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LEGISLATIVE PRIORITIES AND PEOPLE'S HEALTH: EXPERIENCES FROM KERALA IN THE NEOLIBERAL ERA

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Abstract

The present article examines the priorities and preferences of public health discussed in Kerala Legislative Assembly in the last two and a half decades. Vertical and horizontal expansion of health paraphernalia's including institutional structure, diagnostic technology and digitalization of the sector itself 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. Discursive construction of these preferences and priorities 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'.

Keywords: Legislative priorities, Kerala, Neoliberal policies, Health paraphernalia, Telemedicine.

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Introduction

A cursory review of the discourses produced on health in Kerala from different sites would reveal that two values ruled the game. They are 'modernization' and 'development'. Itguided the policy makers of the colonial period and still appears while discussion concerning health emerges in Kerala

Legislative Assembly. However, the later echoes thevalue of 'development' that has been produced and disseminated by the academic experts often to legitimize the implementation of the capitalist and market-oriented health policies in contemporary Kerala as ideal.[i] Since 1990, the Kerala State Legislative Assembly began to discuss intensely on the institutionalization, mechanization, and 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 paraphernalia's 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. The present study attempts to understand the nuances involved in such a vision emerged coeval with the liberalization of Indian economy. The study focuses exclusively on the debates and discussions emerged in the law-making body of Kerala, the Legislative Assembly, and proceed analytically taking insights from poststructuralist thinking.

Development of Health Service System in Kerala: Legislative Priorities

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 equipment; services of medical experts like doctors, nurses and paramedical staff; other paraphernalia like the number of medical stores, physiotherapy 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. I would substantiate this argument in the coming discussions.

(a) Health Paraphernalia and People's Health

The Kerala Legislative Assembly (hereafter KLA) 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-centers is part of the increasing health paraphernalia. But it is quite important to noticethat, the rationale for building up new institutional structures like health sub-centers in the village are not intended to provide care for the people but it is part of accepting fiscal spending instructed by the Ministry of Health, Government of India. To substantiate it, I quote a question raised by a member to the KLA and its reply by the Minister for Health:

> *Sri. R. Unnikrishna Pillai [Member of the Legislative Assembly]: Sir, we already have more than one sub-center in a village. Still new centers are constructed in the same villages. But these institutions are functioning solely as an information Centre 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 doctor's visit these sub-centers and provide basic treatment facilities at least once in a week?*
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> *Sri. A.C. Shanmughadas [Minister for Health]: Sir, these sub-centers 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-centers 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-centers as treatment units.*[ii]

If the question of the Member of Legislative Assembly contains anxiety on wasting a facility without adequate staff and services, 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 State often established new health sub-centres/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 or preference of the people.[iii]

Along with the vertical expansion of institutional structures, the upgradation of the existing institutional facilities was another major priority of the government throughout the 1990s. Approximately 97 per cent of the submissions in the KLA during 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 back in 1979, have been used as a strategic tool for rationalizing such demands for upgradation.[iv]Since the Legislative Assembly considered the Pai

Committee Report as a vital document for planning 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 tothe 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 facilities and to ascertain the extent of unused capacity with respect to existing equipment's 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 equipment's and machines can be maintained with optimum efficiency'.*[v]

As already said, the suggestion made by the Pai Committee has often been indiscriminately appropriated to demand for 'development' in one's constituency. The report has with time become a gauge for demands to upgrade health facilities irrespective of whether they address the real requirement of the people or not.

But more important is the fact that the Pai Committee Report is an exemplar of a report that is wrought in the language of economics and the economic rationality determined by the logic of the market. In such a discourse, 'people' and their 'health'are secondary and the systematization or ordering of institutional facilities receives primary or sole attention. Thus, more than people's health, it is growth of health infrastructure and its standardization become their priority. 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 800maternity cases, one pharmacist for every 70 beds, and one clerk for every 50 bedded hospitals, underscores this logic. I would like to add here that, 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.

A series of discussions on implementing projects funded by international agencies like WHO, UNICEF, Asian Development Bank and the World Bank, occurred in KLA were also justified on the basis of improving infrastructural facilities.

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-centers, 82 subsidiary health centers and community hall affiliated to 28 PHCs, wards and operation theatres for 11 taluk hospitals.*[vi]

The 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 adding new sections like starting up super-specialty wings either in Government medical collegesor running on a partnership basis or private owned; conversion of medical college into a referral hospital;[vii] andconversion of Primary Health Centers into Community Health Centers, dominate the discussion.Though the government 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 KLAasking for human care provision (rather than technological care) for the sick appear to be sidelined.

For example, a member of the 8th Kerala Legislative 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 for Health to look seriously into the matter and meet the demand of the people. But the reply given by the Minister for Health was a clear indication on what rules him while implementing polices. 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.'[viii]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 agenciesin order to access the huge package of infrastructure development funds. These funds are often meant to implement various (experimental) health projects, but implemented concealing their real political intention and introducing them in the name of health sector reforms.

If institutional upgrading and purchasing of machines and equipment's were the key priorities within the health sector during 1990s, creating specialty-care and superspecialist care and technologizing through information technology have become the key indicators of development in the KLA discourses during the first decade of 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 (Sri 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/equipment's; 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 specialty courses, and also receive sanction to create new super specialty posts, as part of the reform programme'.[ix]

It is significant to notice that most of such buildings and equipment's accumulated through various projects are lying idle in the state and, therefore, the KLA had decided to conduct an enquiry on the idle capacity of health care resources. This enquiry cum research conducted by the Achutha Menon Centre for Health Science Studies. Trivandrum found out,using 'efficiency radar', that 59.3% of land, 53.2% of the building space and 40.1% of the rooms remained idle.[x]It is argued that government on the one hand moves with the assumption that machine cures, but a major complaint and demand in the assembly is for curing/repairing the machines. I would read this as a paradoxical situation.

(b) Technologization of Medical System

Yet another dimension of the technologization of the medical system is the increasing volumes of hospital wastes due to the enormous use of 'disposables' introduced in the name of 'safe diagnoses.' Though it is unavoidable, the sad thing is that, the responsibility of hospital waste management, however, is shifted to the shoulders of Local self-governing institutions.The solution to hospital waste management was the introduction of incinerators. These incinerators were purchased exclusively for government hospitals with which they can burn the waste created in the hospitals.[xi] First, they discoursed on introducing new diagnostic technologies without reckoning the known consequence of disposing its waste, and then they debated on the hospital waste management that thetechnologies of diagnosing continuously created, and finally they begin discoursing on the sickness created by the new hospital wastes. We know that, it is through enacting laws that the usages of disposable medical aidwere made compulsory. But ignoring the consequences its accumulation as hazardous waste, they are now discoursing on the necessity of introducing waste management programmes funded by international funding organizations indicating that unless did so the medical wastes will create new sick bodies.

The discussions on the necessity to introduce tele-medicine begins, 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.'[xii]Tele-medicine is demanded for not because it improve the quality of human life, but it's because availability will lift the state at par with neighboring states who have already acquired these facilities, it also results 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 centers with the help of information technology. Though, we cannot rule out the advantage of tele-medicine, what really happened in the ground was further accumulation of e-wastes.

While arguing so, my intention 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 as an aid to care and cure the sick. Furthermore, most of the time, such policies and programmes are implemented without looking at the interests, demands, and needs of the people. Instead, they 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 pharmaceutical companies and machine and tool manufacturing companies.

Summary

In short, my perusal through the Kerala Legislative Assembly proceedings reveals that the major discussion in the law-making body of Kerala in the last three decades embodies demands for more hospitals, machineries and specialists. By the second half of the 1990's, 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 specialtiesat par with advancement in medical science research became the major problems identified by the Legislative Assembly. They viewed them 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.It tacitly conceives human beings as machines in the fashion that machines can be corrected and make functional in a workshop, so also human beings as machines can be corrected in 'super specialty' hospitals (or human workshops). I argue that these are the visible effects of the implementation of the neoliberal utopia.

Thus, the major health priorities of Kerala Legislative Assembly in the recent past turned to be 'healing' of health care equipment and thereby strengthening of the economy through the influx of private and foreign capital. The concerns and preferences that surface on the floor of KLAactually demonstratethe mentality of the governing and not that of the governed. 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'.

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