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PARADOX IN STRATEGIES AND PRACTICES: DECENTRALIZATION AND HEALTH SECTOR IN KERALA

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Abstract

The present research examines the impact of the policy of decentralisation on health sector in Kerala during last twodecades. Health being a state responsibility constitutionally, the policy of decentralisation was proposed in the health sector expecting more accessibility to health care institutions and better provisioning of quality health care delivery at affordable rates. However, a critical examination of health policies and practices of the last twodecades suggests that the decentralisation had led to local level resource mobilisation for health sector,which I would argue, is a shifting of burden and a contradiction to the stated vision of decentralization.I have also argued that the new policies actually reduced the state and local self-governing institutions (LSGI)into mere implementing agencies of the centrally designed policies and programs.

Keywords: Decentralisation, National Rural Health Mission, Health sector, Kerala,LSGI

Introduction

One of the objectives of the decentralised development plans that had implemented in India was to improve efficiency as well as equity in the health sector through devolution of power to Local Self-Government Institutions (LSGI). The effective implementation of decentralisation anticipated better health outcomes and its equal distribution irrespective of caste, class, gender or regionaldifferences.[i]The decentralisation in India was implemented in different degrees depending upon the willingness of each state to devolve powers, resources and so on to the local self-governing bodies. The state of Kerala, however,

implemented it effectively.Unlike in other states of India, decentralisation in Keralais received with expectations that it will provide local fiscal autonomy, and the suggested devolution of powers will allow the LSGI's to take decisions according to the localneeds. Altogether decentralisation was envisaged as a radical reform rather than a mere change in managerial or political structure. Health being a state responsibility constitutionally, the policy of decentralisation was proposed in the health sector expecting more accessibility to health care institutions and better provisioning of quality health care delivery at affordable rates. However, while analysing the effects of decentralisation for last two decades,Iwould argue that,the local self-governing institutions have become capillariesthrough which the global capital achievedtheir market interests enforced even in remote villages of Indiarestored. As a consequence of it, the potential of the LSGI's to ensuresocial justice andlocal economic development got weakened.[ii]

Peoples Planning Campaign in Kerala

Scholars largely consider the decentralisation campaign introduced in Kerala,in the year 1996 under the name People's Planning (*Janakeeyasuthranam*),as a radical development initiative and asa struggle for further democratisation of Kerala society breaking from its past efforts. They even went to argue that people's planningis a form of local resistance against market driven logic of globalisation, which has little space to address thefelt need of marginalized people.[iii] Some scholars were quite apprehensive about the success of peoples planning campaign in Kerala and went on to argue that institutional structures created under the decentralisation would defend people from the effect of neoliberal reforms.[iv]The peoples planning campaign or the decentralised planning in Kerala urgedto earmark 35 to40percent of its resources to the local self-governing institutions. The latter can design and implement the development plan of their own choice. The people's plan also envisaged mobilization of local resources as well. However,documents show that during the initial days of implementation the local resource thus mobilisedthroughvoluntary labour, donations, and in the form of beneficiary contributions were much below the targets fixed in the draft. [v]In addition to this, scholars have also criticisedthe practice of the state pressurisation on the LSGIs to complete a project executed under people's planning within a stipulated financial year. Scholars further

argued that bringing participatory planning into the operational frames of the five-year plans would make the former largely a mechanical exercise and reduce the whole effort as a mere instrument of planning rather than a means to empower people. For them, Kerala rather followed a prescriptive mode of implementation duringparticipatory planning.[vi]

Though there was an effort to strengthen the local autonomy through decentralisation, some scholars who were involved in the implementation of the peoples planning campaign themselveshave pointed out some disturbing trends experienced during the first phase of decentralisation. I quote,

> *"Surprisingly, there has been an increase in the vertical programmes sponsored by the state government in the form of 'missions.' Foreign aid agencies have been a major source of funding and encouragement for such parallel programmes. Even though the texts of these programmes include references to decentralisation and local self-government and initiative, most of the programmes themselves constitute threats to the stabilisation of the decentralisation process."*[vii]

Further, an evaluation of decentralisation in Madhya Pradesh, Kerala and Tamil Nadu revealed that therewas an 'elite capturing' of benefits in Kerala and Tamil Nādu.[viii] Though theoretically participatory democracy ispowerful, empirically itsbase continues to be weak.[ix]Despite the availability ofseveral guidelines and instruction issued by the planning commission and the central government, there were confusions in the actual planning and implementation of schemes at district level.In short, even though the decentralisation was initially conceived as an alternative to the centralised planning and a means to achieve equity in developmentwith people's participation, it received lots of criticism in terms of its implementation. It is in this background I examine the effects of decentralization on the health sector of Kerala.

Decentralised Health Sector in Kerala: Critical Review of Academic Discourses

The academic writing on health in Kerala that began to appear from 1980'sonwards, have suggested that the decentralisationis the only viable alternative to strengthen the otherwise weakening public health system in Kerala. These academic discourses

emphasised that the decentralization would bring inter-sectoral coordination, make resource mobilization through community participation and both would in turn would reduce morbidity rate.[x]Increasing morbidity rates,despite low mortality, and high life expectancy were pointed out as the major challenges faced by the health sector in Kerala. Such academic writingsendorsed thatcommunity financing and decentralisation arethe key strategies to deal with the existing problems of health sector that especially emerged due to the fiscal crisis of the state. By the first half of the 1990's, debates in the Kerala legislative assembly were also began to demand decentralization of health sector as the only means to cut down state expenditure on health.While transferring the authority to manage health care institutions from the district level to the local self-governing institutions, it wasassumed that the transfer of powers and responsibilities couldlead to the establishment of a much more efficient public health system with little financial burden on the state.[xi]In short, the decentralization proceeded envisaging that the devolution of power to the LSGI would solve the fiscal crisis and the intersectoral coordination would reduce morbidity rate.

'Health' beyond Health Sector

The intersectoral coordination wasadvocated based on the realization that the development of health has to be sought through developing non-health care sectors likefood, housing, water supply and sanitation. The WHO report published in 1984 emphasized the importance of non-health sectors on improving health conditions and calls for intersectoral planning and action to achieve this end. Further, it emphasized that the health consciousness must be developed among the 'prime movers', since such a consciousness will have effects on their activities.[xii]Beyond that, the report argues for the utilization ofthe services of nongovernmental organizations, mass media and informal communication networks, to generate pressure in support of intersectoral action (intersectoral actions refer to a collective activity of different sectors. Here it means a collective of different departments/sectors, including health, involved in making certain effects on health and development).[xiii] Moreover, this WHO report calls for further researches that wouldreiteratethe inter-sectoral linkages as the need of the hour. Also, this confirms the funding that Kerala has received from WHO.[xiv] Some of them even

consider this as a major shift in the case of health sector and demanded for clear policy documents in the light of new changes.[xv]

However, bylate 1990's scholars beganto discuss the effects of decentralisation. Some of them believed that the devolution of fiscal, political and managerial powers from the centre to the local self-governing institutions is a better alternative to overcome the limitations of centralised planning and the consequent uneven development.[xvi]Meanwhile, another group of scholars argued that the decentralisation of health sector failed to provide minimum health care services. These authors got worried that benefits of decentralisation were leaking to outside the boundaries of administrative jurisdiction.[xvii]A report of the evaluation of the functioning of Primary Health Centres under decentralised governance argues that decentralisation did not bring any significant changes in the health sector.[xviii]It is argued that panchayats in Kerala allocated a lower proportion of resources to health than the state government allocated prior to the decentralization, despite resources grew of the former at an annual rate of 30.7 per cent.Though the decentralisation in its initial phase worked as a big movementto mobilise people through *Gramasabhas* and other forumsresearches in the field of health sector suggests that such forums and mobilizations did not benefit in either formulating a comprehensive policy on health or resulted in actual participation of the beneficiaries in framing policies that could affect their health. In the following section I examine the effect of thedecentralisation on health sector during its second phase.

Arogyakeralam: Post NRHM Scenario

Yet another major reform in the health sector of India was envisaged through the policy of National Rural Health Mission (NRHM). This was officially launched as a health reform initiative in 2005. Though Kerala was not included in the first list of Indian states where it is to be implemented, soon she was also incorporated in its purview. Interestingly, the Kerala edition of NRHM was implemented in the name of *Arogyakeralam*.[xix]The context of the introduction of NRHM was the political compulsions forincreasing the resource allocation towards health from 0.9% to 2.3% of GDP. Whether it is decentralization of health sector introduced through people's planning or the *Arogyakeralam*, both of them got legitimacy because of their projectionas the alternative strategies to ensure better allocation of resources to health sector. The new

health policy reform package that has come through Arogyakeralam/NRHM proceeds with the assumption that economy or economic growthdetermines health.[xx]In the NRHM documents, the concept of 'development' is still a major legitimizing tool toshiftthe concern of health policy and 'poverty' is the reason for poor health. The solution for both lies in the market and in the management.

The NRHM was initially proposed as a complete centrally fundedscheme and meant to implement health programmes and projects designed by the Ministry of Health, Government of India. Buteven before completing a half a decade of implementation, it turned out to be a programme whereinthe state had to contribute almost 40 per cent of the total expenditure. This should be read in the background of the fact that according to Indian constitution constitutionally health is a state responsibility and with the implementation of the Constitutional amendmentof 73rdand74th,thelocal self-governing institutions are also made responsible for health care of the people. The later devolution was legitimized on the ground that there are regional variations in the health-related issuesand suchissues need to be addressed locally. Even after making such statements, one could see the Centre Government rolling back from their stated decision to decentralize health sector. While taking back the control of the health sector from the handsof the states and the local self-governing institutions, they stated that it has the responsibility to fulfil the commitments of the government to the people's health. Often documents like Bhore Committee Report, that asks for increasing the center's allocation to health sector,are sited to legitimize their roll back.

But the paradox here is that, though the leading role of the state and the local self-governing institutions are hijacked by the centrethrough such statements, the actual financial burden to meet the demands from the health sector are left to the shoulders of the state governments. Further, it created a condition in which the Centre would plan and design health projects and at the state and the LSGIs remain an implementing agency. The former often designed reforms to cater the interests of the corporates, where the well-being of the marginalized will be a least concern. It has already been noted that it was theInternational Advisory Panel (IAP), which is consisted of members from corporate companies, who plan health program under NRHM.[xxi]Yet another

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problem of this central insistence to follow their prescription is that, all of the health indicators that the Centre wanted to have in its states are already achieved by the state of Kerala, but still she is asked to spent on indicators that has a little relevance in improving health sector of Kerala.

Yet another conflict of interests between the new programme of the Central Governmentand thedecentralization efforts in the state of Kerala is their focus on the managerial efficiency. The Centre asserts that the managerial efficiency is the key priority in thehealth sector reforms. It is evidenced in incorporating the expenditure priorities of theReproductory Child Health II (RCH),as oneof the major components of NRHM. Expenditure heads like Innovations, Public Private Participation, Non-Governmental Organization, Infrastructure and Human Resource, Training, BCC/IEC, Procurement, Programme management under RCHII etc. are directly targeting "managerial efficiency" under NRHM. They are also referred to as the essentials for the existence ofefficient public health system under the 'new public health' regime. An in-depth analysis of the expenditure statement of the year 2009-10suggests that even within health outcomes the promotion of institutional deliveries and compensation for sterilization camps have become major items of expenditure. In addition to this, almost 11% of the total expenditure under this item is used exclusively for propagating new public health concerns through school public health programs or RCH outreach camps. Additionalities under NRHM have also incorporated various components which are byproducts of new notions of public health management. Probably one important shift with NRHM isthe focus on non-clinical interventions, which, I would argue, is framedon the logic of behavioral economics or individualistic approach towards public health. These approaches either targets on the modification of individual behaviour discursively or non-discursively or proceeds with the assumption that ill health is due to the lack of health education or non-hygienic practices. Here, thelion share of expenditure on the new notions of public health included expenditure on theanalysis and monitoringof health practices, evaluation of public health system, and onpublic health campaigns. The expenditure on promotion of AYUSH and expenditure to promote public private partnership,andpromotion of NGO participation also form key priority areas.

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Performance of Health Care Institutions under LSGI's

In India, Primary Health Centres (PHC) are considered as the central pillars of public health system. As per the minimum needs programme, which was implemented during 5th five-year plan, there should be one PHC for every 30, 000 people. There are 943 PHC's in Kerala.[xxii]While assessing the performance of PHCs in Kerala in the backdrop of decentralised planning, it is argued that when comparing to the state expenditure prior to the implementation of decentralisation,the panchayats in Kerala had spent onlya negligible amount on health in the first half of the last decade. Further,of the allotted money, the 62.7 per cent was spent on the salary head and the remaining 29.5 per cent was actually made available for the care of patients.

The study further state that while the panchayat resources grew at the annual rate of 30.7 per cent, the health resources grew only at the rate of 7.9 per cent. The Primary Health Centres were funded to the extent of 0.7 to 2.7 per cent of the total cost. Thus, it has been warned that Kerala should find alternative strategy to channel panchayats towards health before health loses its battles for resources.[xxiii]Yet another study,that evaluated the performance of primary health centres based on a micro level survey, argues that the socio-economic variables play an important role in the rate of utilisation of services. People were mainlyavailing preventive services like buying vitamin tablets or iron and folic acid for pregnant women and immunisation for infants and children. Less than 30 per centof the people availed curative services from PHCs and the study points out that the non-availability of medicines and treatment were the main reasons for low level utilisation of services.[xxiv] Hence PHCs are reduced to the status of agentsfor implementing family planning programme and immunisation projects.

A preliminary survey conducted last year suggests that the major source of funding to PHC's is still coming from the state. An interesting finding regarding the expenditure pattern is thatwhatever meagre thefunds coming under the NRHM,they are exclusively used for beautification purposes or for peripheral maintenance works like purchase of stationaries, computer repair services, minor electrical and plumbing work.[xxv] Almost 50 per centof the state funds wereutilised for purchase of alternative (non-modern) medicines and the second priority in spendinggoes to *swanthwanam*, a palliative care programme.A micro level survey conducted among patients who

hadapproached agovernment taluk hospital for medical services suggests that 86.67 per centamong them belonging to below poverty line. While 80 per cent of the patientscomplaint about the lack of space in the consulting room, 72 per cent complained about lack of drinking water availability in the hospital premises. At the same time, 86 per centof the patients were satisfied with facilities in the waiting area and 68 per centwere happy with clean toilet facilities in the hospital. Majority of the patients are satisfied withthe service of the doctors and nurses, but only 6 per centsatisfied with the dispensing of medicine. Out of the total funds received by PHC, almost 30 per cent is spending on infrastructure and water facilities. In short, it is observed that compared to the pre-NRHM era, PHCs along with Taluk hospitals, have performed better in terms of infrastructure and cleanliness but it faired far belowin providing necessary medicines or other direct medical such services. HenceArogyakeralam too did not attract much general public, which is reflected in the lower-level utilisation of public sector hospitals.

'Management' replacing 'Development': A Public Health Critique

Under the provisions of the decentralization of governance, there were Hospital Development Committees (HDC) at every hospital. When the NRHM came into being, the HDC was replaced by Hospital Management Societies (HMS). In Kerala, under the provisions of the Panchayat Raj Act, there were hospital development committees (HDC) in all hospitals. Since theywere formed under the rules of the Panchayat Raj Act and by incorporating elected representatives of the local self-government institutions, they were accountable to the people. Thegovernment order issued to legalize the winding up of the Development committees and the constitution of the Hospital Management Societies states that the HDC formed under the Panchayat Raj Act had become 'untenable' and therefore it should be dissolved. The shift from 'development' to 'management' is legitimized on the grounds of efficiency. This shift from Hospital Development to Hospital Management is, I would argue, a shift towards the neo-liberal market logic. The policy document finds reasons for failure in the successful operation of health service inits improper management. For them, management means financial control, profit making, and increasing competitive spirit. Therefore, the change in the concept and constitution of new institution should not be viewed as an innocent act. By arguing for

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constituting a management committee, the NRHM/Arogyakeralam is prescribingthat a government institution (its form and practice) should invariablybe modelled on the frame, desire and intentions of a globalcorporate company

Concluding Observations

In conclusion, I would like to state that the much-soughtdecentralisation policy did notbring any significant changes in the health sector neither in terms of utilisation of primary health care institutions nor in the way of curative care or in the reduction of morbidity rates. Thus, the policy of decentralisation had limited success. The state was able to reduce its expenditure, but this reduction wasreflected much in patient care and not on institutional care.[xxvi]While going through the academic discourses one can observe that they all proceed with the assumption that the decentralisation would save public health system in Kerala. But there is hardly any literature that raises the questions like whether LSGI's are capable enough to plan according to the local health needs and do they have fiscal autonomy to design programmes. Apart from transferring responsibilities of various levels of institutions to different levels of local self-government institutions in the name of administrative efficiency, effective mobilisation of community resources, and participation, nothing much had happened in terms of health outcomes or health care outcomes.

Theoretically speaking decentralisation means empowering of local self-governments by transferring various resources as well as responsibilities, including health care institutions, from the state to LSGIs. Many scholars have already argued that the decentralisation is an apolitical move for the withdrawal of state or retreat of the state from social welfare sectors. However, with the completion of two decades of decentralised planning one can see that the Centre is gaining power over states in general and health care in particular. While the first decade of decentralisation created a popular image that the panchayats have resources and power to take decisions according to the local needs, butI would argue that,in course of time, the decentralisation itself had become instrumental in local mobilisation of resources to meet the needs of global market interests, often sacrificing local health care demand. This has become further evident when the health sector reforms came in the form of NRHM. Now the responsibility toaccumulate health care resources was shifted to the newly constituted

HospitalManagement Committees and planning and implementation of various programmes have been taken away from the state departments and the same is conferred to societies registered under the Charitable Society Act. This transference made theNRHM unaccountable to the activities they are involved in. Much more desperate was the situation of the corporate companies planning for Indian Health sector. The NRHM opened a space for the corporates in planning health reform in the form of constituting an International Advisory Panel. This Panel consists of representatives from corporate companies in medical business field. Once it is set up, then the local needs areidentified (and determined) by the International Advisory Panel and they also decide on the strategies to be chosen to satisfy the health needs of the people.[xxvii]This has resulted in a situation, wherein the state governments as well as local self-governments are made to dance according to the tunes of these global players. The corporates achieved their goals, however, through the support of bureaucrats and politicians at various level. I would argue that all these changes only spoiled the spirits of thedecentralisation, where the local self-governing institutions are supposed to plan and decide what should be done on local health issues. In short, through the health reform discussed above, we could see how the whole priority has been shifted from focusing on people to that of the profit ofbig corporates. I add that it was effectuated through the employment of newly created "health professionals" who are trained in new public health management.[xxviii]Finally, I would like to statethat the Indian government has nowcontracted the"great men's disease" when they promoted these business leaders as healthadvisors of government who are least concerned on the desires of the poor and the needy.[xxix]

[i]Decentralisation especially fiscal decentralisation has played statistically significant role in reduction in infant mortality rates. For more details see,Asfaw, Abay, et al. "Fiscal Decentralization and Infant Mortality: Empirical Evidence from Rural India." *The Journal of Developing Areas*, vol. 41, no. 1, College of Business, Tennessee State University, 2007, pp. 17–35.

[ii]Here I am inspired of Michel Foucault's argument. He argues that power should no longer be viewed as a force exercised from above based on universal right, but rather, we should concern ourselves with where the exercise of power becomes less and less juridical; where power becomes "capillary". He is not concerned with the reasons behind the pursuit of power or the intentions behind it but rather is interested in how power itself works. Foucault looks at power in the lower-levels, such as discipline in prisons and schools, and observes how it has extended to the higher level; how the accepted discourses of truth and knowledge at the lower level of society is applied to more "general mechanisms" in order to serve "forms of global domination". See his *History of Sexuality* Vol I, *Discipline and Punish*, and *The Birth of the Clinic*.

[iii] Shobha Raghuram, "Kerala's Democratic Decentralisation: History in the Making", *Economic and Political Weekly*, Jun. 17-23, 2000, Vol. 35, No. 25, pp. 2105-2107.

[iv] P. K. Michael Tharakan and Vikas Rawal, "Decentralisation and the People's Campaign in Kerala", *Social Scientist*, 2001, Vol. 29, No. 9, pp. 1-6

[v]T. M. Thomas Isaac. "Campaign for Democratic Decentralisation in Kerala." *Social Scientist*, vol. 29, no. 9/10, *Social Scientist*, 2001, pp. 8–47

[vi] Jos Chathukulam and M. S. John, "Five Years of Participatory Planning in Kerala: Rhetoric and Reality", *Economic and Political Weekly*, Dec. 7-13, 2002, Vol. 37, No. 49, pp. 4917-4926

[vii] T. M. Thomas Isaac, "Campaign for Democratic Decentralisation in Kerala", *Social Scientist*, 2001, Vol. 29, No. 9/10 pp. 8-47

[viii] D. Narayana, "Local Governance without Capacity Building: Ten Years of Panchayati Raj", *Economic and Political Weekly*, Jun. 25 - Jul. 1, 2005, Vol. 40, No. 26 pp. 2822-2832

[ix] M A Oommen, "Deepening Democracy and Local Governance: Challenges before Kerala", *Economic and Political Weekly*, June 21, 2014, Vol. 49, No. 25, pp. 42-46

[x] Scholars who were advocating for the intersectoral integration for improving health condition legitimize their prescription stating that it is the larger goal suggested in the Alma Ata declaration. The slogan of the Declaration was 'health for all' by integrating all sectors with modern medical institutions.

[xi] Sunitha B. Nair," Legislative Decisions and Peoples Health: Where the hell are we going?" Paper presented in the National Conference organised by School of Indian Legal thought, Mahatma Gandhi University, Kottayam, 13th March 2016.

[xii]'Prime mover' is a new concept used by the advocates of new public health management. In the study under review, prime mover means those who are employed as technical staff close to policy makers, policy makers themselves, or those who are directly responsible for the implementation of programmes. Cited in Sunitha B Nair, "Contextualizing "Health" in Kerala: An Excurse on Academic Discourse", *Government Arts and science Research Journal, Kerala Padanangal essays on Kerala*, Vol.7, Issue.1, January 2016, pp47-78.

[xiii]Godfrey Gunatilleke (ed), "Intersectoral Linkages and Health Development Case Studies in India (Kerala state), Jamaica, Norway, Srilanka and Thailand", *WHO*, Geneva, 1984.

[xiv]PGK Panikkar and CR Soman jointly wrote a book titled *Health Status of Kerala: The Paradox of Economic Backwardness and Health Development*. One of the emphases of the book is to reiterate the importance of intersectoral linkages for sustaining Kerala's high health indicators.

[xv]The emphasis of such a policy should be improvement in quality rather than expansion in quantity. The new health policy would have to clearly define the role of the state sector, reorient the family welfare services, encourage novel ways of funding health care outside government allocation, emphasize para-medical training, draw up a state level formulary and effectively decentralize the health care system.Thomas Isaac T. M., and Michael Tharakan P. K. "Kerala: The Emerging Perspectives: Overview of the International Congress on Kerala Studies." *Social Scientist*, vol. 23, no. 1/3, Social Scientist, 1995, pp. 3–36

[xvi] For more details refer Elamon, Joy, et al. "Decentralization of health services: The Kerala people's campaign." *International Journal of Health Services*, vol. 34, no. 4, Sage Publications, Inc., 2004, pp. 681–708.

[xvii]D Narayana and Harikurup, "Decentralisation and Health Sector in Kerala: Some Issues",*Working Paper* no: 298, CDS, January 2000.

[xviii]Varatharajan, D., et al. "Assessing the Performance of Primary Health Centres under Decentralized Government in Kerala, India." *Health Policy and Planning*, vol. 19, no. 1, Oxford University Press, 2004, pp. 41–51

[xix] The National Rural Health Mission introduced nationwide on 12 April 2005 was a new health delivery system in India that claims 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.

[xx] 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.

[xxi] For more details refer Sunitha B Nair," Global Planning for Local Health: Public Health perspective of NRHM",*Journal of Integrated Community Health*, Volume.6, Issue 3&4,2017.

[xxii] India's Primary Health Care system is based on the Primary Health Centres (PHC) which constitutes the corner stone of the rural health careand each centre is equipped with provision for preventive, curative, promotional and rehabilitative aspects of public health and has an effective referral system. The centre forms a platform for the first level of contact and a link between individuals and the national health system for bringing health care delivery at the door steps of the community.

[xxiii] It also points to the fact that panchayaths should serve the local people through PHC's rather than acting as power centre to wield authority over PHC staff. Patient care is an important activity which is left out from

panchayat responsibility partly due to government guidelines and partly due to ignorance or ego clashes. D Varatharajan, R Thankappan and SabeenaJayapalan, "Assessing the performance of primary health centres under decentralised government in Kerala, India", *Health Policy and Planning*,19(1), Oxford university Press,2004.

[xxiv] Padmaja K, "An Evaluation of Primary Health Care system in Kerala", *PHD thesis submitted to Cochin University of Science and Technology*, Department of Applied Economics, 2005.

[xxv]The analysis was based a micro level survey conducted among selected government hospitals in Kannur district Kerala.

[xxvi] This has to be read along with the fact that households in India spend on medical care three to four times higher than the total health expenditure of government and 9-13 times higher than the government curative care expenditure. Besides,the medical education of doctors at the expense of the public exchequer has grown rapidly helping not only the private sector but also the medical personnel need of the western countries to which so many of the highly qualified doctors migrate. Refer,"State's Dwindling Role in Health Sector." *Economic and Political Weekly*, vol. 28, no. 7, 1993, pp. 269–269.

[xxvii]Sunitha B Nair," Global Planning for Local Health: Public Health perspective of NRHM",*Journal of Integrated Community Health*, Volume.6, Issue 3&4, 2017

[xxviii] As Foucault says purposely their propaganda is to create a discussion surrounding on this model of public health systemwhere strengthening of public health system is possible only through private participationand a trained army of new public health management professionals.

[xxix]According to Paul Krugman it is a syndrome which exists in scientific world referring to a situation where when a researcher in one field develops strong opinion about another field which she or he does not understand. Krugman basically argues that a country is not a corporation or company and what people learn from doing business cannot be helpful in formulating economic policy for a nation. For more details refer Paul Krugman, *A country is not a company*, Harward Business press, USA, 2009.