CHAPTER VI

AROGYAKERALAM: (UN) HEALTHY PRACTICE?

“One has to invoke what Vicente Navarro (1998) had termed ‘intellectual fascism’ of the McCarthy era to explain how some critically important elements of the discipline of public health were virtually blacked out to create space for accommodating a national and international agenda for health service development for India during the last two decades and more. It had necessarily to be ahistorical, atheoretical, and apolitical. Disinformation, misinformation, suppressing and manipulation of information have been the tools used to impart an aura of legitimacy to the patently illegitimate agenda imposed on the people of the country”.
(Debabar Banerji, 2005: 7)

In the preceding three chapters, I discussed in depth the discourses centring on health emerging through the three sites; legislative assembly, academic literature, and popular magazines. Here, I shift my registry from discourses to practice and will analyze the present health policy reforms that have been going on in Kerala called Arogyakeralam. Arogyakeralam is not an independent, indigenous, innovative project of Kerala. Instead, it is the brand name used in Kerala while implementing the pan Indian health delivery project called the National Rural Health Mission (NRHM). In this chapter, I will expose how the underlying assumptions and political positions of the various discursive fields that I have analyzed above have become the rules in the very making and implementation of contemporary health policy reforms in Kerala. My intention is to extrapolate how the discourses that effectively establish privatization and globalization of the health sector as the ideal model for the future is becoming central in the actual state-initiated health policies.
Here, I would not argue that there is a causal link between the discourses that I have analyzed earlier and practices that I am analyzing here. But the discourses might have been constituted a condition for making open policy statements that are more advantageous for the burgeoning global capital and not the suffering poor in the long run. In the NRHM documents, 'development' is still a major legitimizing tool in shifting the concern of health policy, and 'poverty' is the reason for poor health and the solution lies in market and management. The new health policy reform package that has come through Arogyakeralam/NRHM also proceed with the assumption that economy or economic growth\(^{137}\) determines health. Overall, the chapter will establish that even when stating that the policies are implemented for the welfare of the people, in effect they are becoming more and more tailor-made for the interest of the market where the well-being of the human being has peripheral concern.

NRHM/Arogyakeralam proceeds with the assumptions that the existing State governmental machinery is ineffective in bringing quality health to the people. Therefore, NRHM/Arogyakeralam directs the State to shift the responsibility of undertaking health concerns from the Governmental Department to that of a Society registered under charitable act. That is, it asks State to become an NGO or an NGO to become 'State' like. Secondly, it strongly argues for an architectural correction within the health service system through public private partnership. Thirdly, it argues for more spending on health on the assumption that the money spent on digitalization of health service system, modernization and standardization of health service system, etc will deliver quality health. Further, it urges people to join community or personal

\(^{137}\) The central government has decided to increase GDP share on health, but it was basically done to facilitate private health care market than the public health system in the name of strengthening the public health sector.
insurance schemes to meet the expenses for receiving quality medical services. That is, NRHM/Arogyakeralam asks people to find their own money to get 'quality' health service from both private and public hospitals, if not in the present, in the near future. On the whole, NRHM/Arogyakeralam is oriented to establish a condition for and legitimization of the interests of the global corporate capital and the complete withdrawal of the State from the responsibility of the health of the population. The shift is not a sudden development. A series of health programmes have been implemented in the name of sectoral reforms and they are all embedded with such a notion. In the following section, I would give an overview of health sectoral reforms and its context to situate the present policy shift.

Health Sector Reforms in Kerala: A post 1990 Scenario

Academic writing on health during 1980's suggested community financing and decentralisation as key strategies to deal with the impact of fiscal crisis on the health sector. By first half of the 1990's, legislative discourses were dominated by discussions on decentralization as a means to cut down state expenditure on health. Similarly, privatization of the health sector was also proposed as an alternative strategy to develop a modern health service system by both academic and legislative discourses throughout the 1990's. Since the late 1990's, various programmes and projects were implemented with external support in the name of the development of a health service system for people's health. It is quite significant to note that the new public health management programmes started coming up basically targeting to manage the huge man power resources and infrastructure of the public health service system. Thus, what we see since the first half of the 1990's are that a series of
programmes like health secondary system project, modernizing government programme, standardization and so on are getting implemented in the state as part of 'reforming' the health service system, in such a way as to achieve 'cost effectiveness' at all levels of intervention. The majority of these programmes are funded by international funding agencies.


140 Modernizing governance programme funded by ADB was a major initiative in the tenth five year plan (2002-2007). The plan of action was to restructure and reform state enterprises. MGP initiatives are called fast track projects expected to improve the service delivery mechanism of the state. Under the project institutions will be selected in selected departments and made models in terms of service delivery. By the second half of 2006 government has spend around 511, 87, 02, 042 rupees under MGP. For more details, refer, Proceedings 12th Kerala Legislative Assembly, first session, 2006 June 19th, Monday; ADB Evaluation study, ref: no: REG 2007-22, September 2007, ADB support to public resource management in India, operations evaluation department, Asian development Bank and ADB completion report, project no: 31328, loan number: 1974, April 2007

141 A committee was constituted by the Director of Health Services in May 2002 to prepare a report on the standard pattern of the Government Medical Institutions under Kerala Health Services Department in terms of infrastructure, equipment and service delivery. As per the expert committee report, health services is the second largest department under the government with about 45,000 employees working in about 1272 institutions under it. If the grass root level institutions viz. the sub-centres are also considered, the number of institutions may go up to about 6366. At present there are about 41 categories of institutions under the Kerala health services with more than 295 categories of employees. There are sub-centres, dispensaries, mobile health units, government hospitals, mini primary health centres, block primary health centres, community health centres, Taluk headquarter hospitals, district hospitals, general hospitals and specialty hospitals such as women and children hospitals, T.B. Hospitals, leprosy hospital and mental health centres. But according to experts, these institutions are not 'categorized' under any 'standard' pattern and thus their functioning is not satisfactory. It is stated that they are not distributed as per standard norms; there is no uniformity in service provision, bed strength and staff structure and moreover, the gross disparity in the number of institutions across panchayats, across municipalities, across Taluks and across districts. It is stated that the number of health service institutions and health paraphernalia like medical equipments, laboratory facilities and other infrastructural facilities are remaining unutilized and therefore now the State does not require new structures, rather they need to standardize the existing facilities.
claiming to strengthen the state public health service system. Interestingly, these programmes are often projected as mechanisms to ensure 'accountability' and 'quality assurance' as directed by World Health Organization. But what makes the present policy different is that the practice of the new health policy is an example of the people state becoming a corporate state. Therefore, the present chapter provides a critique of the current health policy in Kerala.

**Arogyakeralam**

The word 'Arogyakeralam' means 'healthy Keralam'. As a programme, it is the 'brand name' for the NRHM activities implemented in Kerala as well as for the Societies registered for implementing the NRHM. NRHM became the health policy of Kerala from 2006 onwards. Initially, it was implemented under the name Kerala State Rural Health Mission. But, the whole policy was renamed as Arogyakeralam with effect from 1 March 2007 with the central slogan 'arogya keralam aiswarya keralam'. Arogyakeralam is envisaged to transform the health care scenario at the village and town level, catering to 30 per cent of the poorest of the poor population of Kerala, especially women and children. The advocates of the Arogyakeralam argue that it is a united attempt to regain the declining status of the kerala model health, which has been suffering in the last two decades due to the lack of resource management. They add that NRHM is a golden opportunity to regain this lost status and they could sustain a good health index through implementing the programme Arogyakeralam (p. 11).
Many of the health standards that NRHM aims to achieve through the programme at all India level have already been achieved by Kerala\(^{142}\). Hence, apparently *Arogyakeralam* is not meant to achieve those goals. The health outcomes expected through NRHM have already been achieved by the state of Kerala or those outcomes are no more significant in Kerala. In this context, NRHM did not need to include Kerala. Moreover, Kerala was not in the earlier list of the States where NRHM was planned to be implemented. The incorporation of Kerala into the NRHM year after the beginning of the NRHM programme thus needs attention. Of course, NRHM came to Kerala on the request and pressure that the government of Kerala put on the Government of India. Since many of the targets set by the NRHM have already been achieved by Kerala, paradoxically, at the outset, Kerala shows a counter case for achieving the indices set by NRHM, but without following the developmental ideal of the NRHM. Despite this fact, NRHM is designed in a particular way with unsaid political interests and Kerala has been included in it. It forces us to think that achieving the standard set is not the sole concern behind the implementation of NRHM; rather, something else is hidden behind the stated objective of improving the Indian health standards. Here, it is significant to notice that NRHM/Arogyakeralam gives more emphasis to architectural correction of the existing health sector and synergization of 'health'-allied

\(^{142}\) Health and development indicators.

<table>
<thead>
<tr>
<th>Health Indicators</th>
<th>Kerala</th>
<th>India</th>
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<tbody>
<tr>
<td>Birth rate (per 000 population)</td>
<td>16.70</td>
<td>24.80</td>
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<tr>
<td>Death rate (per 000 population)</td>
<td>6.30</td>
<td>8.00</td>
</tr>
<tr>
<td>Infant mortality rate (per 000 population)</td>
<td>11.00</td>
<td>60.00</td>
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<tr>
<td>Maternal mortality rate (per 000 population)</td>
<td>0.30</td>
<td>4.37</td>
</tr>
<tr>
<td>Total fertility rate (per woman)</td>
<td>1.99</td>
<td>3.30</td>
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<tr>
<td>Couple protection rate (%)</td>
<td>72.10</td>
<td>52</td>
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<tr>
<td>Life at birth male</td>
<td>71.67</td>
<td>64.10</td>
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<tr>
<td>life at birth female</td>
<td>75</td>
<td>65.80</td>
</tr>
<tr>
<td>Life at birth total</td>
<td>71</td>
<td>64.80</td>
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Source: Directorate of Health Services

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factors for creating a better health situation. These two aspects are the important measures adopted to restructure the existing public health programmes, and perhaps they may, in the long run, subvert Kerala's 'public' health sector into a 'private' health sector. To implement this programme or achieve these goals, the NRHM/Arogyakeralam envisages for major infrastructural building and de-linking the responsibility of implementing health delivery system from the State Health and Family Welfare Department to a Society registered under Charitable Act.

Since Arogyakeralam is NRHM renamed, to understand the former better, we must thoroughly go through the NRHM documents, which I will undertake in the following pages. Here my intention is not to do a programme evaluation, rather I will look into the assumptions on which this project is conceived and implemented. I hope this will reveal the politics within it and how it will affect the well being of the people. Thus, I will be able to explain how a stated people-centered programme become paradoxically anti-people.

"This is for the first time that a truly demand driven health action plan for the people of the state has been developed. Not only is the health action plan driven by demand, it is also impregnated with innovation, imagination and clarity of purpose. The intentions are simple and straight—to see a reengineering of the public health system with assurance of quality health services to the poorest of the poor in the state."(action plan p.2)

Effective implementation is required... conventional ways will no longer hold good, instead "most modern management methods and techniques is required to put in place with professionals handling the scheme of things. The state health and family welfare society is totally committed on this issue and will ensure that the target and goals set forth in the state action plan for 2007-08 are attained within the time and cost line set forth in the Plan."(action plan p.3)
National Rural Health Mission (NRHM): The Aim and the Roots

The National Rural Health Mission (hereafter abbreviated either as the Mission or NRHM) is the recently introduced health delivery system in India. The Mission was introduced nationwide on 12 April 2005 and is intended to last till 2012. Recently, a decision has been taken to extend it up to the year 2017. Thereafter, it may continue or discontinue, according to the decision of the Central government and the main funding agencies. It is basically intended to strengthen primary health care through grass root level public health interventions based on community ownership. It aims to improve the availability of and access to quality health care by people, especially for those residing in the rural areas, the poor, women and children. It plans to achieve its goal by increasing funding to the health sector, synergizing a few allied sectors, and through an architectural correction of the existing institutional structure. NRHM was originally meant to provide health care in this manner for 18 Indian States having low health care indicators. The programme aims to bring quality health to women, children and the rural poor through architectural correction of the existing health delivery systems and synergization of various other aspects related to health. While aiming at improving the availability and access of quality health care, it also wants to promote a new healthy life style.

From the mission document itself, it is very obvious that the programme is a new health financing and management strategy. It envisages increased budget allocation for the health sector and adopts what is called ‘financial envelope for the states’. For example, it recommends increasing the budget allocation for health from 0.9 per cent of GDP to that of 2-3 per cent during the Mission period. The Mission visualizes that the health delivery system must be treated as an integrated field and argues that NRHM will bring economic and social
development through architectural correction in the basic health care delivery system. It adopts a synergetic approach by relating health to determinants of good health viz., segments of nutrition, sanitation, hygiene, and safe drinking water and aims to mainstream the Indian systems of medicine to facilitate health care. The plan of action includes increased public expenditure on health, reducing regional imbalance in infrastructure, pooling resources, integration of organizational structures, optimization of manpower, decentralized management of health programme, community participation, induction of management and financial personnel into district health system and operationalizing of community health centres into functional hospitals meeting Indian Public Health Standards in each Block of the Country.

Though the Mission documents may present it as an innovative internally-framed policy for the betterment of health indicators of India, it actually is an Indian response to the directions and desires of global capital for the restructuring of the health sector of India ultimately for the interests of the capitalists. It effectively is part of the second stage of the Structural Adjustment Programme. In the first stage of structural adjustment, the Indian economy was opened up for the global capital investment. In the second stage, global capital has been allowed to directly intervene in the functioning of Indian Governmental machineries and readjust it for the advantage of foreign capital. The celebrated modernizing government programme is tailor made for this purpose, where the government machinery is reframed for avoiding risk to foreign capital invested and ensuring them profits.

The following statement in a UN document explaining the context of the birth of NRHM in India must be read in this background. The document says that:

"Factors which enabled setting up of the NRHM included a strong Civil Society critique and mobilization, for example, through the National
Health Assembly in 2000 and through major policies such as the Indian Health Charter. Increased political support for more public spending in health and for the reorganization of health services was also a factor. This led to the incorporation of the agenda of health care reorganization in the common minimum programme in 2004, which was a significant structural adjustment in funding flows and priorities? Global agencies through international covenants such as MDG (millennium development goals) and global donors added to the creation of an enabling environment for NRHM.\footnote{Emphasis added. Quoted from The First Meeting of Country Partners: WHO Commission on Social Determinants of Health Executive. Draft August 2006.)}

The above document tacitly reveals that NRHM has come as part of the global interests in restructuring the Indian public health system. But more important is the revelation that the financial source of the NRHM comes from external funding agencies, though the Mission document says that the funding is coming from the increased budget allocation of the central ministry. Of course, there is a truth in it, but, interestingly, this increase was adopted as a response to the global instructions. In fact, the word ‘envelope’ hides the sources of finance and it is often projected as central ministry-funded programme. The Mission document states that NRHM is a conglomeration of some of the existing vertical programmes. It is a fact that many of these vertical programmes merged with NRHM are aid-dependent programmes\footnote{"The rich countries mobilized organizations such as the WHO, UNICEF, and the World Bank to promote their agenda of selective PHC. This led to the opening up of a virtual barrage of what the international agencies called international initiatives. These ‘vertical’ or ‘categorical’ programs were ill-conceived, prefabricated, technocratic programs, imposed on the poor countries of the world" (Banerji 2005).} and this merging also contributes to the total financial allocation of NRHM. This is evident from the Mission document itself:

A variety of partnerships are being pursued under the existing programmes of the Ministry, especially the RCH II and independently by the States with their own resources with non governmental partners...The RCH II had development partners, including UN agencies [USAID]. Under this the States are trying contract in,
contract out, outsourcing, management of hospital facilities by leading NGOs...The immunization and polio Eradication Programmes effectively make use of partnerships with WHO, UNICEF, the Rotary International, NGOs etc. (National rural Health Mission, Meeting People's Health needs in rural areas, framework for implementation, 2005-12)

Thus, NRHM is framed on the belief that economic growth determines the health of the people and argues for a better financial management as that is the only means to bring quality health. Therefore, the whole Mission document discusses at length the fiscal aspect of health. It says that NRHM is a new health financing mechanism and health finance managing system. There will be a National Expert Group which will set the protocol and do the cost comparison. The Mission document speaks about the increasing health expenses of the people and its unaffordability. This document also says that hospitalized Indians spend on an average 58 per cent of their total annual income for hospital expenses; 40 per cent of hospitalized Indians borrow heavily or sell assets to cover their expenses; 25 per cent of the hospitalized Indians fall below poverty line because of the hospital expenses; and only a few negligible hospitalized has some sort of Insurance coverage and that too is inadequate. Looking at these findings, we may think that NRHM is heading to an argument that sickness makes people poor. But this document states their position in a different tone. The poor are prone to sickness because of their poverty and their ill health is due to poverty. That is, poverty is the cause of disease and ill health. In that sense, it echoes the old cultural poverty argument.

The fundamental ideal of NRHM is based on the belief that money will bring good health or increased spending will bring quality health and access. Therefore, the whole suggestion to improve the economy of the poor is to gift
them money temporarily in the form of insurance. The overemphasis on improving the infrastructure facilities of hospitals of various kinds also form part of it. NRHM does not see any problem with the existing socio-political order. The policy makers still believe that the corporate-governed neo-liberal state with its logic of market, competition and privatization would remove the poverty of the people and will bring them into a situation of good health utilizing quality health provided by the competitive market. Thus is nothing but an utopian idea, and, more, it is, as Banerji said 'Disinformation, misinformation, suppressing and manipulation of information have been the tools used to impart an aura of legitimacy to the patently illegitimate agenda imposed on the people of the country.'

NRHM claims that the method they adopt to improve the health delivery system is innovative and is a response to the demand of the people. But in fact, it basically is an extended version of an USAID project called IFPS (Innovative Family Planning Services) implemented on an experimental basis in Uttar Padhesh from 1992 to 2004. We should also bear in mind that some of the components in NRHM is still aided by USAID. Therefore, whether the NRHM will really address the cause of people is yet to be established. IFPS was launched to improve the health of women and children. Here also, the primary aim and the central target of the Mission is not different. The emphasis IFPS gave to reproductive child health could be read from the following quote. It is important to notice that an important component of NRHM is also RCH and the major financial resource for NRHM comes through the implementation of RCH. I quote from a report on IFPS project.

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The Report begins with stating the poor condition of reproductive child health in India and states that,

'This deteriorating condition has been promoted by USAID to fund and launch a 12 year long 'innovative' programme for improving reproductive health and reduce fertility in northern India. Uttar Pradesh was the targeted state, because of it being the most populous state in India and the RCH indexes are very poor. The Innovation in Family Planning Services (IFPS) project carried out from 1992-2004, sought to design, test, and expand innovative approaches for improving quality of and access to family planning and RCH services, particularly for women, rural populations and other undeserved groups.'

The report claims that,

'Lessons learned from the IFPS Project ... have been instrumental in planning for USAID's follow-up IFPS-II Project... and the central government's RCH-II Program of the National Rural Health Mission. Several of the key innovations first developed under IFPS in Uttar Pradesh-such as the establishment of district level societies to guide health programs- are now integral components of the RCH-II Program and the NRHM.'

There are apparent similarities between the structure of the implementation of the IFPS and NRHM. Both emphasize on district-level plans to implement their programmes. IFPS has a District Action Plan (DAP). Similarly, NRHM also has a District Mission and a District Society which work as the central agency in the implementation of the NRHM. That is, the NRHM which is modelled from the IFPS District Action Plan calls for the provision of project management units for all districts to manage the implementation of district health plans. Similar to IFPS DAPs, the involvement of the Panchayat Raj institutions and the strengthening of community health centres and sub-centres are critical steps in the NRHM. Another key similarity between NRHM and IFPS DAPs is the promotion of public-private partnerships to achieve health goals (267). All these, in one way or the other tell us that NRHM as a plan and method of implementation is neither new nor internally
generated, rather it is an extension of an experiment made somewhere in the National level and according to the interest of foreign capital. Therefore, inherent in the programmes are the interests of external agencies like USAID and other similar agencies and not that of the interests of the real sufferers, though it is popularized as a ‘people planned’ programme.

The Government Departments becoming Societies: Bypassing the State

The NRHM/\textit{Arogyakeralam} in Kerala (also in other states) is executed through the State and District Health Missions and a few registered Societies. The State has constituted the Missions and Societies under the instructions of the Government of India. The constitution of the Missions and Societies are binding through the MOU signed between the State and the Government of India (GOI). The society has been constituted and made the nodal agency for executing the NRHM claiming that Government Departments delay the execution of the process and are inefficient in executing many programmes like Public Private Participation and insurance. There are clear GOI instructions on how the society must be constituted and who all could be its members. Of course, the NRHM declares that it is a programme by people, but in practice, it becomes a programme forcefully implemented on the people.

The Mission and the Societies constituted under \textit{Arogyakeralam} have the following structure.

State Health Mission shall be constituted with Chief Minister as the Chairperson and an integrated State Society with the chief Secretary heading its Governing Body. Secretariat of the state Health Society will act as the Secretariat of the State Health Mission and similar structure envisaged at district level. An integrated State Health Society at the State level and an integrated District Health Society at the District level will be the functional requirement under the proposed approach. It will be followed by the merger of various societies such as SCOVA/RCH society,
Vector Borne Disease Control Society, Societies for Leprosy, Blindness Control, Cancer, etc. both at the State and District levels into the State Health Society and District Health Societies.

For the implementation of this programme, a society has been constituted according to these guidelines and the society is called the Kerala State Health & Family Welfare Society at the state level and District Health & Family Welfare Society at the district level. The state and district level Societies so constituted are the nodal agencies for implementing *Arogyakeralam*. The responsible government body that had been implementing health related programmes and policies in Kerala hitherto is called the Kerala State Health and Family Welfare Department. The Societies that are newly constituted retain the same name, but with minor changes. It is now named as the Kerala State Health and Family Welfare Society (instead of Department). The Society is not a government body as such, but is a society registered under the Charitable Act. Since legally it is not a government body though a few members of the society include government civil servants, its responsibility and accountability to the people is limited. But the name and the functioning of the Society creates a State-like effect. That is, the society bypasses the responsibilities and liabilities of the government department towards the people, especially in charting specific programmes and implementing the policies. Since the society is constituted on the basis of the 1955 Travancore-Cochin literary, Science, and Charitable Act, its rules and many court rulings in the last 50 years have also made it difficult for exercising social control over the functioning of such Societies. The newly-formed society not only replaces the Government Department, but also makes non-existent a few other societies constituted to implement some of the already undergoing vertical programmes. The integration of all existing vertical programmes has been

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\[146\ Go\ (p)\ 354/05/H&FWD\ dtd.\ 31\ December\ 2005\]
made by stating that they are ineffective. As the quote above says, in Kerala, all other societies constituted to implement vertical programmes are first instructed to merge with the Tuberculosis society and then into the Health and Family welfare society. The society is critical in implementing the NRHM/Arogyakeralam. It de-links state responsibility and shifts it to a non-governmental organization and also says that it will promote the non-profit sector particularly in under-served areas. I read this development not merely as a mechanism to speed up the implementation, but as being meant to speed up the rooting of neo-liberalism. Moreover, the replacing of the Society for Department is associated with the preference for a ‘minimalist state’.147

In addition to this, the mission replaced the Hospital Development committees with Hospital Management Societies. In Kerala, under the provision of the Panchayat Raj Act, there were hospital development committees in all hospitals. Since these were formed under the rules of the Panchayat Raj Act and by the elected representatives of the local self governments, they were accountable to the people. A government order issued to legalize the winding up of the Development committees and constitution of the Management Societies states that the development committee formed under the Panchayat Raj had become ‘untenable’ and had to be dissolved. The shift from development to management is legitimized on grounds of efficiency. The shift from Development to Management is a shift towards the neo-liberal market logic. Here, management means financial control, profit making and increasing competitive spirit. Such a management is required when the public sector is conceding to the private sector. By

147 K.R. Nayar argues that, “inter-sectoral convergence is proposed to be achieved by establishing yet another organization, this time probably a quasi-government society at the state and district level".
arguing for constituting a management committee, NRHM/Arogyakeralam is envisaging that a government institution (its form and practice) should be modelled after corporate organizational management ideals. The corporate management ideals underscore that ‘economic is the political’ and ‘the market is its transcendent ideal and gives it ontological directions’ (Kapferer 7). In such a programme, people and their well-being could appear only at the surface level to legitimize one’s action and not in the deep order of really bringing well-being.

NRHM/Arogyakeralam also instructs the constitution of another committee at the Ward level. They are called Ward Health and Sanitation Committee which will be attached to a Sub-Centre. They are at the lowest level of the health plan. 50 per cent of its members must be women and 30 per cent must be from the non-governmental sector. If a Ward strictly follows the instructions of NRHM in the constitution of the WHSC, then the number of the members from non-governmental sector will be in majority. Though the NRHM directions say that WHSC committee is the lowest unit that plans the management of the hospitals, in practise, they are more an agency responsible for the monitoring and implementation of the plans. The Ward committee works as a conduit between the NRHM and the people in the sense that it is the Ward Committee which has to conduct household surveys in the ward, maintain a health register, translate NRHM indicators into Ward Health indicators and intersectoral integration (sanitation, hygiene, nutrition, drinking water).

Till recently medicine was worked in the field as defined by the wishes of the patients, his/her pain, symptoms or malaise. Foucault says that:

>This area defined medical treatment and circumscribed its field of activity, which was determined by a domain of objects called illness and which gave
medical status to the patient’s demands." Recently it has gone beyond this defined field, that now medicine began to respond to another theme which is not defined by the wishes of the patients, certain things (including medicine) began to impose on individuals as an act of authority. Health has been transformed into an object of medical treatment. Hygiene, sanitation, drinking water, nutrition, household surveys are ways of "medical interventions that are no longer linked exclusively linked to disease... Today medicine is endowed with an authoritarian power with normalizing functions that go beyond the existence of diseases and the wishes of the patients. (Foucault p. 13)

NRHM as a whole has this dimension and the Ward Health and Sanitation committee is the agency instrumental in accentuating this process. Since it is constituted incorporating people from the locality itself, ultimately the responsibility in shifting the field of health will fall on the shoulders of people.

Public Private Participation: Transferring the Public to Private

NRHM/Arogyakeralam strongly stands for Public-Private Partnership in delivering health services. Perhaps one of the important intentions of the NRHM itself is to make a decade-long suggestion for making Public-Private Participation (hereafter PPP) a reality. Or in other words, inherent in PPP is the dimension leading to the complete transfer of the health delivery system gradually into the hands of the Private sector.148

The Mission document defines the introduction of Public Private Participation as an ‘instrument for improving the health of the population’. It proceeds with the declaration that private sector is a national asset. The documents arguing for PPP defines ‘Public’ as government or organizations functioning under state budget, ‘Private’ as private/non-profit/voluntary sectors and

148 The case of the educational sector in Kerala is the best example. Now the public school system is on the verge of complete erasure and the private sector has begun to determine what service should be delivered.
‘Partnership’ as collaborative and reciprocal relationship between two parties (i.e., Public and Private).

The 11th plan has constituted a task force to study and implement the PPP in health as recommended by the NRHM. The draft report of the task force and the NRHM documents state that PPP will provide ‘universal access to equitable, affordable, and quality health care’. They also argue that PPP will be accountable and at the same time responsive to the needs of the people and is highly recommended for the reduction of child and maternal deaths. The task force of 11th plan that has been constituted to enquire into the possibilities of PPP concluded that PPP is necessary to achieve the goals of NRHM. A Mission document titled NRHM framework for implementation states that:

the involvement of non-governmental sector organizations in critical for the success of the NRHM. ... Many good hospitals in our country are run by Trusts. Many of these hospitals are excellent in the process of capacity building of health functionaries especially nurses ... NRHM would support linkages with the large number of trust and society managed hospitals and dispensaries in remote areas to see how best they could provide service guarantees to the poor (draft .pp 53-55).

PPP envisages, contracting in, contracting out, subsidies, leasing or rental, and privatization of health services including human capital and infrastructure. Contracting in means, hiring individual on a temporary basis to provide service, contracting out means government pays out individual to manage a specific function, subsidies means government gives funds to private groups to provide specific service, leasing or rental means government offers the use of its facilities to a private organization, and privatization means government gives or sells a public health facility to a private group. “Contracting out is resorted to when health facilities are either underutilized or non functional while contracting in is used to improve quality of service or improve accessibility to high technology service or improve efficiency (draft .p. 13).

PPP is operated through the accreditation of non-governmental hospitals. Empanelling of Private hospitals who are willing to cooperate with the NRHM has already been started in Kerala and so far more than 400 private hospitals
have been accredited. The district-wise list of such empanelled hospitals is
now available. A critical agency in the implementation of NRHM is the
District Mission and the District Societies. The empanelled hospitals are
accredited with these two bodies. How it is going to operate is also tacitly said
in a slogan which appears in the Mission Documents—‘Money follows the
Patients’—that is, the District Mission will reimburse the hospitals expenses
incurred on a patient. The Mission Document says that, “Progressively the
District Health Missions will move towards paying hospitals for services by way of
reimbursement, on the principle of ‘Money follows the patient’.” That is, a patient
who requires treatment from a private hospital can approach any of the
empanelled hospitals and demand for the service. The cost for the service thus
rendered will be reimbursed by the District Health Mission. The Document
does not make any comment on how the District Health Mission is going to
reimburse the money. Even if it is through the insurance card introduced or
from the NRHM fund itself, ultimately it will become a means to transfer the
public fund to the private institution. Moreover, promoting such a mechanism
will gradually erase the public health system.

The task force report recommends that the method to augment resources for
introducing PPP (or meeting the expenses that would incur after introducing
PPP) could be raised through accepting donations, introducing user fees and
insurance schemes. Contract appointment is the sole way of appointing staff
which aims to reduce the negative impact of vacant positions and the
economic burden. The report also recommends voucher schemes and
community-based health insurance to reduce the adverse effects of health care
costs on poor patients and to improve equity in health system (draft p 13). It
also says that PPP should not be an ad hoc arrangement since in the short run,
it is disadvantageous for the private sector and they should not be let to loose. I quote:

Since there is element of contradiction in the objective of strengthening of the public health system by private sector in which the private sector apparently is the ultimate looser, therefore, it is essential that the framework for the whole process of partnership is not ad hoc (draft Report on Recommendation of Task force on Public Private Partnership for 11th Plan).

What is hidden in this is that the present concession to the people is only a means to link people to the changing structure of the health delivery system. Such benefits will be temporary, and in the long run, it will become a mechanism to make profits for the private sector.

All PPP should meet at least two basic criteria: Value for Money and sharing risk. Under value for money, it controls CAG (comptroller and audit general) interventions in checking accounts:

CAG should be requested to develop specialized skills for assessment of Value for Money and risk sharing characteristics of PPP projects. Auditing of government expenditure through PPPs requirement would be different from the traditional audit of expenditure directly made by government departments. Unless the CAG develops capacity for auditing of public expenditures through private partnership, large scale expansion of PPPs would be difficult (p.16 draft Report on Recommendation of Task force on Public Private Partnership for 11th Plan).

The paradox lying in such assertion is that on the one hand the NRHM is arguing for accountability and transparency, but, on the other hand, by characterizing departments like CAG as inefficient and claiming that would arrest the spread of PPP, they tacitly argue for bypassing a public auditing of the whole financial management of the PPP. The following statement in the Mission Document makes tis clearer:

Transparency, Accountability, Trust, measurable efficiency perimeters and pricing remain vexatious issues in the partnership process.

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The Mission document is silent on to whom it will become vexatious. Of course, CAG auditing is not vexatious to the people. It may be vexatious for the private agencies who want to accumulate profit. Any public auditing, whether it is CAG or any such agency, will be vexatious for the private sector. In short, such recommendations in NRHM itself give sufficient room for private capital and power to freely flow in the health delivery system and determines that they want is the best option for the general public. The possibility of private capital determining the structure of health delivery system is not far away if NRHM promotes PPP in this fashion.

NRHM gives provision for region-specific adjustments in entering into PPP. That is, there is no national policy on entering into PPP, rather it allows each State and District Mission freedom to enter into PPP according to their wishes. The state-level and district-level societies support PPP with resource and technical assistance and the district societies are the agency to operationalize the partnership at the district level. Thus, it leaves the freedom of choice to state-level and district-level societies regarding the nature and extend of private partnership, I quote:

Government must understand the advantageous and disadvantageous and requirement of the partnership. They need to understand that partnerships are based on common objectives, shared risks, shared investments and participatory decision making.¹⁴⁹

This will ultimately lead to a situation in which all responsibilities will fall on the head of the state and all the profits will flow into the hands of the accredited private hospitals. In this process, common people will be forced to buy cost-effective services from the private sector according to the resources

¹⁴⁹ Draft Report on Recommendation of Task force on Public Private Partnership for 11th Plan
they have where there is sufficient provision for denying the service to patients who are not able to pay. (This will be clearer in the detailed discussion on insurance schemes in the following sections of this chapter.) I add here that introducing PPP too is a major architectural correction that NRHM tacitly advocates. But through this kind of architectural correction, what will be happen is nothing but the ceding of the existing public sector into the hands of the profit-making private sector.

In the Mission documents and other records that advocate PPP, the advantages of the people are highlighted in the forefront and it is not privatization. For them, PPP is a tool to augment the public health system. But it is consciously silent on the fact that the gift given to them now is temporal and short lived. Ultimately, it is going to be a programme advantageous for the private capital.

All these provisions in NRHM make it clear that the programme has been designed on the assumption that ‘health is economics’, it is a commodity, and to get quality service, one must pay. Those who do not have the money are not eligible to get service. Those who are poor are now supported with insurance cards. In future, each one should get insured and find out their own means to get quality health services. It is a way of asking people to insure themselves. The other unsaid part of this suggestion from the state is that it is withdrawing from the responsibility of health service provision and thereby from the well-being of the people.

In the previous chapters, we have already seen that legislative discourses are already dominated by the horizontal and vertical expansion of health paraphernalia and whether it is decentralization or privatization, the interest was to bring in private capital into the field. Thus, any attempt to control
private health-care institutions and any attempts to bring such measures were rejected by claiming that the government needs to learn more about how it is implemented in other neighbouring states and so on. According to government experts, 'given the state of affairs where private sector is dominating, government is forced to incorporate private institutions in the health care delivery mechanism of the state'. If there is no such situation, the NRHM and its provision of introducing PPP would create such a condition. This should also be read along with discussions in the legislative assembly that some of the private hospitals should be taken as models of good practice and the government should learn lessons from these model practices. Though Kerala is well known for its better public health system and many scholars have attributed developmental policies based on social justice of leftist governments as the reason for high human development indicators including health indicators, the recent initiative of the leftist ministry (led by the CPM) through Arogyakeralam shows that neither the right nor left is interested in the health of the poor or well-being of the population. Instead, health is used as a means for the State to control the masses through the logic of market. The state brought all its priorities under the programme of Arogyakeralam where it can easily bring in the market interests under the curtain of National Rural Health Mission. The politics of such prioritization is very evident from the health concerns of the present programme. If in the 70s, the state's concern was to improve the health of population through strengthening the health service system, by the beginning of the present millennium, the state is considering management of health personnel and health service institutions as the major problem and all health sector reforms are directed to revamp them and ultimately cede them into the hands of private capital, whether it is
hospitals, paramedical institutions, pharmaceutical companies or insurance companies.

PPP denotes the new form of political-economy of governance premised on the extension of market relationship. In that sense, NRHM and PPP is a further step of adhering the health sector into the neoliberal market economy. It plays with welfare, but makes the state a post-welfare state. The second aspect will become clearer when we discuss yet another important intention of the NRHM, which is the introduction of insurance. NRHM proceeds with the assumption that the market and market logic are better ways for organizing economic activity because they are associated with competition, economic efficiency and choice. In conjunction with this general shift towards the neoliberal tenet of ‘more market’, deregulation and privatization have become central themes in the debates over welfare state restructuring (Larner 2000). I would argue that NRHM/Arogyakeralam is leading to this aspect and not to liberate people from the hands of the market and market is based on determined economic logic, where welfare has no value, but only profit making is the aim. Moreover, this shift in the nature of the state, which is gradual withdrawal from the care of the people and succumbing to the logic of market, is a way of a welfare state becoming a corporate state. That is, NRHM/Arogyakeralam is gradually transforming “what was once public space held in the larger public interest is made into corporate space. Paradoxically that which was common (the Commons) is transmuted into corporate territory and given back to the public as part of corporate largesse” (Kapferer, 2004.8)
**Insure or/and Perish**

The NRHM’s directions to introduce health insurance and its widening either through social insurance or individual insurance are part of the accentuation of the privatization of the medical service. The introduction of Community-Based Health Insurance (CBHI) for the people living under the below poverty line is something I would read as yet another step towards the complete withdrawal of the state from investing in the health sector. Of course, now the introduction of insurance is projected as beneficial for the people and at the same time, as an income for the hospital management committees of the concerned institutions which provide health care, whether it is public or private. The NRHM prescribes that initially the Central government should subsidize a part of the premium and IRDA must promote such CBHI. The Mission document also ensures that there will be periodic evaluations to check the effective delivery of health insurance coverage. But where it will ultimately lead to is my prime concern in this section.

The NRHM strongly recommends the introduction of health insurance for people living below the poverty line (BPL) and persuades all of them to get enrolled in any of the health insurance schemes stating the following reasons:

Household expenditure on Health Care in India was more than Rs.100,000 crore in 2004-05. Most of it was out of pocket and was incurred during health distress in unregulated private facilities, leading to the vicious circle of indebtedness and poverty. As a matter of fact, in a country of over a billion people, barely 10 million are covered under the private health insurance schemes. Even if we take into account Social Health Insurance Schemes like CGHS; ESIS etc., the coverage increases only to 110 million of which only 30 million are poor. In order to reduce the distress of poor households, there is therefore an imperative need for setting up effective risk pool systems. Involvement of NGOs and community based organization as insurance providers and as third party administrators can help to generate more confidence in the risk pooling arrangement being pro-people and in the interests of poor households. Innovative and flexible
insurance products need to be developed and marketed that provide risk pooling from government and non-governmental facilities (Report for the Working group on Health of Women and Children for the 11th Five year plan, 2007-12).

Further, the mission document states that hospital expenses are making people poor and impoverished. I quote:

...hospitalized Indians, on average, spend 58 percent of their total annual income; more than 40 percent of hospitalized Indians borrow heavily or sell their assets to cover expenses, more than 25 percent of hospitalized Indians fall below the poverty line because of hospital expenses.150

Insurance has been introduced as the sole remedy to all this putting these as facts. As a prelude to the introduction of the health insurance scheme, NRHM insists that the states achieve the Indian Public Health Standard (IPHS).151 This standardization has been prescribed stating that regional imbalances have adversely affected the availability of services in the backward districts/areas and that the absence of a clear-cut standardization criteria resulted in the failure of systematic and uniform institutional development strategies. Though these aspects are there, the insistence on achieving IPHS and funding for realizing so through infrastructure building is closely linked with the introduction of the health insurance schemes. The insurance companies do not want to lose their profit and achieving IPHS and confining the insured within the confines of the less expensive system is an operational logic of the insurance companies. They are not interested in supporting good health for the people, but in making profits out of the situation of ill health. Hence, the


151 The context of issuing the GO (MS) No. 568/08/H&FWD dtd. 6.1. 2008 on revised standardization comes here.
insistence that there must be a standard system of medical facilities available in all localities. This is evident from the Mission document, which says that:

it is realized that the introduction of such a system [insurance] without the back up of a strong preventive health system and curative public health infrastructure would not be cost effective. Such a venture would only end up subsidizing private hospitals and lead to escalation of demand for high cost curative health care. The first priority of the Mission is therefore to put the enabling public health infrastructure in place (Mission document 2005-12).

NRHM’s insistence on architectural correction too serves the interests of the insurance companies.

Primary health care would be provided without any charge. However, in the case of need for hospitalization, CHCs would be the first referral unit. Only when CHC is not in a position to provide specialized treatment, a patient would be referred to an accredited private facility/teaching hospital. The patient would have the choice of selecting any provider out of the list of hospitals accredited by the District Health Mission. Reimbursement for the services would be made to the hospitals based on the standard costs for various interventions decided by the experts from time to time (Mission Document, 2005-12).

This shows that even though NRHM declares that it goes along with introducing a demand-based health delivery system, in practice, it is imposing the interests of the neoliberal capital on the local, whether it is insurance companies, or private health delivery services. More interesting is the risk pooling involved in the insurance scheme. Though it is not clearly stated, the idea we could get reading the sentences like the following is not promising to the common people and for the welfare state in the long run. The Mission document says that:

While the private insurance companies would be encouraged to bring in innovative insurance products, the Mission would strive to set up a risk pooling system where the Centre, States and the local community would be partners. This could be done by resource sharing, facility mapping, setting standards, establishing standard treatment protocols, and costs, and
accreditation of facilities in the non-governmental sector (Mission document, 2005-12).

That is, the governmental machineries and funds must be spent for the interests of the insurance companies and the state should bear the risks involved in it.

NRHM envisages converting the public health delivery system like a private institution in the long run through the support of integrated and universal insurance scheme. I quote:

It is envisaged that the hospital care system would progressively move towards a fully funded universal health insurance scheme. Under such a system, the government facilities would also be expected to earn their entire requirement of recurring expenditure including the salary support out of the procedures they perform, while taking care that access to those who cannot pay is not compromised. This system would obviously work only when the personnel working in the CHCs are not part of a state cadre but are recruited locally at the district level by the District Health Mission on contract basis. Since evolving such a system is likely to take some time, at the first instance, it is proposed to give control of the budget of the CHC/Sub Divisional and District Hospitals to the Rogi Kalyan Samitis or equivalent public bodies set up for efficient management of these health institutions (NRHM framework for implementation, 2005-2012: pp. 27-28).

Following the instruction of the NRHM, Kerala has introduced an insurance scheme for families living under below the poverty line. The insurance scheme that Arogyakeralam has initiated is called the Comprehensive Health Insurance Scheme (CHIS). Arogyakeralam claims that the insurance scheme they have introduced is different from the CBHI introduced in other Indian states since the former incorporates all classes of the people of Kerala and does not restrict its benefits to the people living below poverty line fixed by the Central government. The CBHI scheme is modelled on the RSBY (Rashriya Swasthya Bima Yojana) which was launched nationwide on 15 August 2007. CBHI ensures health insurance for a BPL family of five members up to 30,000 per year. The premium will be paid by the state and central government, but a fee
of Rs. 30 will be charged from the beneficiary family. United India Insurance Company is the nodal agency to execute the programme.

In Kerala, the programme was launched on 1st October 2008. The difference Kerala made in selecting the beneficiaries is that, in addition to the 10 lakh people coming under the BPL, the Kerala government incorporated yet another 12 lakh people under the scheme by paying their premium whereas premium for first 10 lakh people will be paid by the Central Government. That is, at present, an amount Rs. 42 crore will be paid by the central government towards premium for the 10 lakh people and an amount of Rs. 100 crore will be paid by the state government for the added 12 lakh people. In Kerala also, the United India Insurance Company is the nodal agency though they have outsourced the process of insuring to three other agencies. The premium amount for an insurance card coming under this scheme is Rs. 536 (Rs. 506 will be paid by the government and Rs. 30 for the card will be paid by the beneficiary). But the Mission document says that those who are above the poverty line (APL) could also join the project by paying the same amount. The scheme is operating with the integrated efforts of various government departments including the Labour, Repatrition, Health and Family Welfare, Village Development and Local Self Government. But the Labour Department is in charge of executing the project. The basic unit through which the insurance scheme is implemented is PHCs.

RSBYCHIS is the name of the insurance scheme that Kerala has introduced. There is a separate body to look after the insurance programme. This body is called Comprehensive Health Insurance Agency for Kerala (CHIAK). It prescribes that the beneficiary of RSBYCHIS must be a member of a Kudumbasree group. They will issue a multipurpose smart card. The card contains the personal details of the members of the family which are included
in the scheme. Only five members in a family are included in the card. Like the central scheme, the RSBYCHIS also has the value of an insurance coverage up to Rs. 30,000. If the head of the family dies, the insurance company will give Rs. 25,000 to the survivors. There is a list of employees like Public Relation officer, District Manager and Field officers who are responsible for enrolling the families and marketing the insurance scheme. A field officer is eligible to get Rs 2 per card and District manager will get Rs. 1000 for the first three months. The card can be utilized for the services available in private sector as well. The hospitals empanelled as part of PPP are the private hospitals that are bounded to accept the smart cards. The important thing is that, hereafter, those who are BPL should also pay for the services they are getting from the public institutions. The family can spend the insurance amount either for the treatment of one among the members, or more. But they must pay the amount exceeding the limit. There is provision for bifurcating the money among the members as well. During each visit, the insured person should produce the card in the hospital where he/she is seeking service, whether it is a government or empanelled private hospital. The hospital will deduct an amount from the smart card given according the rate fixed for the service already by the health delivery institution. This includes, doctor fees, laboratory expenses, and other employees’ charges. All the rates are prefixed and it varies from the nature of sickness and service required. The consequence of this is that the free services that the BPL people are getting now in public health care institution and becoming paid services. People are asked to pay and receive service. Now the insurance company would give money but only up to a limit. Those who want more support need to pay higher premium. Or they must spend once again out of their own pockets.
NRHM states that the objective of introducing insurance smart card is for resource levelling. By resource leveling, they mean paying more money to the institution that serves more. That is, if a CHC or PHC is treating more patients or giving more services, it will receive more income for the institutional level development and this will go to the hospital management committees. Moreover, I suspect this may even be used as a criterion in the future to provide incentives as in the case of ASHA. The incentive will prompt employees to work more. Apart from this, NRHM-insurance envisages that if an institution is getting more patients, that institution will get more share of the funds. PHCs and CHCs are now receiving an annual grant under the uniformal resource distribution system. Thus, the NRHM-prescribed insurance scheme will ensure more resources to those institutions that are capable of attracting more patients. That is, a government institution and its employees, irrespective of doctors or class four employees, must work under the market logic of making profit and receiving performance incentives. That is, competition is the underlying logic for ‘improving’ the health sector, which I would argue is a market oriented management strategy. Such an approach would change the existing medical ethics of serving people efficiently to competing on the body and health of the people, where human well being has tertiary importance. The NRHM equates the delivery of quality health with the quantity of the money paid. Of course, the money might bring quality consumption, but not necessarily quality health. The money paid and putting the sick on machineries might give some symbolic satisfaction; whether that really would bring quality health is yet to be proven.

The paradox of the NRHM is that it identifies economy as the problem which, at the same time, assumes that the economy and economic structure will alleviate the disparity that the economy has constituted. The Insurance scheme
prescribed by the NRHM tells the people that the primary condition to get quality health service is money and if they do not have it, they must start saving or invest in insurance. The insured amount now is Rs. 30,000. If they want more, they must insure themselves. Else the value of a person living under BPL will be less than Rs. 30,000. Though NRHM is targeting now the BPL, ultimately it is asking the whole population to get some kind of insurance coverage, thus giving the wide and yet untapped insurance market to the newly-burgeoning insurance companies. That is, if critically look at the catch word of the NRHM that it is introduced to provide quality health services and then will become a slogan to attract people to the ‘undefined health’ services that they prescribe, especially insurance. By quality health, NRHM means accessibility of the poor to high technology medical care. That is, by quality, they mean new technologies. I would argue that the introduction of new regulation and technologies will not bring quality health, neither the increased spending.

To sum up this chapter, I have discussed at length the NRHM and its Kerala brand (Arogyakeralam) together to give a picture on where the present health policy' is heading to. Like all other previous policies, NRHM and Arogyakeralam have been introduced stating that there is limitation in the existing health policies and the new aim is to give more facilities to the people and increase the standard of health services. Our critical reading of the policies and exposure of the assumptions on which they are built reveal that NRHM/Arogyakeralam in a short period will change the whole health delivery system. There will not be any public service and it will be ruled by the interests of the private sector. The architectural corrections, PPP and insurance are directed towards that end, though it is not explicitly stated so. Interestingly, NRHM/Arogyakeralam is being promoted stating that it is a
new way of development and that infrastructure building with the name of achieving IPHS, PPP and insurance are the means towards that end. These are some of the discussions made in the academic, legislative and popular magazines. This means that the priorities articulated through legislative discourses or academic discourses are very much reproduced through practices of health service system now implemented called NRHM/Arogyakeralam.152

In the previous chapters, we have seen the notions of health articulated through legislative discourses, popular discourses and academic discourses. Though apparently they may look different, they supplement each other. For instance, popular magazines propagate ideal notions of health which are often articulated as ideal body, ideal organs, ideal personalities and produce an image that 'health' can be consumed through the modern medical market, gymnasiums, fitness programme centres and changes in life style. Meanwhile, the legislative body considers healthy citizens or healthy populations as

152 NRHM has been criticized by various scholars by stating various reasons. Some of them I will mention here. K. R. Nayar argues that though NRHM stands for a “cost-effective interventions, such as the rational distribution of medical and financial resources, should be part of the vision but they are often brushed aside in favour of the privatization logic”. He also add that NRHM is a strategy to please all and “the influence of the World Bank and accompanying reforms during the post structural adjustment period, apart form the pliability of the ruling classes” in its making can not be ruled out. Imrana Quadeer argues that “NRHM is merely a conglomeration of some existing schemes and programs, apart from ASHA there is hardly any new initiative” and she is suspicious on the consequences of the private public participation. To quote: “...The recent policy initiatives are full of empty rhetoric and lack concrete policy directions to develop a working well functioning public health system in place. It is also clear that the over all direction of these policies is to promote a private based health care system, knowing well the fallacies of the private health care and their inability to cater to the needs of the vulnerable section. It is also unfortunate that the multinational have enormous influence on the domestic policies and the government is totally unwilling to do anything which can be detrimental to their business. Unless there is a major shift in the attitude of the government towards the needs of the majority of the population universal access to public health services and essential medicine will remain a far cry”. Debabar Banerji argues that the whole NRHM is built up on a 'lack of evidence base'.
always an output of an ordered health service system and the governments responsibility is to order the health service system by all means. This implicit understanding of what health is, quite evident from the state health policies in the contemporary period. It is quite surprising that academic discourses have sidelined any empirical interrogations of the axiom that health service system produce health and reiterated the empirically-disproven axiom (refer chapter 3). It is observed that in the post 1990s, academic discourses on health are dominated by the framework of political economy where a well-ordered health service system and the ordering of the health service system in the context of financial constraints of the state became the discussion without questioning the truth claim of academic or legislative discourses. In short, these discourses created conditions for certain interventions of corporate agents in the field of health in the name of health sector reforms. Thus, it is observed that various external developmental agencies like World Bank, Asian Development Bank, NGOs and QUANGOs\textsuperscript{153} are creating their own space to intervene in the field of health which is otherwise a State responsibility. I would argue that in the contemporary era, the intervention of these corporate agencies in the field of health sector development should be seen as transformation of the State itself as an instrument of corporate agencies. This means that the social effect of these discourses is more dangerous.

We have already seen that both the academic discourses and legislative discourses reiterate the role of health service system in producing healthy citizens and development of health services itself is seen as a sign of

\textsuperscript{153} QUANGO refers to quasi non governmental organization with public funding. "Quango" is the colloquial, but better-known designation for "non-departmental public body" which collectively encompasses many roles and performs many functions in all areas and on behalf of the government. For more details refer http://quangos.ercouncil.org/.
development. In practise as well, the government is allocating its resources for the development of health services under the same assumption and the priority is always on the development of health service system or its 'modernization'. However, the attempts to modernize, renovate, standardize or technologise the health service system through various programmes and projects is neither to improve the health of citizens or the 'population' rather than they are meant to strengthen the health service system as well as the States economy. The policies of democratic decentralization or privatization or co-operativization should be seen as part of transformations or transmutation of the State in the current historical moment and I would argue that State is becoming a corporate State which means State has become an instrument of corporate agencies.