CHAPTER V

LEGISLATIVE (DIS)ORDERING OF HEALTH:

HEALTH DISCOURSES IN THE KERALA LEGISLATIVE ASSEMBLY

This chapter is an excurse into the Kerala Legislative Assembly proceedings to understand how its elected representatives, whether leftists or rightists, discourse on health and what emerges out of these discourses and whether it has any similarity to the discussions happening in other fields. By Assembly Proceedings, I do not mean doing an ethnographic observation of the practice of the elected members to the Kerala Legislative Assembly. Instead, it is a reading of the compiled discussions and debates in the Assembly which were recorded and made available in various forms of documents such as Questions and Answers, Submissions, Call for Attention, Bills, Assurance Committee Reports, Subject Committee Reports and various other Governmental Reports published occasionally. However, in this chapter, I will examine only the documents belonging to the last two decades (i.e., in the post 1990s). This period has been concentrated considering mainly two factors: first, it coincides with the period when not only scholars but also various national governments and international organizations articulated the view that neo-liberal economic policies are fundamental to the overall development of a state; second, it is also the period when decentralized People's Planning was implemented in Kerala with the explicit intention of resisting the
expansion of the neo-liberal economic exploitation or as exhibiting a 'third way' for ensuring development of the people.\textsuperscript{110}

While reading the discussions on health in the Legislative Assembly for the said period, one quickly encounters the strong underlying assumption they (the representatives or regional elites) hold that it is health paraphernalia\textsuperscript{111} that determines the health of the people. Here, health paraphernalia, in terms of assembling together institutional structures that includes super-specialty hospitals, ultra-modern equipments (both diagnostic and curatory equipments), specialized technicians (personnel including specialist doctors and super specialists, trained workers for specific diseases, technicians to handle machines and so on), are considered as major health priorities and systemic requirements which supersede human beings. If the vertical expansion of the institutional structures was the emphasis of the State in the pre-1990 period, the horizontal expansion supplemented it in the post-1990s.

The legislative discourses converge on the notion that the health indices of the state could be improved only through institutional, technological, and professional interventions. All of them are discursively constituted as 'services'. But such interventions in the name of service are not simply 'services' in the sense 'to serve' the people, rather these services are discursive strategies of governmentality. It is in this context that I examine the nature of

\textsuperscript{110} 'Third way' is the concept developed by Antony Giddens by which he visualizes a need for a third way in between two antagonistic perceptions of development. He argues that the Third Way is the need to move away from a sterile debate between left and right — between those who favour either the State or the free market doing everything. Instead, he is looking towards a new form of political philosophy that focuses on adapting economies and societies to the demands and pressures of globalization. See also D. Mario Nuti, 'Making Sense of the Third Way', \textit{Business Strategy Review}, Volume 10, Issue 3, 1999, 57-67.

\textsuperscript{111} By health paraphernalia I mean the institutional and human resources, as well as physical resources such as buildings that are related to assembling an infrastructure for dispensing health. The dominant discourse on health believes that such infrastructure will bring good health to the people.
the legislative discourses on health and extricate the generative logic from which these policies and priorities of health have emerged.

For the convenience of analysis, I have divided the chapter into two major sub-sections. The first section looks into the health priorities emerging in the discussions that occur in the Legislative Assembly and the second section examines some of the major policy discussions that are projected as essential prerequisites for the development of a health service system in Kerala.

I

Legislative Priorities

In this section, I will explore the legislative priorities of health and its generative logic. In chapter two, we have seen that it is the metaphor of 'modernization' and 'progress' guided policy makers of the colonial period while taking decisions to introduce new health facilities in Kerala. In the discussion on academic literature, I have mentioned that the metaphor of 'development' has been utilized in legitimizing the argument for capitalist and market-oriented health policies. Interestingly, the moving spirit in the Assembly proceedings too is nothing if not the metaphor of 'development', whether it belongs to the period of rightist or leftist governments. All of them were intensively discoursing on institutionalization, mechanization, capitalization of health in the name of development and modernization of society. These discourses, by and large, are restricted to a discussion on increasing the health care delivery mechanisms and not introducing measures to improve the overall wellbeing of the people. This priority is fixed and advocated on the assumption that once systemic requirements are built, it will automatically produce healthy citizens. However some of the disturbing
trends within the development of health service system since 1990 indicate otherwise. An analysis of the same from the point of view of critical social sciences is a desideratum.

Development of the Health Service System

The legislative discussions on health in the post-1990s emerge from the assumption that healthy citizens could be produced by increasing institutional structures and infrastructural facilities such as the number of beds and medical equipments; services of medical experts like doctors, nurses and paramedical staff; other paraphernalia like the number of medical stores, physiotherapic units, drugs and vaccines; and administrative staff in proportion to the vertical and horizontal expansion of institutional structures. Legislative interventions in the health sector are prioritized depending on this assumption. In the preceding chapter, we have already seen how the academic writings on health constructed and disseminated health realities in terms of certain indicators. The Legislative Assembly, accepting such academic knowledge as truth, has uncritically engaged in the selective propagation of the same through various health policies/programmes/projects with the belief that these measures are not only inseparable from producing healthy subjects, but also essential to reckon a State as developed.

Now let us discuss in detail the priorities within health service development. As mentioned earlier, Assembly proceedings roll on the notion that the health of the people can be improved through horizontal and vertical expansion of institutional structures (i.e. hospitals and its auxiliaries). Building village sub-centres is part of the increasing health paraphernalia. But, it is quite surprising to note that, the rationale for building up new institutional structures like health sub-centres in the village are not even intended to provide care for the
people, but to fulfill the criteria for accepting funding and to adhere to external guidelines tied to accepting fiscal help. For instance, the Minister for Health for the 8th Kerala Legislative Assembly i.e. during 1990’s responds to a question of one of its members in the following way. I quote both the question and the answer.

Sri. R. Unnikrishnapillai [Member of Legislative Assembly]: Sir, we already have more than one sub-centers in a village. Still new centre are constructed in the same villages. But these institutions are functioning solely as an information centres for mothers and children and not as a centre providing primary care extended by doctors. Therefore, will the government take necessary steps to make sure that the doctors visit these sub-centres and provide basic treatment facilities at least once in a week?

Sri. A.C. Shanmughadas [Minister for Health]: Sir, these sub-centres are introduced as part of the National Health Policy and they suggest that we must construct a sub-centre for every 2000-5000 people. Therefore, one Panchayat may have more than three or four sub-centres depending on the population. Accordingly, we have sanctioned 720 sub-centers in the last financial year... We do not have plans to upgrade these sub-centres as treatment units.\textsuperscript{112}

If the question of the Member of Legislative Assembly contains anxiety on wasting a facility without adequate staffing and utilization, the Minister does not feel any problem in that. The latter defends his stand by stating that the State must establish such sub-centres if it wants the support of the Central Government no matter whether Kerala requires it or not. The otherwise advanced health facilities available in Kerala are often overlooked by the Central Government while charting policies for the entire nation. Since health falls in the State list, there is ample room for the State to look into the suggested policies. Here, whether there is merit or not, the Government decides to follow what is suggested by the Central Government, despite being clearly aware of its inapplicability in Kerala. Furthermore, the Legislative

\textsuperscript{112} Proceedings of 8th Kerala Legislative Assembly, 11th Session, June 25, 1990
Assembly does not attempt to find linkages between the health problems people face and the health services available. The State often established new hospitals or dispensaries on the basis of the population in a locality, the number of the health service institutions available there and economic or social underdevelopment of the area, and not on the real requirements of the people. Illustrative statements are available in the Legislative Proceedings on the criteria for establishing new institutions and often such statements substantiate the assumption that such institutional developments will ultimately improve the health of the people.

In the early 1990s, the discussion on establishing new Medical Colleges appeared in the Assembly. But interestingly, also in this case, it was the flow of capital and its accumulation rather than the attempt to get cheap and good medical services for the needy that was the motivating factor. To substantiate this, I quote at length a discussion that occurred in the 8th Assembly where members and ministers considered the pros and cons for establishing a new Medical College:

K.C. Joseph [Member of Legislative Assembly hereafter abbreviated as MLA]: Sir, I would like to know whether the government could start new medical colleges in Kannur district, given the fact that the number of seats in medical colleges in Kerala is insufficient to meet the needs of the medical aspirants in Kerala and they are forced to spend lakhs of rupees to study medicine outside Kerala state?

R. Ramachandran Nair (Minister for Health): Sir, yes, it is a fact that the number of medical seats in Kerala is limited. But it will be difficult for the government to start medical colleges given the present fiscal status...

O. Bharathan [MLA]: Sir, given the fiscal constraints of the government and the necessity of Medical College in the northern part of Kerala, will

113 Question raised by Ishaq Gurukkal on criteria for sanctioning new hospitals and dispensaries. Proceedings of 8th Kerala Legislative Assembly, 12th session, 17th December, 1990.
the government think of starting a medical college under the co-operative sector in Kannur district?

R. Ramachandran Nair: Sir, establishing a medical college under the co-operative sector should be presented to the Minister for Co-operatives.

M.V. Ragahavan [Minister for Cooperatives]: Sir, the government will discuss the matter with the co-operative units and think about it since it is good to have a medical college under the cooperative sector.

K Muhammaddali [MLA.]: Sir, given the fiscal constraints of the state and the flow of lakhs of rupees from the students from Kerala state to the nearby States in the form of capitation fee for medical seats, can the government think of starting a medical college in Ernakulam district either under cooperative sector or under any other sectors other than public?

R. Ramachandran Nair [Minister for Health]: Sir, this suggestion will be considered when we start a new medical college in Kerala next time.114

The flow of money in the name of capitation fee to a few private medical colleges in the neighboring states prompted one member to bring the question of establishing a new medical college in Kannur district. Interestingly, there was no demand or collective effort from the people of Kannur to establish a new medical college there. So, putting such a demand on the basis of the outflow of money from the state has certain other connotative intentions. To understand the full implication, we need to look into the second part of the discussion as well, where we could see the health minister’s statement that the Kerala government does not have the financial ability to establish a new medical college and establishing the same in the cooperative sector can be considered. I would read this as the first step towards arguing for allowing private capital to establish a medical college, and this had happened within a decade itself (this aspect we will discuss in the latter part of the chapter). So, the anxiety of Mr. K.C. Joseph, MLA, was not so much on the outflow of

money, but rather a means to make the argument in favour of establishing privately owned medical colleges in Kerala. Thus this discussion propagates the impression that preventing the outflow of money is more important than the wellbeing of the people.

Along with the vertical expansion of institutional structures, the upgradation of the existing institutional facilities was a major priority of the government throughout the 1990s. Approximately 97% of the Submissions in the Assembly of this period were requests for additional building constructions or for upgrading of existing facilities, whether it is for medical colleges or village sub-centres. Suggestions from the Pai Committee Report, submitted to the government as far back as 1979, have been used as a strategic tool for rationalizing such demands for upgradation. Since the Legislative Assembly considered the Pai Committee Report as a vital document for health development and its recommendations have been repeatedly quoted by MLAs as a basis for their demands for enhanced institutional and infrastructure facilities in the health sector in their respective constituencies, it is important to look into the reason for setting up such a Committee.

The Pai Committee was appointed to conduct a study and provide rational suggestions regarding health services in the state. It was asked to,

'identify deficiencies with respect to the accommodation of medical and paramedical personnel with a view to their rational utilization and to suggest solutions to overcome present deficiencies; to arrange for rational distribution of medicines in the different institutions with a view to making available at least the essential drugs in those institutions throughout the year; to examine the adequacy of essential diagnostic

115 The government of Kerala as per GO. Rt. 3750/77/HD. dated 8-11-1977 constituted a high power committee under Dr. K.N. Pai to review the working of hospital system under the Health Services Department and suggest measures for the rational development of health services in the state.
facilities and to ascertain the extent of unused capacity with respect to existing equipments and services with a view to identifying the causes and suggest remedies; to examine the desirability of creating a centralized biomedical equipment, repair and servicing unit with the existing expertise in electronics and medical services in Kerala so that the available equipments and machines can be maintained with optimum efficiency'.

The suggestion made by the Pai Committee which was appointed to enquire into such specific matters has often been indiscriminately appropriated to demand for some ‘development’ in one’s constituency. The report has with time become a gauge for demands to upgrade health facilities irrespective of whether they address a real requirement of the people.

But more important is the fact that the Pai Committee Report is an exemplar of the domination of the language of economics and economic rationality by the logic of the market. In such a discourse, ‘people’ and their ‘health’ are secondary and the systematization or ordering of institutional facilities emerges as the primary determinant. Therefore, despite being a report that attempts to make people healthy, one finds little discussion on people becoming sick in this report. Instead, there is a repeated emphasis on making the ‘health service system’ more systematic by defining it in terms of precise metrics such as one doctor for every three beds; one nurse for every six beds; one midwife for every 800 maternity cases; one pharmacist for every 70 beds; and one clerk for every 50 bedded hospital.

It is surprising to note that even during Question Hour Sessions in the Assembly117, we see negotiations on which constituency should get more health service institutions and more infrastructural facilities. There was no

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117 Probably the most crucial platform where members can fruitfully use this time to question and debate on any governmental programmes.
debate on the very usefulness of the implementation of current programmes or on the political implication of ongoing health policies. Members repeatedly ask for more allotment of infrastructural facilities in their respective constituencies since the hegemonic discourse is construed so that a higher number of such facilities is indexed with a more advanced level of development. Perhaps the repeated references to the Pai Committee Report in Assembly debates too must be read from this perspective. Questions like “How many recommendations of the Dr. Pai Committee Report are pending implementation?”; “Are there any recommendations to remove public health doctors from administrative responsibilities?” elicit responses like “The government has yet to start a workshop to repair the machines and equipments with the support of the Keltron Ltd.;” “We have not introduced intermediary hospitals in between the primary health centres and district hospitals;” “We need to create posts according to the number of beds in the hospitals” which point towards the submissive attitude of members towards the dominant discourse on health.\textsuperscript{118} Such reports, I argue, reveal the dovetailing between the academic discourses and the discourses happening in the Assembly. In the absence of written state health policy documents in the 1980s and 1990s, reports like the Pai Committee Report and subject committee reports acquire the status of policy documents and function as guidelines for the government.

The Kerala Legislative Assembly also witnessed a series of discussions on implementing projects funded by international agencies like WHO, UNICEF, Asian Development Bank and the World Bank. The preference for such projects is justified by recommendations of various committee reports on how to improve health service system vertically and horizontally. As an

\textsuperscript{118} Proceedings of 8\textsuperscript{th} Kerala Legislative Assembly, 11\textsuperscript{th} session, June 25, 1990.
illustration, here I present a query into the implementation of the India Population Project (funded by World Bank), an externally funded programme. I quote:

Sri V Dinakaran [MLA]: Sir, what are the advantages of IPP project? Where all did government implement this project?

Sri. A C Shanmughadas [Minister for Health]: Sir, this project is implemented in Palakkad, Idukki, Malappuram, and Wayanad districts of Kerala. The major advantages of this project are that it will increase the couple protection rate from 17% to 50%; deliveries taken by trained staff will increase from 30% to 90%; raise the number of children who are protected with preventive measures from 10% to 75%; child mortality rate could be reduced from 70/1000 to 28/1000... Moreover infrastructure facilities are increased as part of the project like starting of 768 sub-centres, 82 subsidiary health centres and community hall affiliated to 28 PHCs, wards and operation theatres for 11 taluk hospitals.\footnote{Proceedings of eighth Kerala Legislative Assembly, 11th session, 4th June 1990 & Proceedings of eighth Kerala Legislative Assembly, 12th session, December 27, 1990}

Systemic priorities are often recognized and presented as the signs of development. Horizontal expansion is manifested in terms of improvement in the status of existing institutional structures. Hence, expansion of the existing facilities by either adding new sections like starting up super-specialty wings in all medical colleges in the ownership of government or on a partnership basis or complete private basis; or conversion of medical college into a referral hospital;\footnote{Proceedings of the ninth Kerala Legislative Assembly, fourth Session, July 28th, 1992, Government of Kerala.} or conversion of primary health centres into Community Health Centres, dominate the discussion. Discussions on the consequence of accepting external funding and the possible negative impact arising from promoting the intrusion of private capital into a basic service like health are often undermined by the discussion centering on improving the tangible
indicators of development like buildings and machinery.121 Though the government apparently claims that the suggestions of scientific experts form the basis for having such priorities, it is quite evident that getting funds is most often the basis of selection of projects and drafting policies. Uncommon voices in the Assembly asking for human care provision (rather than technological care) for the sick appear to have been sidelined. It is not the wellbeing of the sufferer that matters in the discourse of health in the assembly but the rules governing the discourse. For example, a member of the 8th Kerala Assembly put a submission detailing the importance of appointing Leprosy Health Visitors (LHV) to give human care to the affected. The member said that although there are facilities to appoint the LHV, they are not appointed, instead family welfare workers have been given the additional charge of looking after the matters of leprosy patients. The member urged the Minister to look seriously into the matter and meet the demand of the people. But the reply given by the Minister for Health is revealing. He said that to care for leprosy patients, a multi-drug therapy has been implemented in five districts of Kerala using the fund allotted by the Government of India. He added that, the Central Ministry has instructed us to implement the modified multi drug therapy using the service of the family planning health workers and not leprosy health workers. Since we don’t want to lose the project and its (financial) benefits we implemented it accordingly.122 What we can learn from such statements is that neither ‘care’ nor ‘cure’ matters for the government, but what is of primary concern is to blindly follow the conditionalities set by external agents in order to access the huge package of infrastructure

121 Question raised by Sri T. Padmanabhan on actions taken for upgradation of primary health centres into community health centres. Refer Proceedings of the Eighth Kerala Legislative Assembly, thirteenth Session, March 7, 1991, Government of Kerala
development funds. These funds are often meant to implement various (experimental) health projects, but conceal their real political intention by introducing them in the name of health sector reforms.

If institutional upgrading and buying machines and equipments were the key priorities within the health sector during 1990s, creating speciality-care and superspeciality care and technologizing through information technology have become the key indicators of development in the Assembly discourses during 2000. This is very evident in the discussions on the 'Health Sector Reform Programmes'. For instance, in response to a question on the reform of health sector raised by a Prof A D Mustaffa and others, the Health Minister (P Shankaran) replied that 'the government has decided to start cardiology, nephrology and psychiatry specialty sections in all district hospitals; opening up of dental clinics and purchase of machines/equipments; open private hospitals/wards in the government hospital premises; renovate secondary and tertiary level institutions through health secondary system project of World Bank; receive approval to start 18 super speciality courses, and also receive sanction to create new super specialty posts as part of the reform programme'.

Like the academic discourses and the popular discourses, the discourses in the Kerala Legislative Assembly also construes the introduction of advanced medical technology, especially diagnostic technology as imperative to bring good health. It incorporates measures to diagnosing the sick as well as the healthy population on an 'equitable' basis. For example, a separate 'sickle cell' disease control programme was started at the Calicut Medical College for the treatment of sickle-cell patients. The programme is intended to identify the

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infected by diagnosing all tribal population under the assumption that sickle-cell anemia is a hereditary disease, an assumption that has been questioned by other scholars.\(^{124}\) If infected, it would direct them for treatment by educating them about the disease, discourage marriages between the infected, conduct counselling, reduce infant mortality rate by identifying the infected below 2 years, etc. The project will end by 2010 and the fund allotted was Rupees 39.29 lakhs.\(^{125}\) The above decision clearly substantiates that rather than caring or curing the sick, diagnosing sickness in the population has emerged as a major preoccupation for the health sector in Kerala. In other words it is those equipments that enables the categorization of people as ‘sick’, that are crucial for the government rather than ‘care’ or ‘cure’.

But relation between more emphasis on diagnosing and curatory practice too is interesting to note. I quote a discussion from the Assembly proceedings:

Thomas Chazhikkadan (MLA): Sir, I would like to know whether the government has noticed that medical equipments costing crores of rupees are remaining idle in many government hospitals? Can we start a package programme to repair all this? Can we conduct a survey and estimate how many equipments are lying idle?

R. Ramachandran Nair [Minister for Health]: Yes we have noticed this and found that many such equipments are lying idle and in disrepair in medical colleges as well. We have a plan to repair them by forming committees within the particular institutional structure that includes experts as well. We can think about doing a survey and make an estimate of such equipments.\(^{126}\)

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\(^{124}\) Devika J & A K Rajasree (2008), Health, Democracy and Sickle-cell Anaemia in Kerala, Economic and Political Weekly, November 8,p.25-29

\(^{125}\) The project was initially proposed till 2000 and the fund allotted was Rupees 39.29 lakhs. Proceedings of the tenth, Kerala Legislative Assembly, eighth Session, 23\textsuperscript{rd} July, 1998, Government of Kerala.

It is quite important to notice that, later, Alliance for health policy and systems research, an initiative of the global forum for health research in collaboration with the WHO, Geneva funded for the study on 'ideal capacity in resource strapped in Kerala. This study is carried out by Achutha Menon Research for Health Science studies and department of health and family welfare, government of Kerala. More interestingly, the study claims, using 'efficiency radar' they found out that 59.3% of land, 53.2% of the building space and 40.1% of the rooms remained idle. It concludes that,

'There exists a large untapped potential of major hospitals inputs such as land, building space, beds and manpower among the government hospitals in Kerala. The untapped potential varies between 12.3% for doctors, 23.3% for nurses, 25.75 for beds, 53.25 for building space and 59.3% for land...the reasons for the existence of idle capacity were identified as unfavorable bed-doctor and bed-nurse ratios, undesirable access characteristics such as poor facility hours, insufficient funds for maintenance, inadequate and inappropriate utilization of staff especially the specialists and technically skilled staff (D. Varatharajan, 2002, p.45).

Simultaneously it is observed that legislative body is interested in documenting the unused machines in hospitals of their own respective constituencies. Thus it is observed that academic researches also added sanctity to the legislative priorities.

It is significant to notice that the government on the one hand moves with the assumption that machine cures, but a major complaint in the assembly is for curing the machines. In the case quoted above, the machine is even occupying the space for the sick. Of course, this need not be the case all the time. Yet

127 D Varatharajan et al, 2002, Idle capacity in Resource strapped in government hospitals in Kerala size, distribution and determining factors, AMCHSS, Sree Chitra Thirunal Institute of Medical Science and Technology, Kerala.

128 For instance T.P.M. Sahir raised the question that whether government had noticed 8 rooms in Calicut medical college are occupied by unused machines. Then the health minister P Shankaran, agreed to make an estimate of the idle machines/equipments and how long it is remaining idle by appointing a committee. Proceedings of the Eleventh Kerala Legislative Assembly, fourth Session, July 9th, 2002, Government of Kerala.
another dimension of the technologization of the medical system is the rising volumes of hospital wastes due to the enormous use of ‘disposables’ introduced in the name of ‘safe diagnosis’. Therefore, recently the Legislative Assembly considered the problem of waste management as a problem in itself and also the reason for creating a new kind of sickness. But the law-making body is not ready to take the responsibility for creating such a condition. Instead, this burden is shifted onto lower tier governments like the Panchayat Raj institutions. Accordingly, waste management is a responsibility of PRIs (Panchayati Raj institutions at various levels) and hospital waste management is the responsibility of the health department functioning under the State Government also. However, the solution to hospital waste management was the introduction of eleven incinerators. These incinerators were purchased exclusively for government hospitals with which they can burn the waste created in the hospitals.129 In the second half of the present decade, some of the discussions in the Assembly brought in the issue of sickness created by the hospital waste. Thus, circularity is encountered. First, they discoursed on introducing diagnostic technologies ignoring the known consequence of disposing its waste, and then they debated on the hospital waste management that these very (post)modern technologies of diagnosing continuously create, and finally they begin discoursing on the sickness created by the new hospital (technological) wastes. We know that, it is through enacting laws that the usages of disposables are made compulsory and now they are discoursing on introducing waste management programmes funded by international funding organizations fearing that they will create new sick bodies.

Discussions on the necessity to introduce tele-medicine begin, in a sense, with arguments like the following— "modern machines are very much required in the modern period and therefore the government must make modern machines available." Tele-medicine is demanded for not because it improve the quality of human life, but its because availability will lift the state at par with neighbouring states who have already acquired these facilities, it also result in further upgrading of taluk and primary health centres since it demands the integration of all medical colleges through computerization; upgrading of taluk and primary health centres with the help of information technology, and finally, such a (post)modernization programme will result in the flow of foreign funds to the state (often for experimenting with new things?). I quote below the Minister for Health's reply to a member who was anxious that the laxity with regards to introducing tele-medicine could risk categorizing the state as backward.

Sir, the government is seriously planning to implement a tele-medicine system in Kerala. The government is planning to use IT mainly for health education campaigns and for medical treatment. In order to keep DHS (Directorate of Health Services) as a planning and monitoring cell and the basic infrastructure, government has allotted almost 40 lakhs so far; another 30 lakhs is earmarked for integrating Medical Colleges, Dental Colleges and Nursing Colleges through information technology. In the above-mentioned system, medical colleges will be the tele-referral centres. The district and taluk level hospitals and other health centres will function as the remote tele-consultation centres. The Government has already implemented a pilot project by keeping Thiruvananthapuram Medical College as the tele-referral centre and Mangalapuram, Vizhinjam and Vellarada PHCs [Primary Health Centres] as its remote tele-consultation centres.


131 I quote the query of Sri. K C Venugopal [MLA] here. 'Sir, I would like to know whether the government has noticed that when comparing with neighboring states, we have failed to utilize the latest information technology for the development of health services. In order to implement tele-medicine systems, the government should seek more foreign funding.'

To sum up, my intention in analyzing the Assembly discourses on the technologization of diagnosing is neither to refute the value of the medical technology nor to belittle the positive aspects of medical science. Instead, I have been trying to expose the dangers involved in concentrating on the production and accumulation of medical technology. Care and cure are only buzzwords for introducing new technologies. Often technologies remain as ‘effective diagnostic’ tools and not care and cure tools. Furthermore, most of the time, such policies and programmes are implemented without looking at the interests, demands, and needs of the people and instead follow the instructions of the funding agencies ranging from the Central Government (which designs uniform programmes for all state, neglecting the specific social and political conditions in each state) to such international funding agencies as pharmaceutical companies and machine and tool manufacturing companies.

Health as an Employment Generation Sector

Making health institutions an employment-generating machine and not a care-generating machine is yet another dimension of the legislative discourse. Almost 95% of the unstarred questions in the question hour session of the Legislative Assembly are related to either appointing medical staff in rural health service institutions or their transfer from one location to another. Discussions on providing employment for the fresh medical graduates, most often on contract basis, is also quite prevalent. An excurse on the legislative discourses of the post-1990s would reveal that often health project and programmes are implemented on the demands and interests of various funding agencies and for employing trained medical staff on short-term basis. The latter is an emerging demand that the Legislative Assembly must be concerned about since it is with its sanction that private medical colleges
began to functioning. They must be accommodated in some place, which, in turn, gives private capital the opportunity to advertise the guaranteed employment for those successfully completing their studies.

It is observed that almost 50% of the unstarred questions are related to the shortage of doctors in rural areas especially in primary health centres and the shortage of specialists in secondary-level institutions. Even though the shortage of government doctors is often projected as major factor for health crisis during late 1990’s, the decision of the legislative assembly to send government doctors to private hospitals on deputation basis seems to be quite suspicious. Nayar has noted that Cooperative Medical Services grew in Kerala that was started with the goal of absorbing unemployed medical graduates due to indo -Pakistan war. Paradoxically, now, the increased absorption of unemployed graduates comes at a time when cooperative medical services are declining. If there are any institutions working as cooperatives, they have largely reoriented their outlook from the cooperative logic to a corporate logic. The increasing number of medical students produced are now seeking refuge in the mushrooming private hospitals in the state which often function with little consideration for medical ethics.

In spite of this, it is observed that the nature of employment in the government sector is undergoing major changes. The nature of employment created during the post 1990s is very critical, especially when one examines


the security of these employments. The state has almost stopped appointing permanent employees. They now prefer only contract employment, employing giving a consolidated pay, and employment on daily wage basis. In addition to that, expert doctors in the government sector are deputed to private sector hospitals as part of public-private partnership agreements. I read this as analogous to the changed attitude towards labour created in the post 1990 neoliberal economic logic. In the last two decades, a whole lot of projects have come up in the name of health sector reforms, including the Health Secondary System Project, Modernizing Government Programme and National Rural Health Mission. All these encourage appointing doctors on a contract basis (and not on a regular basis) irrespective of whether they belong to the specialist cadre. This could be seen in all the policies mentioned above and all of them are externally funded. For example, the Modernizing Government Programme was a programme executed with aid from the Asian Development Bank.\(^\text{135}\) The declaration in the Assembly regarding appointment of doctors on a contract basis should not be read merely as a result of the shortage of doctors or as a consequence of the disinterest of doctors to work in the government sector in rural areas due to the lack of facilities there. Rather, they are part of the changing attitude towards life and state policies. This kind of complaints from doctors working in the government sector, to work in rural areas was far less in the pre-1980s. Towards the mid-1980s there began a change in attitude towards working in government hospitals and serving in the countryside. The neoliberalism-constituted cultural consciousness on the one hand and the changing state policy of withdrawing from any overarching responsibility towards social security measures should be read side-by-side to

understand the politics of these discussions. That is, the entire discussion centered on the non-availability of doctors to serve in rural area should be read as an indicator of the shifting mentality and the state's despair in controlling them.

In short, my perusal through the assembly proceedings reveals that the major discussion in the law-making body in the last two decades embodies demands for more hospitals, machineries and specialists. By the second half of the 1990's onwards, unhygienic conditions in hospitals due to improper waste management; inadequate diagnostic facilities for specialized and super specialty treatments; lack of services by specialized and super specialized professionals in the field; deficiency in developing new specialities at par with advancement in medical science research are the major problems identified by the Legislative Assembly as major drawbacks regarding the development of health services. But institutional structures, technology and medical professionalization based on super specialties, I argue, are derivatives of the uncritical acceptance of the notion that development in terms of apparatuses like infrastructure will lead to the creation of a healthy society. The Legislative Assembly proceeds by uncritically accepting the notion that the condition of sickness is a 'fact' and it is 'biological' and society can formulate no other response than to leave its cure to technology. It also imbibes the notion that 'the sick' have to be confined in a hospital and should be treated with machines. In short, it tacitly conceives human beings as machines in the fashion that machines can be corrected and ordered in a workshop, so also human beings as machines can be corrected in 'super specialty' modern hospitals (or human workshops). It is quite interesting to notice that the health of the people is often used as a metaphor for employment creation, investment
in new technology, investment in expertise knowledge and so on. I argue that these are the visible effects of the implementation of the neoliberal Utopia.

Furthermore, like the discourses emerging in other fields, the Legislative Assembly also discursively constructs that the health of the people is in the hands of modern market, especially the market for medical technology and medical science in general. Thus, the major health priorities of Legislative Assembly became 'healing' of health care equipments and thereby strengthening of the economy through the influx of private and foreign capital. The concerns and preferences that surface here demonstrate the mentality of the governed and not of the governing. These preferences and choices have been mobilized and shaped by various technologies of power. An effect of this discursive construction is that it conditions room for the state to withdraw from social welfare, and created a condition for privatizing and economizing health sector by legitimizing and employing the market language of 'rationality' and 'efficiency'.

136 It is astounding when we notice that these apparatuses, sciences and technologies are globally integrated in markets and any direct intervention of the State in a different sort is consciously discredited in advance and thus condemned to destroy itself for the benefit of 'market'. By their very nature, markets are indiscriminate, promiscuous and inclined to reduce everything, including human beings, their labor and even their reproductive capacity to the status of commodities, to things that can be bought, sold, traded, and stolen. George Soros, 'Global Economy and Brutal Life', *Atlantic Monthly*, January 1998.