International Journal of Research in Economics and Social Sciences (IJRESS)
Available online at: http://euroasiapub.org
Vol. 7 Issue 7, July- 2017
ISSN(o): 2249-7382 | Impact Factor: 6.939 | Thomson Reuters Researcher ID: L-5236-2015

Restructuring Public Health System:

A Critical Evaluation of the NRHM in Kerala

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Abstract

The present study is an attempt to understand how the legislative and academic discourse effectively establish privatization and globalization of the health sector of Kerala as the ideal model for its future prospects and how these discourses are becoming central in the contemporary state-initiated health policies there. The study proceeds by critically examining the NRHM, regionally renamed as *Arogyakeralam*, which is claimed to bring out architectural corrections in the Health Service System of Kerala. 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. I argue that the important measures adopted to restructure the existing public health programmes, may, in the long run, subvert Kerala's 'public' health sector into a 'private' health sector. Moreover, it explains how the otherwise stated people-centered programme is become paradoxically an anti-people programme.

Keywords: NRHM, Kerala, Arogyakeralam, Public Health, corporate capital, neoliberalism,Globalization, Privatization.

> "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)

The presents study is an attempt to analyze health policy reforms introduced in Kerala under the National Rural Health Mission (hereafter NRHM). This programme, renamed and implemented here as *Arogyakeralam*, is claimed to bring out architectural corrections in the Health Service System. *Arogyakeralam* is not an independent, indigenous, innovative project of Kerala. Instead, it is the brand name, as said above, used in Kerala while implementing the pan Indian health delivery project called the National Rural Health Mission (NRHM). The study would expose that the underlying assumptions and political positions in the academic discourses and legislative discourses on health in Kerala1 have become the rules of the state in the very making and implementation of contemporary health policy reforms. 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 my argument is that these discourses have constituted a condition for making open policy statements that are becoming more advantageous for the burgeoning global capital and not for the suffering poor. 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. Also, the solution for both lies in market and management. The new health policy reform package that has come through *Arogyakeralam*/NRHM also proceed with the assumption that economy

[1]Sunitha B Nair, Political Economy of Health: Policies, Priorities and Agents in Kerala, Unpublished PhD Thesis Submitted to Jawaharlal Nehru university,2010

or economic growth[2] determines health. Thus, though the program apparently states 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.

The 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, modernization and standardization of heath service system will deliver quality health for all. Further, it urges people to join community or personal insurance schemes to meet the expenses for receiving quality medical services. That is, NRHM/*Arogyakeralam* asks people to find, largely, 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 previously in the name of sectoral reforms and they are all embedded with such a notion[3].

[2] 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.

[3] K R Nayar and Sunitha B Nair, Kerala's Roadmap to Privatization in Health services, Journal of Health and development, Vol2, No 1&2, January -June 2006

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 '*arogyaKeralamaiswaryaKeralam*'. *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 since 1980s due to the lack of resource management. They add that NRHM is a golden opportunity to regain the lost status and they could sustain a good health index through implementing the programme *Arogyakeralam.*

Interestingly many of the health standards that NRHM aims to achieve through this programme at all India level have already been achieved by Kerala4.Hence, apparently *Arogyakeralam*is not meant to achieve those goals. 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 a 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

[4]Health indicators

Health Indicators	**Kerala**	**India**
Birth rate (per 000 population)	16.70	24.80
Death rate (per 000 population)	6.30	8.00
Infant mortality rate (per 000 population)	11.00	60.00
Maternal mortality rate (per 000 population)	0.30	4.37
Total fertility rate (per woman)	1.99	3.30
Couple protection rate (%)	72.10	52
Life at birth male	71.67	64.10

Source: Directorate of Health Services

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. Despite this fact, NRHM is designed in a particular way with unsaid corporate 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. This become apparent when realising the fact that the NRHM/*Arogyakeralam* is giving more emphasis on architectural correction of the existing health sector and synergization of 'health'-allied factors for creating a better health situation. I quote,

> "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)

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. However, I would argue that these important measures adopted to restructure the existing public health programmes, may, in the long run, subvert Kerala's 'public' health sector into a 'private' health sector. I would explain how stated people-centered programme become paradoxically anti-people.

National Rural Health Mission (NRHM): The Aim and the Roots

The National Rural Health Mission was introduced nationwide on 12 April 2005 and is intended to last till 2012. However, the program was further extended to 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 grassroot 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. While aiming at improving the availability and access of quality health care, it also wants to promote a new healthy life style. The NRHM was originally meant to provide health care in this manner for 18 Indian States having low health care indicators.

From the Mission document itself, it is 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 theIndian 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 progamme, 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 Panchayat 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:

> "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".5

The above document 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

[5]*The First Meeting of Country Partners: WHO Commission on Social Determinants of Health Executive. Draft August 2006*).

Mission document says that the funding is coming from the increased budget allocation of the Central Government of India. 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 programmes6 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, out sourcing, 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

[6] "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).

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.

As said, 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. This, is nothing but an utopian idea, and more than that, 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.'(2005: 8)

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 Innovative Family Planning Services

(IFPS) implemented on an experimental basis in Uttar Pradhesh from 1992 to 20047. 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 key target of the Mission is not different. The emphasis IFPS gave to Reproductive Child Health (RCH) could be read from the following quote. It is important to notice that a significant 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. 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." (2006)

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 Pradhesh-such as the establishment of district level societies to guide health programs- are now integral components of the RCH-II Program and the NRHM.'(2006)

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

[7] USAID India (2006). Constella Futures (prepared by), Ideas, Insights and Innovations: Achievements and Lessons Learned from the innovation in family planning services (IFPS) Project 1992-2004.

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 global 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.

Bypassing the State: The Government Departments Becoming Societies

The NRHM/*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 singed 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 *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 the 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*.8 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. Butthe 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

[8] Go (p) 354/05/H&FWD dtd. 31 December 2005)

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 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 Department for Society is associated with the preference for a 'minimalist state'.9

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. I would argue that the shift from Development to Management is a shift towards the neo-liberal market logic. Here, management means financial control, profit making and increasing

[9] 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".

competitive spirit. Such a management is required when the public sector is conceding to the private sector. By arguing for constituting a management committee, NRHM/argoyakeralam 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 practice, they are working as an agency responsible for the monitoring and implementation of the plans.

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 by incorporating people from the locality itself, ultimately the responsibility in shifting the field of health will fall on the shoulders of people and they may be forced to bear the blame of failure as well.

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.10

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 'Partnership'' as collaborative and reciprocal relations ship 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 concluded that PPP is necessary

[10] 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.

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 mean 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 nonfunctional while contracting in is used to improve quality of service or improve accessibility to high technology service or improve efficiency". (Draft: 13).

PPP is operated through the accreditation of non-governmental hospitals. Empanelling of Private hospitals who are willing to cooperate with the NRHM came in action and more than 400 private hospitals have been accredited. 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. One slogan appeared in the mission documents says 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 (ibid: 13). It also says that PPP should not be an adhoc arrangement, it is disadvantageous for the private sector and they should not be left to loose. To 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 Auditing 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." (Draft Report on Recommendation of Task force on Public Private Partnership for 11th Plan: 16).

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 it clearer:

> 'Transparency, Accountability, Trust, measurable efficiency parameters and pricing remain vexatious issues in the partnership process."

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 what they want is the best option for the general public. The possibility of private capital determining the structure of public health delivery system is almost set with the implementation of NRHM.

NRHM gives provision for region-specific adjustments in entering into PPP. That is, there is no national policy on entering into PPP mode, rather it allows each State and District Mission sufficient 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. To quote:

> "Government must understand the advantages and disadvantages and requirement of the partnership. They need to understand that partnerships are based on common objectives, shared risks, shared investments and participatory decision making."11

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 they have, where there is sufficient provision for denying the service to patients who are not able to pay. I add here that introducing PPP too is a major architectural correction that NRHM advocates. But through this kind of architectural correction, what will happen is nothing but the ceding of the existing public sector into the hands of the profit-only oriented private sector. In the Mission documents and other records that advocate PPP, the advantages of the people are highlighted in the forefront and not the inner dynamics of privatization. For the corporates and the advocates of PPP is *the* tool to augment the public health system. But they are consciously silent on the fact that the 'gift' given to the people now are temporal and is not going to last long. Ultimately, it is going to be a programme advantageous only for the private capital and a one that leave the poor onece again to look for what is trickling down.

Conclusion

All the above said provisions in NRHM make it clear that the programme has been designed on the assumption that 'health is a commodity', and to get quality service, one must pay. Those who do not have the money to pay are not eligible to demand for service, perhaps even live. Those who are poor are now supported with name sake

[11] Draft Report on Recommendation of Task force on Public Private Partnership for 11th Plan

insurance. In future, each one should get insured herself and find out their own means to get quality health services. The other unsaid aspect of this idealization from the state is that once it is operatonalized, it could safely withdraw from the responsibility of providing unconditional health services and thereby from preserving the well-being of the people.

The horizontal and vertical expansion of health paraphernalia through decentralisation and current policy reforms should be viewed as an attempt to bring-in private capital into the field. They are free players and any attempt to control private health-care institutions are rejected by stating that the government needs to learn more about how it is implemented in other neighbouring states and so on in this manner. 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 is not an impending possibility but an actualizing reality. This should also be read along with some of the discussions taken place in the legislative assembly that, some of the private hospitals should be taken as models of good practice and the government should learn from their practices. Thus, with the implementation of *Arogyakeralam*, 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 1970s, 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. The net result of these interventions would be ceding the health sector into the hands of private

capital, whether it is hospitals, paramedical institutions, pharmaceutical companies or insurance companies. The PPP denotes a new form of political-economy of governance premised on the extension of market relationship. In that sense, NRHM and PPP are further steps of adhering the health sector into the neoliberal market economy. It plays with welfare, but makes the state a post-welfare state.

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Acknowledgement

I would like to thank Professor K R Nayar and Prof S Raju for the discussions we had while writing this paper. I would like to thank University Grants Commission for funding me to do minor research project on NRHM.