tion of the medical profession in the perspective of hard reality. Because I found that the observers almost always dealt with the medical profession from individual presumptions and pre-determined positions without bothering to sift empirical findings. Even the bitter critics of doctors have fallen prey, perhaps unwittingly, to the concept of noble profession and, for no coherent reason at all, expect the doctors to remain unaffected by the nuances of the commercial society and to conduct themselves as holy men. Hence, the exploitative practice of the doctors which is an utter contradiction to the ideal of noble profession, shocks them. Why should the noble doctors behave as other wage-earners do? Why should they indulge in trade unionism and economism as the common workers do? Why should they demand 8-hours duty as everyone does? Why shouldn't they, as noble ones, "throw away their privileges as elite doctors in return for promise of decent, scientific, meaningful working life", as the other commoners do not do? When these doctors do not oblige, Phadke goes searching for a "small critical mass of doctors" who may persuaded to raise a sufficiently strong clamour for "a revolutionary change" in the medical system.

I have little hope he will find one and even if he is fortunate to find them, his ideal may remain unrealised. One thing is certain. We cannot run a medical system without doctors—certainly not by a small critical mass of revolutionary doctors. Before jumping ahead to determine the role of doctors in social revolution, let us try to understand and determine their role in health care. What role do we envisage for the doctors in today's health care? What are they performing? What are the nature and cause of short-comings in role performance? What changes should we demand and strive for in the medical system and what will be the role of the doctors in such dynamic situation? In order to find answers to these questions we have to purge ourselves of the myth of noble profession, step out of our idealistic world of believe and turn a fresh look towards doctors as just a social layer with the relevant particularities. We have to collect real life data and analyse them. We have to know how the doctors practise medicine in the state hospitals, how they, as a class or interest group, interact with the recipients, non-doctor workers and the employer. In this context, discussion on professionalism, role expectation, role performance, as well as agitative movements become relevant.

When we do this, we may be able to understand and determine the service-doctors' role on the basis of their own conduct and not through any wishful thinking. Then only will we be in a position to determine their relationship with a people's health movement for a just health care service. The relationship—I quote Thompson again – "must always be embodied in real people and in a real context".

Without going into details, I may draw attention to the experience of USSR and China. There, in the post-revolutionary period, the state had to deal with the entire medical profession in reshaping health care service. Revolutionary exhortations were found to be inadequate. The instrument of incentive and disincentive was ultimately resorted to and it brought results. The problem has yet to be resolved. Professionalism, job satisfaction, economism, role expectation, role performance, private practice, technocratic scienticism etc, are still living problems.

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Light on 'Blind Spots'

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ANANT PHADKE in his review (RJH, June I: 1) of our book *When the Search Began* contends that: "It is not clear from their account as to why the response to this scheme was better than to the earlier one. No economic or political activity has been reported. Perhaps the support of the medical college including the doctor's monthly visit made this difference."

This and other such statements need some clarifications. The insurance scheme demanded Rs 3/person/year as contribution from 75 per cent of the village population and offered hospital services at 75 per cent subsidised cost (See Introduction). Though highly subsidised, hospital charges were beyond the reach of poor villagers. The Jwar Insurance Scheme provide free hospitalisation for all unexpected illnesses and thus provided a sense of security. It was essentially this modification which attracted people and not any economic or political activity.

Regarding Phadke's comments on cost analysis, a close look at the cost analysis will reveal the following:

Hospital indoor admission rate per year = One per 10 population
Government expenditure for 10 people 28×10 = Rs 280/year

Contribution from the people = Meets the cost of peripheral health infrastructure plus spares Rs 18.50

Therefore the amount which can be spared for hospitalised treatment per patient = Rs 280 plus Rs 18.50 Rs 298.50

With a proper referral established between the hospital and the specialised care hospital, I feel that with the amount available, and health insurance coverage for indoor admissions can be provided. It is futile to compare this cost-analysis with existing government PHC set-up where distribution of funds provides only 12 paise/person/year towards drug cost. What is important I believe is that the alternative strategy appears feasible.

Elsewhere Phadke comments that the increase in percentage coverage for health insurance from 46.5 in the first year to 71.5 per cent in the third year does not tally with the earlier claim. The data quoted earlier is from village Nagapur—the village where by trial and error health insurance scheme evolved over the years. The data on increase in coverage (on page 14) is pooled information from the new villages where health insurance scheme was introduced and then implemented once it was found feasible. The strategy of our entry

in village life was totally different.

As for the 'blind spots' the search continues. We began with what was possible in the given social structure, involving people to the maximum, without corrupting them with blind charity. The 'blind spots' can only be eliminated when really democratic health services evolve. What matters today is whether there are attempts towards the democratisation process.

We did try towards decentralisation, e g, village contribution is now collected by villages and is kept in the village as a village fund. Its utilisation is now decided by gram sabha, thereby controlling the village health workers performance. The attempts towards appropriate health education was the natural corallary but the extent to which attempts towards 'conscientisation' can breed 'health actions' is a question we have yet to answer.

It must be understood that for the goal of democratisation to be achieved the consumer should be participating. For people's participation to emerge, a felt need has to exist. The needs cannot be created. If need-based participation ensues, it has to be guided towards democratisation, the value which under-privileged section rarely visualises. It is here that the role of activist lies. The vision of democratisation is perceived by those individuals who can see beyond the immediate gains, i e, people who join the struggle through conscious committment.

As far as health work is concerned it is a moot question whether the consumers are motivated enough to actively participate. In case they are not, health work remains "for the people" and not "by the people." The experience narrated in the book describes our march towards "for the people." Though conscious of the goal "health by the people", we stumbled against the reality, that health is not a priority need of the people and hence we did not see community participation emerging.

One should not compare the strategy of work at organised sector like the Chattisgarh Mines Shramik Sangh and among unorganised rural agrarian population. Running a hospital by contributions from the beneficiaries is not new. What matters is how far the democratisation has been inculcated in health actions. It will be a nice idea if someone from Rajhara hospital shares his/her experiences of the democratisation process in health action, its feasibility and failures.

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