nonhuman and their respective life trajectories— within the technologies of risk. What implications will it have for the discourse of public health and the concept of 'public' inhering that discourse? The constitution of the 'public' in liberal humanism, as we know, is contingent on the 'social' that it presumes and contextualizes through contractual transactions and rights-based subjectivities. The conceptualization of humanity of this 'public' is limited by these two dimensions, which are not necessarily curtailed by the neoliberal risk technologies: a case in point is the paradoxical nomenclature of the 'contract worker', where the precariousness of the worker is intensified by the arbitrariness of the contract itself. In most of the narratives on the plight of the migrant workers, we see a reverberation of the same discourse of liberal humanism where the sympathy for the migrant can only lead to the organization of temporary relief provisions initiating a passive revolution of sorts. The call for a reorganization of public health, therefore, is usually reduced to a nostalgic endorsement of the humanist 'social' in 'social crisis'. A

more difficult task is perhaps to recover the 'human' sans humanism in the moment of the 'crisis of the social'. I am not yet sure how that will pan out in the long run but the pandemic has given us a great opportunity to engage with this politics of life more creatively and energetically.

Notes

[1]Rutam Vohra, "Covid-19 in Gujarat: High Court uses Titanic metaphor to stress on need for collective response," *The Hindu Business Line*, May 24, 2020, https://www.thehindubusinessline.com/news/national/covid-19-in-gujarat-high-court-uses-titanic-metaphor-to-stress-on-need-for-collective-response/article31663998.ece#.
[2]Ibid.
[3]*National Health Policy*, Ministry of Health and Family Welfare, Government of India (2017), 1, https://www.nhp.gov.in/nhpfiles/national_health_policy_2017.pdf.
[4]*Report of the Health Survey and Development Committee* 3 (Delhi: Government of India Press, 1946), Annexure 56, 335.
[5]Ibid.
[6]For details on the Beveridge Report, see Brian Abel-Smith, "The Beveridge Report: Its Origins and Outcomes," *International Social Security Review* 45, no. 1-2 (1992): 5–16. I am grateful to Ranabir Samaddar for drawing my attention to the Beveridge Plan.
[7]*Social Insurance and Allied Services: A Report by William Beveridge* (1942), 6-7.
[8]Daniel Defert, "'Popular Life' and Insurance Technology," in *The Foucault Effect: Studies in Governmentality*, ed. Graham Burchell et al. (Chicago: University of Chicago Press, 1991), 212.
[9]Ibid.
[10]*Social Insurance and Allied Services*, 122.
[11]Ibid., 124-25.
[12]Ibid., 124.
[13]Defert, "'Popular Life' and Insurance Technology," 211.
[14]*Report of the Health Survey and Development Committee* 1, 21.
[15]Ibid.
[16]Ibid., 7.
[17]Ibid., 11–17.
[18]Ibid., 17.
[19]Ibid.
[20]*Report of the Health Survey and Development Committee* 2, 6.
[21]Ibid., 7.
[22]Ibid.
[23]*National Health Policy*, Ministry of Health and Family Welfare, Government of India (1983), 1.
[24]*National Health Policy*, Ministry of Health and Family Welfare, Government of India (2002), 5.
[25]Ibid., 31.
[26]Ibid.
[27]Vikas Bajpai, "National Health Policy, 2017: Revealing Public Health Chicanery," *Economic and Political Weekly* 53, no. 28 (2018): 31–35.
[28]*National Health Policy* (2017), 1.
[29]Ibid.
[30]*National Health Policy* (2002), 19–20.
[31]*National Health Policy* (2017), 18.

[32]Imrana Qadeer, "Health Planning in India: Some Lessons from the Past," *Social Scientist* 36, no. 5/6 (2008): 57.
[33]Ranabir Samaddar, *Burdens of an Epidemic: A Policy Perspective on Covid-19 and Migrant Labour* (Kolkata: Calcutta Research Group, 2020), 1–2.
[34]Kaushik Sunder Rajan, *Biocapital: The Constitution of Postgenomic Life* (Durham and London: Duke University Press, 2006), 12.
[35]Francois Ewald, "Insurance and Risk," in *The Foucault Effect: Studies in Governmentality*, ed. Burchell et al., 198.
[36]Karl Marx, *Capital* 1 (1887), 47,
https://www.marxists.org/archive/marx/works/download/pdf/Capital-Volume-I.pdf.
[37]Thomas Keenan, *Fables of Responsibility: Aberrations and Predicaments in Ethics and Politics* (Stanford: Stanford University Press, 1997), 116.