Enculturalising Casteism in Health Care in India

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Abstract

Immunology depends on culturing technique, practice, and procedure. Society depends on culture. The change in the enculturing technique has always got promoted and accepted, while a change in Indian society is discouraged and not accepted despite claims of change happening. The 'Society of India' heavily depends on casteism and ensures all mechanisms for keeping it functional without change. By accepting culturing techniques from immunology, privileged Indian society developed a new technique with the old ethos that may be called 'culturing casteism'. It has a deep presence in both spheres of health: 'Sociology of Sufferer', namely, the healthcare seeker and 'Sociology of Supremacy', namely, the healthcare profession and professional. This essay explores the way casteism is cultured in both spheres. The essay's main aim is to understand and define the existence of casteism in health. The data establishes that the domination of privileged castes exists and is nurturing casteism in health. Privileged castes have captured the whole (health) sector while the dispossessed and deprived have been trying hard to 'catch' the care.

Keywords

Caste, dalit, casteism, health, health profession and social justice, doctor and patient, India

Introduction

The problem of poverty and disease unabatedly haunts the developing countries. Despite faring better than many developing countries on several counts, India has been plagued by diseases of different kinds, where millions go with scant or without medical care. It is worthwhile to study the sick component of Indian society systematically, and the social aspects are much more relevant to the system's normal functioning.

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Therefore, a sociological analysis of 'patients' (or care seekers) and the medical profession in the Indian context assume great significance.

Social stratification in India is a prominent symptom of illnesses of all kinds, both social and physical. Hence it is imperative to understand social stratification. In a most general sense, it is a sociological concept that refers to the fact that both individuals and groups of individuals are conceived of as constituting higher and lower differentiated strata or classes. In the terms, it has some specific or generalized characteristics or set of characteristics. In the caste stratification systems, individuals are permanently assigned a social position purely because of caste. However, the Indian government has made caste barriers illegal. Yet, India is the most famous example of a caste system. Indian society is broadly divided on the Varna Ashram model, and it is also considers caste in practice and function. However, prominent features of caste hierarchy exist on occupational superiority, which can be tagged as decision-makers in the system. Brahmans were priests and holders of opportunity of religious knowledge—now education holders, Kshatriya were rulers and warriors, Vaishya were traders and merchandizers, and the rest were Shudra who were assigned the duty to work for the above three varna. Untouchables are out of the Varna system based on their occupation primarily, skinning, sweeping, and other occupations that as a result of which they are not directly in touch with persons of any varna—that is why they are known as Untouchable. Untouchables are historically considered so inferior that they were forbidden to mingle with upper varna groups on the streets. In India, Untouchables continue to face 'exile' within systems.

The phrases 'sociology of sufferer' and 'sociology of supremacy' shall be used for subjective purposes in this essay. Those at the margins of access to healthcare facility, utilization, and primary facility for 'good' health will be considered under 'sociology of sufferer'. The phrase 'Sociology of Supremacy' will be used for both, individuals and institutions of care provisioning. Healthcare providers are those trained and educated by an institution and/or certified to provide the service with professional ethics to their 'clients' (care seekers), and the institutions/hospitals/chain of hospitals are the facilities providing services to sick.

Theorizing Caste and Explaining Casteism: Past is Present

This understanding provides the backdrop to explore the construction of casteism as a social, economic, and political category, given the historical background of Indian society. Also, its effect on Dalits due to discrimination, exploitation, and atrocities continues because of traditional subordination, thus affecting their position in Indian society today.

The origin of caste and untouchability lies deep in India's ancient past. The evidence of those origins provided by the archaeological and literary sources is, at best, circumstantial. We now have not hard and clear facts but various competing theories that have proved challenging to substantiate convincingly (Webster, 2007). There are three schools of thought in the origin of untouchability. They are racial

and /or conquerors vis-a-vis native, religious, and economic (Shah G., 2002, p. 11). None of these explanations about the origin of untouchability is a conclusively proved fact. Infact, casteism has been cleverly introduced by the privileged in all human institutions. Therefore, no single cause can explain untouchability. It is deeply rooted in Indian history and the agrarian social order that dominated the Indian economy through the British period and remains the most significant economic sector even now. Although the relation of India's rural untouchables to this social order has shifted in subtle ways in the past two centuries, there remain pervasive continuities, especially in meaning and cultural construction with this deeply rooted past (Michael, 2007, p. 20).

Hence the most apparent feature of Hindu society[1] is its division into caste. Perhaps the untouchables earlier and the most straightforward Western image is embodied in the term 'outcaste'. In this view, being untouchable is beyond the reach of Hindu culture and society and almost cultureless (Michael, 2007, p. 14). This phenomenon had been studied by missionaries, colonial administrators-turned-historian and ethnographers like Abbe Dubois and his contemporary Dr Frances Buchanan—from 1792 to 1823 and 1799, respectively—and later by Nesfield (1855), Risley (1908), Senart (1930) and Bougle (1971). As articulated by Dubois, the earlier outcaste image implies a significant disjunction between the higher caste Hindu and lower caste untouchable or outcaste. The term 'outcaste' expresses the distinction (Michael, 2007, p. 18). The 'occupational factor' comes first in Senart's understanding of the origin of caste. Celestine Bougle, an early theoretician of the Indian caste system, came up with more concrete characteristics and fundamental principles of caste. He defines caste as: heredity, hierarchy and repletion or isolation of the group from another, and found all three principles interrelated, which form a unique institution called 'caste'. He further pointed out that the caste hierarchy was determined less by an occupations' usefulness or complex nature than by their relative purity and impurity. Hutton (1963), the last administrator scholar to review the existing theories of caste, remarked that although most of these theories had contributed to the subject, they generally emphasized the phenomena 'rather than the causes of caste system'. His theory finds criticism for ignoring the fact that 'caste is primarily a system of interreacted groups' in which differences in the distribution of economic and political power are expressed through a cultural language such as restrictions on commensality and matrimonial (Jaiswal, 1998, p. 34). Despite receiving heavy criticism, Hutton's theory shows that caste is not a sudden artificial creation but an organism that evolved gradually through a multiplicity of factors. Even though Hutton regards the caste system as a composite unit of many cells, each functioning independently and, as such, unduly minimizes the importance of those socio-economic and cultural bonds which sustain the system, making it an organic whole. His study remains a classic investigation into the origin, nature, and function of caste.

Later, sociologists shifted the focus to a search into origins, which they regarded as 'speculative to synchronic' studies of caste based on fieldwork. Two authors,

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[1]Hindu society implies a system exists in Indian society because the majority of the population, around 81 per cent are the followers of this religion.

particularly, F.G. Bailey and Louise Dumont, on this subject and other social anthropologists have aligned themselves with one theory (Dumont, 1957, 1960, 1966, 1970).

Two prominent Dalit thinkers during British India engaged with untouchables and their situation through two different theories. Jyotirao Phule (b. 1827–1890) propagated the 'invader theory' as a prominent reason for the low status of untouchable and untouchability. Jyotirao Phule, now popularly known as Mahatma Phule, portrayed Aryans[2] as 'Invaders' and lower caste people as 'original inhabitants' of India and described Arya culture along with the caste system (Phule, 1991) as alien to these original people whom he termed Bahujan Samaj.[3] On the other hand, Ambedkar rejects the 'race theory' and propagates the 'religious theory' of untouchability. He argued, "there is no evidence in the Vedas of any invasion of India by the Aryan race, and it is having conquered the *Dasyus and Dasas*[3] who were supposed to be natives of India" (Ambedkar Caste Origin) (Ambedkar, 1946, pp. 57–82, quoted Shah, 2002, p. 22). According to him, there was no racial distinction between the Aryans and the Dasas.[4] As far as physical characteristics were concerned, there was hardly any difference, he argued, between the Brahmin and untouchables belonging to the same region.

Untouchable, Scheduled Caste and Dalits

These three words seem to have different meanings and differentiation, but they are synonymous in connotation and used for those at the margins. Specific terms come into existence at different time points and evolve over a period, changing from a different time. They were called 'untouchable' during the ancient/historical past, 'Scheduled Caste' during the British and 'Dalit' in the present discourse. The word 'Untouchable' was used in communication in the Vedic times by society. The 'Scheduled Caste' came into existence during the British Period for administration and identification based on deprivation, and the term 'Dalit' came into use correctly and effectively in India after Independence. They are used by the liberal thinkers and the untouchables/schedule castes as an assertive term, portraying the struggle to resent discrimination and fight for their rights simultaneously. Now all three words are interchangeably used in any discourse on caste in Indian society. The term 'Dalit' has been embraced in academia and media within the country and aboard alike. Despite the interchangeability, there is a need to explain the origin of these words as follows.

In practice, there has been a tendency since the Vedic times to emphasize birth as a criterion for membership of Varna, viz., Brahmin, Kshatriya, Vaishya, and Shudra. The idea of Varna has initially been based on race, culture, character, and profession. It takes account mainly of man's moral and intellectual worth and is a system of classes that appears neutral (Kane, 1941, p. 1). The birth-based criteria for allocation of Varna gained supremacy over others in subsequent scripts of the Smritis, Purana

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[2]Has also been claimed by Brahmin.
[3]Majority community, except for Brahmin, Kshatriya, and Vaisya.
[4]Hindi meaning of an enslaved person.

and Upanishad. These were the written codes of conduct projected as the norms for all. The privileged groups promoted the idea as evident historically, which continues the process of strengthening it such that it has metamorphosed in the kind of 'acceptance' that birth-based allocation to Varna/Jati even in present times.

Finally, this birth-based idea is mainly accepted by the residents of this country as the sole criteria of status until death (Ibid., p. 2).

The very contradictory concept popularly used in Indian society and academics is that "Varna is the origin of caste". Previously, the essay used the term "Savarna" as a club of four varnas: Brahmin, Kshatriya, Vaisya, and Shudra. The Brahmin Varna does not have any other caste, similar to Kshatriya and Vaisya. Is Shudra having any caste in Varna? The answer will be "yes". That is why there are so many castes within Shudra Varna. It means Varna is not the origin of caste. Hence practically, caste is the origin of 'occupation'; hence all the different occupations emerged from Shudra varna and were assimilated as 'servant of all three Varna' and compelled to do duty to serve them without any rights, as created by God.

Almost all the Shudra communities and occupation names are similar to Nai,[5] Badhai,[6] Gadria, etc.[7] Caste is the prime decider of occupation and positions. There are some occupations (on the pretext of using the word duty) that can occur without touching, like cleaning/collecting human excreta or carrying a dead animal. Almost all untouchables do sweeping, skinning-related work that can happen without human touching and in isolation. Untouchables live on the outskirts of their village and near ponds, and always in the southern part of villages. The wind direction in the Indian climatic conditions is from east/west to south. Therefore, the wind should first touch the 'Savarnas' and then reach the 'Avarna', the 'untouchables', to avoid 'pollution'.

Dalit[8] is a Marathi word meaning ground, broken, or extracted to pieces. It gained a new cultural context when two movements in Maharashtra—the state Ambedkar lived and worked—in early 1870 used this word to define the agony of a social group constituted of untouchables to assert their rights as human beings. One was known as Dalit Panther, and another was Dalit literature.

Dalit Panther supported consciousness and uprising on the social-cultural front while Dalit literature did so through writings. Eleanor Zelliot (1992), in her book *From Untouchable to Dalit,* writes about this transition "by substituting the word Black for Dalit. The reader can immediately understand that a phenomenon comparable to the American Black Panthers and Black literature has surfaced among the lower castes in social and literary affairs in western India. Like the American movements, the Dalit Panther and Dalit school of literature represent a new level of pride, militancy, and

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[5]Barber to cut hair, body massage and other work regularly during marriages, funerals. Even the womenfolk of the community are assigned the duty to serve women of the three other Varnas even during delivery and rituals. Duty is compelled based on compulsion and not on choice.

[6]Badhai is a carpenter who does wooden work, making even beds/cots.

[7]Gadaria is shepherd who rears sheep. 'Gadar' is the Hindi word for sheep.

[8]Marathi is a dialect spoken in the state of Maharashtra and written in Hindi script.

sophisticated creativity. The Marathi word Dalit like the English word Black was chosen by the group itself and used proudly. Even in the English press, the unfamiliar Marathi word must be used". She further writes, "None of the normal words—untouchable, Schedule caste, Depressed Caste, Gandhi's euphemism, Harijan—had the same connotation". Dalit implies those who have been broken, ground down by those above them deliberately and actively. There is in the word itself an inherent denial of pollution, Karma, and justified caste hierarch (Zelliot, 1992).

Now, in India, those castes under a legally recognizable identity as the protected group are called Schedule Caste (SC), Schedule Tribe (ST) and Other Backwards Caste (OBC). All these historically dispossessed communities comprise the demographic majority of India, around 104 crore (1040 million) out of 130 (1030 million) crores as per government data. Sixteen per cent are SC, and 8 per cent are ST; government highlights no official percentage of OBC, but in jobs, 27 per cent representation (called reservation) for 50 per cent of the population of OBC. Hence the total population of OBC would be around 54 per cent. By adding the population of all the dispossessed community: SC (16.2 per cent), ST (8.2 per cent),[9] OBC (54 per cent) around 80 per cent population of India as per Census of 2011. There are many other religious communities other than Hindu, such as Parsi, Christian, Sikh, Buddhist, Muslim, and Jain. Schedule Caste status is given to those from Hindu or Sikh and Buddhist religion (only an untouchable can convert to this). Even Dalits who converted to Christianity are not given the legal identity of Schedule Caste, while their social status remains the same. Schedule Tribe is from any religion. The numerically highest minority is Muslim, in which 90 per cent are covered into OBC - also called Pasmanda[10] within the Muslim religion. There are many invisible communities known as a de-notified community (Felony or Civilization; Ambedkar) in India—ancestors of Roma and Sinti of Europe and the USA—also out of the census because of 'invisibility'. The legal status of castes (SC, ST, OBC and none) is a principal matter of state, not the union, so that the same caste may have a different legal identity in different states. However, the social status will be the same in line with discrimination, exclusion, and atrocities.

Class-Caste in India: Analogue or Alien

The relationship between the ideas of caste and class has been a matter of controversial discourse. Some say that caste is analogous to class and that there is no difference between the two. Others hold that the idea of castes is fundamentally opposed to that of class. It is necessary to emphasize one feature of the caste system that has not been referred to before. Although caste is different from and opposed to the notion of class, the caste system—as distinguished from caste—recognizes a class system which is somewhat different from the graded status referred to above. One does understand how the Hindus were graded and divided into so many castes. Further, castes get divided into different classes or castes. The Hindu is caste conscious, and he is also

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[9]Office of the Registrar General & Census Commissioner & Ministry of Home Affairs, 2021.
[10]Synonyms of classification of Ajlaf and Arjal together in Muslim religion except for Ashraf.

class conscious. Whether one is caste conscious or class conscious depends on the caste; one comes in conflict with one's own identity. If the caste with which he comes in conflict is a caste within the class to which he belongs, he is caste conscious. If the caste is outside the class to which he belongs, he is class conscious. Anyone seeking necessary evidence on this point may study the Non-Brahman Movement in the Madras and Bombay Presidency. Such a study will undoubtedly indicate that "to a Hindu caste periphery is as accurate as class periphery, and caste consciousness is as absolute as class consciousness" (Ambedkar, 2017, p. 152).

In general, a caste-based society and economy are in which property rights, as well as occupations, are heredity, compulsory and endogenous. The organisational scheme of the caste system is based on the division of people into social groups (or caste) in which the civil, cultural, religious, and economic rights of each caste are predetermined or ascribed by birth and made hereditary. Moreover, endogamy remains the central feature of the caste system. However, the assignment of civil, cultural, and economic rights is unequal and hierarchical. The system also provides a regulatory mechanism to enforce the social and economic organisation through the instruments of social ostracism (or a system of social and economic penalties) and reinforces it further with justifications from the philosophical elements in the Hindu religion (Thorat, 2004). This feature of caste makes society's institution rigid, stubborn and change-resistant. These features imply that the Hindu social order is based on three interrelated principles. These predetermine social, religious, and economic rights among the caste and provide intense social, religious, and economic ostracism supported by social and religious ideology to maintain the Hindu social order.

In Ambedkar's view, the doctrine of inequality is the core, the heart, of the Hindu social order. What is essential is that the philosophical elements of Hinduism also directly or indirectly support this system. He also observed isolation and exclusion (social and physical) of untouchables as a unique feature of the Hindu social order. The principle of rank and gradation governs the caste system as the rights increase in ascending order from the untouchable to the Brahmin. It is a hierarchical interlinked system. Graded inequality based on birth exists and is nurtured too—no rights, only duty and punishments given to untouchable or Dalit. The rights increase as the varna hierarchy is ascends towards the Brahmins, who have all the rights and no punishment. Ambedkar recognised caste as a system of social and economic governance. The organisation of production and distribution is essential based on specific customary rules and norms, which are unique and distinct.

Within this framework, castes are artfully interlinked in a manner such that the rights and privileges of the higher castes become the disability of the lower caste, particularly the untouchables. In this sense, in Ambedkar's view, caste can exist only in plural numbers, and there cannot be such a thing as caste as a singular phenomenon. Castes need to be conceived as a 'system' of societal governance interlinked in unequal measures of societal, cultural, religious, and economic relations with each other (Beteille, 2011).

Profession in Class Structure

The close association between caste and occupation in the traditional social system of India is widely known. Against this background, it is instructive to know the caste background of those who take to modern occupations for which none of the castes had any legitimate claims.

The most significant change in the occupational structure, mostly in advanced industrialist societies during this century, is the growth of white-collar jobs such as clerical, technical, scientific, administrative, managerial, and professional occupations. In recent years, the professions have been the fastest growing sections of the occupational structure and increased the complexities of trade and commerce, giving rapid growth to professions. Trade and commerce are occupations of Vaisyas in Indian society. Indian industrialists are from these segments, and these professions are in the clutch of these sections (Damodaran, 2018).

It is pertinent to recall that the old system of Chaturvarna made a distinction between the first three Varnas, the Brahmans, Kshatriyas, Vaishyas and the fourth Varna, namely the Shudra; the first three 'classes' are the regenerated classes. The Shudra is the unregenerate class. The first of the Varnas were entitled to wear the sacred thread and study the Vedas. Vaisya was/ is for business and trade. The Shudra was entitled to neither, so they were regarded as the unregenerate class.

In a society where education is a private service and to be purchased by the consumer based on the strength of the family's economic resources, entry into those professions, which require significant investments of time and funds, invariably remain restricted to the rich. Inequality in education and class/caste are significant because they are the basis for social distinctions. Sociologists agree that the nature of the society largely determines whether some people are more affluent or more powerful than others (Coser et al., 1983, p. 158).

Even when steps are initiated through appropriate social policies to facilitate the entry of deprived sections onto these occupations, given the persistence of traditional disabilities, the erstwhile deprived categories will, in all probability, not be equipped to avail of these opportunities. This gap between the provision of opportunities and utilization of opportunities (Bondre, 2013) is vast and can be narrowed only by taking drastic measures favouring the deprived.

Health for Justice and Justice for Health: Equality without Equity

In most counties, the justice system serves the wealthy and powerful quite well, so also in India. Similarly, justice for the health of the wealthy and, worse, deprived living in an unequal society (Dias & Welch, 2011). Thus, it is all about social inequality. Why does it exist, and how does it affect everyday life? Why is it tolerated in a society dedicated to the ideal of equality? Inequalities of wealth and power underline many of the world's problems.

In Indian society, Brahmanism is a way of theory, discipline, or conceptualization to understand the social function or sociology of Indian society. Similarly, Marxism is to understand the function of the political economy of Western society. Marxism is silent on sociology; without sociology, political economy cannot be understood adequately in Indian society. A different 'ism' is required to understand Indian society practically, which is Amdekarism.

Ambedkar confronted the Western authors against their racial notions of caste. Ambedkar said that Western writers opted for race roots of the origin of caste because they impregnated themselves with colour prejudice. He blamed other Western authors—Emile Senart to HH Risley, including JC Nesfield and Denzil Ibbetson, for defining 'caste' as a unit by itself and not as one within a system of castes (Kumar, 2014).

Ambedkar as a thinker studied Indian society in addition to the Western with its peculiar way of functioning based on the core system that is different from Western society called the "caste system". This system continues to be the driving force in Indian society even today, discussed in detail initially in the conceptualization. Here the focus is to understand Ambedkar's views on Indian society and consider them as an approach called "Ambedkarism" to study Indian society. Ambedkar defines the nature of Indian society as structurally rigid, with unequal power relations and exclusion based on birth. Birth is the decisive point in Indian society. In his book *Annihilation of Caste* (2013), Ambedkar writes in the preface that: "I shall be satisfied if I make the Hindus realize that they are sick men of India and that their sickness is causing danger to the health and happiness of others".

Health and Illness: Contradictory Correlation

Health is dependent upon economics. And one's economic situation is based on social and psychological mindsets. Both are interdependent, but psycho-social is hidden, and its visibility is based on economics. Social identity is the foundation stone of economics, and economics is the foundation stone of health. Health interlinked with one's living condition. That is why one's health condition can be considered as a 'creator' of symptoms of illness. Health is the deciding factor in illness. Illness refers to the absence of ill health, and vice versa; health is the absence of illness. The perception of 'illnesses and 'health' is governed by the economic propensity to access care (Gwatkin, 2000). The 'Action taken' stage, which is assumed to follow the recognition of the 'symptoms' of illness (or health) in the health culture model, is largely determined by economically driven access. It, therefore, means 'wealth is health' and not 'health is wealth'.

The concepts of health and illness are neither clear-cut nor objectively factual. They are but subjective experiences which are historically and culturally bound and therefore need to be understood in a context (Thorat, 2009). Many approaches concerning the social dimension of health, illness, and medicine have been developed in the past years. The sociological approach is very illuminating and helps us understand

the relations between health, illness, medicine, and society. Similarly, the theories and concepts developed around health-illness and medicine in time are affiliated with social, financial, and cultural conditions. They interact dynamically due to various social, financial, political, cultural, environmental, and other factors that affect health and illness. The systemization of medical knowledge in a society is also related to social relationships, standards, institutions, social structure, and the organization of social life (Kadda, 2010). Several sociological perspectives such as Parsonian or functionalism, the Marxist perspective of political economy, social constructionism, feminism and medicalization, biomedical approaches and holistic approach have also been employed over the years to understand health and illness as social phenomena. These approaches are helpful to understanding the societal aspect of health-as-wellness and illness-as dysfunction by putting them together at intersections with the issues of gender, class, knowledge, and power.

'Sociology of Supremacy[11]' and Sociology of Sufferer'[12]: Fact and Figure

There are two dimensions in this section which capture the holistic picture of healthcare in India. The first section examines the supremacy in healthcare businesses, the second explores the ambit of healthcare professionals, and the third construes Dalit people's lives based on field data.

Sociology of Privatization of Healthcare in India: Examining Supremacy

Sociology is the systematic study of human society. Does it provide evidence and explanations of 'how society works'? Sociology can be considered as the actions of individuals and groups, patterns of similarities and differences between people within a single society and between societies of the distribution of social resources, and economic and political power. Sociology is concerned with studying individuals—social actors and agents operating in the social world and trying to understand how the social world works—by investing in how social structures and relationships develop, persist and change.

    Social and cultural factors play a critical role in the dynamics of economic and political systems. The Hindu social order is universally recognized as a uniquely Indian approach to philosophical and worldly affairs, and its complexity has inflexibilities which cause backwardness, rigidity, and unchanging stereotypes. Considerations of caste community and clan relationship persist at all levels and in all spheres of activity, whether industry, bureaucracy, or politics (Veit, 1976).

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[11]Supremacy is a symptom of the Brahman Tantra (system) based on birth and diluting/not furnishing democracy with the support of religion by hook or by crook and still holding onto all the spheres—business, trade, professionalism, academics, even the mechanism of a democratic system such as politics and bureaucracy.

[12]Based on occupations mainly related to skinning, sweeping, weaving, and washing, 1231 castes are in the schedule.

'The colonial period and pro-independence struggle substantially altered Indian conception of 'how society should be organized'. The Congress Party, later recognized as the party of independence, began its life in 1885 as an organisation of upper class, urban India, who sought greater privileges from the British within the then existing order of colonial rule. It owed its strength to the combinations of mass support in rural India, its intellectual elites' political and organizing role, and the financial contributions of nationalist-inclined industrialists' wealthy landowners. Thus, when the Congress became India's ruling power, its choice of economic policies was affected by commitments to various factions of the party and a strong desire not to alienate any of its supporters (Veit, 1976, p. 25). The aspirations of mass supporters and elites, industrialists and landowners, were undisputedly opposite. Nonetheless, almost all the diverse interests within the Congress had (and still have) symbolic representation. Generally, the real power has been kept in the hands of the politically active urban petty traditionalist and the newly emergent rural upper-middle class.

The 'Bombay Plan' or the 'Tata-Birla Plan' in 1944 was the first collective effort made by the bourgeoisie giant businesses to outline the path of advancement for independent India. They wanted a national government to exist at the centre, which would have complete freedom in economic matters. The 'People's Plan' proposed that the land and underground riches (mineral resources) would be the collective property of the nation, and heavy industries and banks would be subject to state control. Small agricultural producers were to be free from all other taxation, except local rates, large-scale cooperative agriculture, minimum wages, etc. A third plan known as the 'Gandhian Plan' was different from both these plans and the general stand taken by the National Planning Committee. Author of the Gandhian Plan, Shriman Narayan Agrawal, said, "I feel that these plans have not considered the special cultural and sociological foundations on which our economic planning in India must be based; merely copying western plans, whether the capitalist or socialist type, will not do; we must evolve an indigenous plan with its roots firmly in the Indian soil" (Namboodiripad, 1974, p. 32).

The decade before the attainment of Indian independence, was one of intense discussion on the necessity, possibilities, and general direction of planning the post-independence economic setup that the country went through. These discussions led to the emergence of three distinct groups of thinkers on the question of planning: the left radical, the frankly capitalist and the Gandhian. The conflict of trends represented by these three groups has left a clear imprint on post-independence planning *(*Ibid.).

This discussion concludes that except for democracy, which modern India has never challenged as an objective, India has had so many ideological differences to prevent anyone's approach from becoming dominant. In practice, for each policy objective—democracy, egalitarianism, nationalism, and centralism—there are several counter objectives. These include: authoritarianism, elitism, internationalism, and decentralism. In 1948, India announced its first industrial policy resolution, regarded as a retreat from socialism. Nehru defended it because the economy was weak and that the achievement of India's economic development required the full participation of the private sector (Pavlov, 1975, p. 90).

Health problems and health practices are community-specific and deeply embedded within ecological, social, economic, and political systems. These profoundly influence the size, extent, and nature of community health problems. While the public health system evolved on the Health and Development Committee (or Joseph Bhore Committee) in 1946, the private sector is not new to the Indian health service system. It was a predominant mode of service for the well off. Bhore Committee (1946), Mudaliyar Committee (1962), Junglewala Committee (1967), Kartar Singh Committee (1973), Srivastava Committee (1975), and Bajaj Committee (1986) mainly brought effective healthcare and shaped the path of the healthcare system in India. In addition, the Chopra Committee (1948), Mehta Committee (1957), Renuka Roy Committee (1960), Jain Committee (1966), Krishna Committee (1982) and Mehta Committee (1983) were constituted for different tasks and objectives. Different committees, constituted over a while, show that the 'idea of health', which was articulated by Sir Joseph through the committee's recommendations, was being defeated gradually by the government. Over the period, 'health', perceived holistically, has been reduced into health services via family planning to healthcare services. Later, the idea of *'health for all through* the international agenda based on the Alma Ata Declaration-health for all by 2000 *AD*' was implemented. The goal remained unattained by many countries, including India, and the 'deadline' was pushed to 2010. It was seemingly subsumed by the MDGs and SGDs subsequently. Examining and investigating the much-talked international agenda for achieving health and wellbeing is pertinent in today's context to know whether it is serving the purpose of 'health'.

Sociology of Doctors: Indian Scenario

Healthcare professionals are a significant entity in the sphere of health. A doctor is the leading actor in the therapeutic process of healthcare delivery and is solely responsible for people's health. These men and women are trained as professionals by medical institutions to take care of the sick and cure illness. In short, social, economic, and political opportunism affects careers.

All the more, when the social system of India is a hierarchical ranking system often represented as a 'ladder' in which there are differences in access to social resources, individuals at the top ranks have more access. At the same time, those at the bottom lack social resources also called structured inequality (International Encyclopaedia of Sociology, 1972). The social background of doctors becomes an essential indicator in two ways. The first strong indicator is the social mobility among scheduled caste communities in the profession and their acceptance as doctors and entrepreneurs. Second, who are these doctors; what are their caste, tribes, religious affiliations, etc. By analysing this, we can understand the social fabrics, opportunities, and chances of becoming doctors.

Scarce studies on the basic scenario of a doctor's profession—not on the sociology of doctors—were undertaken by medical sociologists till the 1980s. Few systemic studies of medical professionals, in general, have been done, but not of the persons 'who are in the profession' or 'persons studying the discipline

of medicine'. Professional issues have been studied, but issues of the profession have remained neglected when it is much needed to understand the very diversity which exists in India.

Some sociological studies have also been conducted on doctors in the making, that is, on medical students, their background characteristics, professional socialisation, work value and professional aspirations by Rao (1966). In 1972, Madan (1972) examined both aspects—health professionals and organisational aspects of health professionals in Ghaziabad city of Uttar Pradesh. Another study by Madan (1980) does provide important work on 'doctors and society'. Similarly, the occupational roles and structures of doctors and nurses were studied by Oomen (1978). In 1979, Venkata Ratnam located his study in the southern part of India—Tamil Nādu—on medical services and the social background of doctors and nurses in hospitals. The study conducted by Ramalingaswami (1980) stands out in that it examined the social background of medical students and estimated the cost of medical education. This study contributed to understanding the aspirational resources and barriers to actualising aspirations. Chandani (1985) worked on a sociological exploration of the medical profession to examine the social background of doctors, while Nagla (1988) dealt with the socio-cultural background of doctors, their attitudes towards their profession and measures of satisfaction.

Most of these studies are focused on medical sociology by a sociologist. They were/are entirely silent or ignored to study, understand, and discover the causes of non-participation/almost nil participation of the Dalit section in the profession. Investigating social identity and its influence on the medical profession leaves much to be explored.

Despite the policy of protective discrimination pursued by the government of India, the scheduled caste, scheduled tribe and other backward communities are not represented in prestigious professions such as medicine, as studies show (Narayan, 2017). The primary condition for entry into medicine as a profession calls for substantial economic investment. It is the economic resource base of one's family and an appropriate cultural base and social capital for the aspiring individuals, which determines the aspiration and entry into the profession. A minimum level of socio-economic development is a prerequisite for even utilising the unique benefits extended to underdeveloped social categories. On the one hand, they do not seem to have attained the basic minimum level of socio-economic development, which is a prerequisite to entering the profession. The spread of education is minimal among scheduled caste and scheduled tribes compared with its spread among the total population. On the other hand, it seems clear that in a hierarchically organised society, unless specific policies are consciously evolved and vigorously implemented to protect the interest of the underdeveloped social categories, they are not likely to be represented in prestigious professions. Group-specific policies are becoming more relevant and propose better outcomes.

For example, data on the same aspect gathered for the doctoral research[13] has exemplified some of the observations made in the preceding paragraphs. The field data suggested that there were twenty-two health service providers, including Jarrah[14] and quacks. Half of the doctors did not have any professional degree. Most of them had worked as 'assistants in trained doctors' clinics and had opened their own 'clinic'. Nearly 83 per cent of doctors were from twice-born[15] communities, the club of Brahmin, Kshatriya and Bania, two out of twenty-two doctors were women. The majority of doctors were the followers of Hindu religion. Sixty per cent were native dwellers of this block[16] which comprised the study site. There were only eleven as far as degree holder doctors were concerned. All were from twice-born castes. Among them, two had MBBS degrees, three had MBBS and other medical degrees, and six had BAMS/BHMS degrees-Bachelor of Ayurvedic and Medicine Science (BAMS) and Bachelor of Homeopathic and Medicine science degree—both acquired after studying at university-recognized colleges for three years.

Hence, the fact is that despite reservations in medical education, not even a single trained doctor or even quack has a clinic in the vicinity of the Schedule Caste localities. Education is still a matter of a family's social and economic capacity. In the area, schedule caste is so poor that becoming a doctor is a distant dream to many parents and having a successful clinic in the area is also one of the dreams.

Sociology of Sufferer

The sufferer is a noun and synonym for the victim, casualty, subject, target, martyr, object, patient, and case. Though a 'disease victim' might be anyone, but the 'sufferer' would be unable to access health services, opportunities of access and utilisation and equality in the domain. After all sociology of economics will play a decisive role. In this parlance, the objective of this section is to analyse 'who becomes and remains the sufferer.'

As mentioned earlier, the meaning of sociology of sufferers expands its wings on all synonyms in field data collected for the PhD.[17] This section's qualitative and quantitative data are collected from four villages in Agra district of Uttar Pradesh,

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[13]Collected for PhD thesis submitted to CSMCH, JNU in 2017.

[14]Urdu word for quacks, basically a traditional healer.

[15]Twice-born is the English meaning of the Sanskrit word "Dwij". Dwijcan only is a male member—not woman—of the first three varnas in Brahminical Hindu Society: Brahmin, Kshatriya, and Vaisya. The first birth is from the mother's womb, and the second is spiritual after 'Upanayan Sankskar'. First birth, meaning born from the mother's womb, is impure till Upanayan Sansakar. The purity is considered after Upnayan Sanskar. That is why the word Dwij came into existence.

[16]Shamashabad is the block's name located in Agra district of the state of Uttar Pradesh. It is India's highest populated state, bigger than Pakistan, and very politically active on Dalit issues, where a Dalit woman has became Chief Minister of the state three times. It has a significant number of Dalits. Agra is famous for the Taj Mahal and manufacturing shoes and leather items in India and abroad.

[17]Collected for PhD thesis submitted to CSMCH JNU in 2017.

India. Identification of villages has been done based on differentiation in all four villages, such as different percentages of Dalit, different powerful community that dominates and mixed population in the percentage of socially dominants, Shudra, and Dalit. The percentage of Dalits in all four villages is different. The identity of the dominant caste and classification of health centres can be as two sub-centres, and the rest two are non-sub centres. Two hundred respondents were studied in this research. Half of the respondents were from Scheduled castes, the rest were from OBC, and the others were from the historically privileged castes. An alarming situation emerged based on the details provided by them. The endeavour has been to understand and define the existing situation to establish the 'sociology of sufferers' and use the data of narratives.

A set of indicators was included in the respondents' schedule to understand access and utilisation of healthcare services as 'sufferers' from Schedule Castes. Health perception and the components of health and illness as health as *'illness'* were explored. Hindu religion is prominent in the villages. More than half (60 per cent) have studied up to class five. Education is still a matter of the privileged caste and has a robust correlation between caste and poverty. Availability and access to basic facilities are essential prerequisites of good health. Access to water facility, electricity, toilet and availability of rooms, kitchen, bathrooms, personal transport facility and even the type of PDS—Public Distribution System (subsidised food grain, monthly)—card are significant parameters that directly correlate with good health.

Seventy-two per cent have a separate water source and are not allowed to fetch water from others even in an emergency. Only nine per cent of SC houses have toilets in their home. Landlessness among schedule caste communities is very high, and families are heavily dependent on subsidised food grain (only 17 per cent have subsidised food grain card). Irregularity in the opening of PDS shops makes the situation worse. PDS shops are allotted or run by a local politician or family or relatives. Scheduled caste communities live in unhygienic conditions at the corner of the village without any basic facilities, insufficient water availability, food availability and consumption, and in overall poverty compared to other social groups.

The overall health conditions of the people of India are not satisfactory, and this implies that those from scheduled castes sections of the population would be miserable (Shah & et al., 2006). The causes for discrimination are many and exist in healthcare access, and non-Dalits are governed by age-old beliefs and stereotypes to continue practising discrimination (Acharya, 2010). The SC and ST in India have faced historical and continuing forms of discrimination and deprivation, and this is obliviously reflected in the incidence of poor health conditions among them relative to the others (Deshpande, 2000; Borooah, Diwakar, et al., 2014; Dwivedi, 2017).

The socially weaker sections have higher mortality rates and poor nutritional conditions. The women and children who form the marginalised sections receive less health care than their 'others' counterparts. The data indicated that the conditions are worse for SC than the others, and therefore, the scheduled sections of the population are miserable.

Some questions have been used to know about the number of rooms, availability of kitchen or separate kitchen space and bathrooms as an indicator for primary facility required for human existence. It has also been used as an indicator of their economic situation. Only 4 per cent of Dalits have kitchen space, while 21 per cent of the privileged community has the same, and 89 per cent have pucca (made of bricks) rooms. A considerable difference in the availability of primary facilities in their house reflects a life full of stress and a poor economic and living environment.

Theoretically, being poor and excluded, schedule caste communities are more prone to seasonal disease and chronic illness than other social groups. Data reveals the well-established fact of poverty and illness around the health status of Dalits in India (Ramaiah, 2015). Narratives from the field of Dalit respondents have also been penned down on aspects of availing government health facilities equally, including personnel behaviour. People are afraid to complain about the staff member of insufficient time being given, because of the fear of mistreatment by personnel against whom the complaint has been made or his supporters. "*Doctor does not listen. They do not pay attention to any complaint,*" was the observational 'complaint' shared by one respondent. They also said, "*Jaan Phahchan ho to kaam hota hai anyatha Nahin.* (If you know any staff member, you are likely to get some attention; otherwise, no attention is given to patients)." Also, one statement by a respondent reflected that they felt comfortable consulting the doctor(s) from their community. However, the doctor(s) from other communities often make them feel 'different' and therefore are 'scared' to talk to them. "*Mariz ka apni samaj ke doctor se baat karte huye himmat badata hai.* (Patients get confidence when talking with doctors and staff from their community.)" They feel that casteism is a potent symbol of social capital, which strongly supports their community and suppresses others.

Conclusion: Reclaim the Rights

The exclusion, discrimination, and 'suffocation' aspects of being born as a Dalit in Indian society completely missed out on the ambit of public health researchers and policymakers. Even government studies or data gathering exercises report disparity among social groups but do not consider them 'causes of caste'. As a result, caste appears and gets reported as a mere social factor such as age, sex, literacy, occupation, etc., but one is unable to extract its effect. It is a policy blunder that considers the caste but not its effect. Until last year, India has had four rounds of NFHS reports (National Family Health Survey) (the fifth was released in 2020) that boldly reflect disparity among different social groups. However, the policymakers still refrain from accepting and addressing them as policy matters. It should address both preventive and promotive levels. The disparity in health service outcomes among different social groups should be considered a result of discrimination which has a legal bearing. Therefore, the responsible person should be held accountable. Social diversity should be respected in spirit and encouraged at all levels of the system by providing significant space for people from diverse backgrounds. Orientation of health personnel

on the caste question should be part of their study and training, and sensitivity should be enforced and ensured in the curriculum. The NFHS and other micro-level data are solid evidence that discrimination exists, but nothing has been put in a system to weed out discrimination. Hence, a policy intervention is immediately required.

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