Medical Care and Health under State Socialism

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The transformation of the social relationships of welfare is central to socialist and communist social policy and may be thought through in relation to six key aspects of social policy: (1) the priority afforded social policy, (2) the form of control over welfare provision, (3) the agency of welfare provision, (4) the nature of the relationship between welfare provider and user, (5) the rationing system adopted by the welfare institutions concerned, and (6) the assumption embodied in the policy regarding the sexual division of labour. This article reviews medical care and health policy in three countries, the Soviet Union, Hungary and Poland from the standpoint of a perspective of ideal socialist and communist medical care and health policy derived from an analysis of Marxist and allied critiques of capitalist medical care policy and theoretical work on socialist social policy. The author concludes that medical care policy in all three countries exhibits very few characteristics of socialist medical care. It also examines the possibility (for the moment suppressed) provided by the Solidarity movement in Poland of a new development toward a more genuine socialist medical care and health policy.

The article has been slightly abridged from the International Journal of Health Services Volume 14, number 3, 1984 and excludes the detailed review of medical policy in Hungary.

Socialist Medical Care Policy

The aim of this article is both to explicate a socialist conception of ideal medical care policy and to review medical care policies in the Soviet Union, Hungary and Poland to see whether they provide concrete examples of socialist medical care.

It is clear from George and Manning's (1) review of the few specific statements on socialism and health made by Marx, Engels, and Lenin that their emphasis is on those *causes* of ill-health located in the nature of capitalist society. As an example take Lenin's view that "thousands and tens of thousands of men and women, who toil all their lives to create wealth for others, perish from starvation and constant malnutrition, die prematurely from disease caused by horrible working conditions by wretched housing and overwork" (2). A socialist health policy would therefore be concerned primarily to prevent avoidable disease. There is far less in their writings on the particular form of curative health service that should be provided to cope with unpreventable disease.

Few subsequent Marxist theorists, addressing the nature of socialism have had anything specific to say about medical care. Bahro (3) is an exception here. His discussion of the need to alter the division of labour radically under socialism is illustrated by the example of the organisation of work in a hospital: "We can just as well imagine the everyday situation in a hospital, to take an example from a different sphere, one still more strongly burdened with the prejudices of the traditional division of labour, in which the entire staff consisted of people with full medical training, or other pertinent qualification, who also took part in all nursing and ancillary work and in social and economic functions as well." This twin concern with both preventive medicine—the fact that it will become a high priority under socialism—and the altered form of curative medical care will recur as the conception of socialist medical care emerges in this article.

Lesley Doyal's (4) excellent analysis of the causes of, and ways of curing, ill-health under capitalism is structured around these twin concerns. Her brief postscript to *The Political Economy of Health*, where she considers the implications of this analysis for the struggle for a healthier society, discusses both aspects. On the question of prevention of ill-health under socialism, she is sensibly cautious:

> Naturally we would not argue that a transformation of the mode of production would abolish illness—people will always become sick and die. But what we can show are the ways in which potentially avoidable illness has become prevalent under capitalism ... [It follows that] the demand for health is in *itself* a revolutionary demand.

This concern with preventing avoidable ill-health is a touchstone of socialist policy. It would reach into every corner of working and domestic life. Not only would each work process be evaluated from the standpoint of whether it made workers ill or not, but also such diverse aspects of life as food, housing, transportation, and personal relationships would be affected far more than under capitalism by considerations of their health-enhancing potential. Changes in life-style in relation to all of these things would be a matter of general public concern and action. Necessary economic and social changes that would enable people to live, eat, and relate differently would be a matter of medical policy.

On the form of curative medical care under socialism, Doyal (4) writes:

> The struggle must therefore go beyond the immediate demand for more state-organised medicine, towards a critical re-evaluation of the more qualitative aspects of the current organisation of medicine and a redefinition of our health needs. This is not, of course, to suggest that in a socialist society all existing medical knowledge and skills would simply be abandoned in favour of something called "proletarian medicine" ... [But] no technology would be used uncritically and without some assessment of its value according to criteria which had been democratically decided upon ... Hence a socialist health service would not only have to provide equal access to medical care but would also have to address itself seriously to such problems as how to demystify medical knowledge and how to break down barriers of authority and status both among health workers themselves and also between workers and consumers.

The theme of the necessity of changing *the social relationships embodied in medical practice* under socialism is taken up by other Marxist critics of the National Health Service (NHS) in Britain. After criticising existing left orthodoxy, which sees within the existing structures of the NHS a more-or-less socialist form of medical care requiring only an injection of formal democracy, Mick Carpenter (5) argues:

> A socialist health service ... will be one where all barriers of hierarchy and mystification, between health workers and between them and the sick people they work with are torn down. It will be a health care provided neither because of the material necessity

of wage workers nor out of an imposed set of obligations which fall upon certain people, mainly daughters and wives.

Vicente Navarro (6) has pursued this theme of changing the social relations of medical practice, insisting that "Communist medicine is not bourgeois medicine better distributed but, rather, a qualitatively new form of medicine created by new relations of collaboration and cooperation in the process of the production and reproduction of health."

The forms of medical technology and science themselves are therefore likely to be transformed under communism. This is not to argue that all capitalist medical science and technology is false or wrong, merely that capitalist social relations of production are reflected in the present choice of research areas and in the forms of technology used. Different social relations, those of reciprocal cooperation, would be reflected in the technology of communist medicine. An attempt to specify the way medical technologies under capitalism reflect the social relations of capitalism has been made by the Radical Science Journal collective (7). For instance, Shelly Day (8) suggests that obstetric technology reflects both capitalist and male interests in the way it reinforces the passive role of women just at the point where (ideally) their active control of birth process is required. Postnatal depression, Day argues, may result from this highly contradictory experience.

Recently a number of authors and organisations have attempted to construct in a more concrete way the expectations we should have of a genuinely socialist medical care policy. Colin Thunhurst (9) has argued that the scope of health services should be increased to embrace an occupational health service controlled by workers. Alex Scott-Samuel (10) has suggested the need for a socialist epidemiology in which a community diagnosis focus would be central, where questions would be asked by those who live in a locality about who is ill and why and what could be done to create more healthy living and working conditions. It has also been argued (11) that the service should allow for alternative modes of treatment, and for the involvement of people in the provision of services in the way that is now prefigured by some Well Women clinics. There should be a "different relationship between health team and patient ... [providing] the patient with the opportunity to participate in a fully informed decision concerning the course of treatment."

The Politics of Health Group (11) has argued that we need to challenge the medical dominance and "hierarchy" in the health service; to give patients more say in their own health care; to capture more control over our health; to give "community care" real meaning; to achieve more and better routine healthcare for non-life threatening complaints; and to fight the *causes* of ill-health.

One organisation that has tried in its practice to prefigure these conceptions of a genuinely socialist medical care policy in the here and now is the Community Health Council in Brent, North London. Its publication *It's My Life Doctor* (12) designed for use by the local community, sets out seven common medical problems, how they might be prevented, how the National Health Service fails in relation to them, and what kind of preventive and curative health policy would be more appropriate to the needs of people suffering such problems.

The feminist critique of medical care practice under the NHS is also well advanced (13). A socialist health service that responded to the feminist critique would abolish the sexist content of medical practice. Thus, women's ailments and conditions (e g, menstruation, menopause, pelvic inflammatory disease) would be given proper attention. Gender stereotyping of women through the use of such labels as "hysterical" would be challenged. Women would take control over their bodies in matters of sexuality (abortion on demand) and childbirth (natural childbirth). The form of service would be altered so that women did not just perform the caring functions such as nursing while men performed a separate curing function. Nor would women be left to carry the burden of caring for the family. A socialist epidemiology would also incorporate a feminist epidemiology. Central to this would be the recognition that the disabling double burden of paid work and domestic work should be alleviated.

The conclusion so far that socialist medical care would embody a transformation in the social relations of medical practice reflects the general conclusions I have drawn elsewhere (14) that the transformation of the social relationships of welfare is central to socialist and communist social policy. I have argued that the conception of a transformation of social welfare relationships needed to be thought in relation to six key aspects of social policy: 1) the priority afforded social policy, 2) the form of control over welfare provision, 3) the agency of welfare provision, 4) the nature of the relationship between welfare provider and user, 5) the rationing systems adopted by the welfare institutions concerned, and 6) the assumptions embodied in the policy regarding the sexual division of labour. I also argued that a distinction should be drawn between socialist and communist social policy. The summary of our expectations of both socialist and communist medical care policy indicated in Table 1 is based on those general considerations relating to social policy as a whole and the specific considerations reviewed so far in this article relating to medical care in particular.

A few comments on Table 1 are necessary. First, it has been argued so far that a policy for health under socialism (and communism) would not just be a policy of providing a transformed medical care service. Issues of medical care would be redefined into issues of health, which in turn would become issues of working conditions, housing, and economic and social life in general. It has been argued (15) that a socialist conception of health can only be developed once medical care itself is removed from the centerpiece of analysis. The view taken here is that in assessing progress in any socialist society, we need to consider both the form that socialist medical care provision will take (to cure and care for those suffering from unavoidable disease) and the extent to which a socialist health strategy has been developed that places equal emphasis on changing social conditions to prevent avoidable ill-health. The table attempts to show both how the form of medical care would be different and how a socialist health strategy would be developed (though perhaps concentrating more on medical care policy than on health strategy). Measures of whether a socialist health strategy is being developed are provided by the criteria dealing with the priorities of medical care as between cure and prevention, and by the assessment of the outcome of medical care (health) policy in terms of morbidity and mortality.

Second, the priority given to medical care under socialism cannot simply be measured in terms of the resources put into the health sector of the economy, whether in terms of money, person power, or facilities. While we would expect health ex-

penditure to become a higher priority in the initial stages of socialist development, the infusion of resources is clearly no measure of socialist progress in medical care in societies already at the threshold of communism. As we have argued, greater benefit in terms of the health of the population is more likely to come from transformed working and living conditions that prevent avoidable ill-health. A measure of the output of the health service in terms of morbidity and mortality rate is a better indication of the priority afforded to a society's health than a measure of money spent on the health sector. A lower level of morbidity and mortality is also likely to reflect the importance attributed by a society to the preventive aspects of medicine, which are otherwise so difficult to quantify.

What people suffer and die from is another important measure of socialist progress. This applies both to underdeveloped and developed socialist societies. In the former, the eradication of the preventable infections and communicable diseases will be a crucial indicator; in the latter, a reduction in the incidence of the new illnesses of developed societies will be a measure. Socialist and feminist epidemiology has already made progress in identifying the social causation rooted in the capitalist mode of production of such conditons as cancer and cardiovascular diseases. A genuinely socialist health strategy would therefore be expected to have acted upon the conclusions of this new epidemiology and effected changes in the relevant social conditions which will show up in terms of reduced morbidity and mortality from these new "capitalist" diseases.

Third is the rationing of medical care. Elsewhere (14) we have concluded that services did not necessarily have to be free at the point of use to be allocated along socialist lines. As long as incomes were more-or-less equalised, and as long as the commercialism of the private market was no longer present, the attaching of a price to a service provided by the state (e g, housing) could permit the users of a service to ration their own use of the service (a smaller or bigger house?) according to their own set of priorities. Now there is the argument that charges for health services, even if incomes were equalised, should not be made because an individual use of the service has indirect impact on the health and welfare of others, and everyone's use must therefore be encouraged even if an individual would order her or his own priorities differently. Indeed, there is even the argument for

Table 1

Expectations of socialist and communist medical care policy

Aspect of social policy	Aspect of medical care policy	Socialism	Communism
Priority	1. Outcomes in terms of health	Less and more equal morbidity and infant mortality than capitalism; greater and more equal life expectancy	Less and equal morbidity and infant mortality; greater and equal life expectancy
	2. Resources in terms of money	Higher expenditure than capitalism	Need for higher expenditure may no longer exist
	3. Resources in terms of person-power/facilities	Higher level of resources than capitalism	Need for higher level of resources may no longer exist
	4. Priorities in terms of cure, care, prevention	Prevention and care prioritised	Prevention and care central
Control over welfare provision	5. Central control	Central direction with political cadre influences	Centre provides democratically resolved planning guidelines only
	6. Local control	Democratic worker and user involvement	Mass participation in policy resolution and implementation
	7. Control of medical technology industry	Nationalised and progress toward socialised relationships	Socialised working relationships within industry and between it and the health service
Agency	8. Agency of provision	State, workplace, family and market giving way to community provision	Community provision
Relationships between provider and users	9. Status of doctors	Lower than under capitalism	Equal status with all workers
	10. Division of labour in medicine	Reduction of vertical and horizontal divisions	Abolition of vertical divisions; movement between horizontal divisions
	11. Nature of medical technology	Progress toward new forms	New forms of medical technology reflecting communist social relations
	12. Status of patients	Higher, accompanying deprofessionalisation of doctors	Equal status with providers
Rationing systems	13. Region and class access, usage, and outcome	Progress toward equality	Equal access, usage and outcome
	14. Rationing procedures between individual patients	Free usage with access rationed by work and need according to democratically determined formulae	Free usage with access according to self-perceived need
Sexual divisions	15. Sexual division in medical care employment	Progress toward no division	No sexual division of medical labour
	16. Sexist content of medical practice	Progress toward no sexist content	No sexist content of medical practice

a practice of financial inducements to use a particular service for the beneficial impact that an individual's use of it might have on the health of others. This assumption of nil direct cost to the individual consumer of the service is built into the table as a measure of socialist progress (even though this may not be such a crucial aspect of a socialist health service as is usually assumed). It can be taken as one measure of a nation's collective commitment to the health of all its members.

There are a number of other problems associated with the criteria used to determine socialist and communist progress in medical care, including those of putting into operation the general measures indicated in the table. How exactly is the "lower" status of the medical profession to be determined? How is progress toward deprofessionalisation to be measured? What are the indicators of the abolition of the sexist content in medical practice? These problems of operationalisation are often compounded in practice by the non-availability of data. Despite these difficulties, however, I believe it is possible to draw some general conclusions about the socialist status of the medical care policies of the countries studied.

Soviet Medical Care Policy

There are many accounts of the Soviet health service by writers of various shades of socialist opinion. These vary from the openly enthusiastic (16) to the fundamentally critical (17). The summary survey provided here is distilled from these and a number of other secondary sources (18-20). For the discussion of the extent to which there are sexist aspects to the organisation and content of medical care, more general works on the position of women in Russia have been consulted (21-23). Detailed references are not generally provided to these frequently used sources.

George and Manning (1) state that, at the outset, Bolshevik medical care policy goals included: comprehensive qualified medical care; availability to everyone in the population; a single, unified service provided by the state; a free service; extensive preventive care, with the aim of creating a healthy population; and full worker's participation in the health service. While many of these goals continued to guide policy and many were achieved, the development of medical care policy also came to be shaped by other historical exigencies, especially in the periods of socialist retrenchment during the New Economic Policy (1921-1929) and of intense industrialisation and forced collectivisation of the 1930s. The way these factors influenced medical care policy and the final outcomes of policy will now be considered in detail, under the following headings: the priorities of medical care; the control of medical care; the agency of provision of services; the relationships embodied in medical care; the agency of provision of services; the relationships embodied in medical care; the rationing procedures adopted; and lastly, the extent of sexist organisation and content of medicine.

Priorities of Medical Care

Does Soviet medical care live up to the expectation we would have of it if it were socialist in terms of 1) providing more health care resources than comparable capitalist societies, 2) distributing health care resources and activities disproportionately in favour of prevention, and 3) providing for a healthier population than populations in equivalent capitalist societies?

The Soviet Union spends a far smaller proportion of its gross domestic product on health care than the Common Market countries. Michael Kaser (18) estimated that 2.8 per cent of GDP was spent on health care in the USSR in 1968, compared with 5.1 per cent of GNP for the United Kingdom, 8.0 per cent for Italy, and 5.0 per cent for Ireland. A more recent estimate (24) based on 1974 figures suggests this has dropped to 2.5 per cent. However, in terms of the number of doctors and hospital beds per head of population, the Soviet Union is far ahead of these same countries. There were, in 1977, 34.6 physicians per 10,000 people in Russia compared with 2? ? in the EEC as a whole. There were 121 hospital beds for the same population in 1977 compared with 95 for the EEC (24). These details are summarised in Table 2. The apparent paradox between low expenditure levels and high-level provision is resolved once it is understood that first, there has been far less capital expenditure on Soviet medical care compared with the EEC. In 1970, 5 per cent of health service outlays was devoted to capital expenditure in the USSR compared with 10 per cent in Britian in 1971-1972 (18). This explains the often reported poor quality and overcrowding of medical care institutions and the lack of surgical and pharmaceutical equipment that occurs from time to time.

As to the priorities within health service expenditures, it is clear that, despite the early creation of a preventive arm of the health service, the hospital sector of medicine dominates all the other sectors and consumes the largest proportion of resources. The Bolshevik government in the very early days established the important departments of sanitation and epidemiology, with responsibility for flying propaganda squadrons combating social sources of disease. This was seen in 1928 by one sympathetic commentator (25) as "offering a good example of the new attitude and principles of Soviet medicine." Even in 1925, however, expenditure on sanitary and hygienic education and on campaigns against contagious disease consumed only 2.6 per cent of the health service budget (25). The Council on Medical Education in 1925 aimed to produce doctors with not only a thorough scientific understanding of the connection between biological

Table 2

Medical Care Expenditures, Resources, and Outcomes in the Soviet Union, Eastern Europe, and Comparable Capitalist Countries[a]

Indicator	Soviet Union	Hungary	Poland	Nonsocialist comparison
Percentage of GDP spent on medical care	2.5[b]	3.3[b]	3.9[b]	5.1-6.7[c] (EEC states)[d]
Population/physician	289[e]	435[e]	606[e]	455[e] (West Europe)
Population/hospital bed	82[e]	114[e]	113[e]	105[e] (West Europe)
Infant mortality/ 1000 live births	27.8[f]	24.3	22.4[f]	11.4-17.6[e,f] (EEC excl. Portugal)
Life expectancy:				
Male	66.5[f]	66.1[f]	66.5[f]	70.2[e]
Female	74.3[f]	72.8[f]	74.9[f]	76.3[e] (Britain)

a Sources: references 18, 20, 24. b 1974. c 1971-72. d percentage of GNP. e 1977. f 1975.

processes and disease, but also with: 1) sufficient social science background to enable them to understand current social life and world events: 2) the materialist point of view, which is essential to a correct understanding of the mutual relationship between an organism and its milieu, 3) the social service point of view, which takes into account the working conditions and home life of the patient; and 4) the knowledge and ability not only to treat diseases, but to prevent them. However, an analysis of the curriculum of the Medical School of Moscow University of 1925-1926 suggests that even if we are to include such topics as "Historical Materialism and the History of Revolutionary Movement," only about 5 per cent of the content was directly related to these four points. The socialist idea of creating a new medical knowledge and practice derived from new social relations of production reflected in a new division of labour between doctor and patient, does not seem to be borne out by the existence of this disease- and clinically-oriented curriculum.

Turning to the present day, the proportion of doctors working in hospital care compared with ambulatory care is increasing. There is more rapid increase in the number of doctors specialising in tertiary medicine (e g, surgeons, neurologists, psychiatrists) (17). One estimate (19) of the proportion of health care resources devoted to "environmental health and physical education" is 4.8 per cent. There is evidence, though, that the quality of primary care is better than that of hospital care.

The outcomes of the Soviet health service, measured in terms of morbidity and mortality rates, cast considerable doubt on whether sustained socialist progress in health has been achieved. During the early years of the Revolution, progress was made in decreasing mortality and morbidity. By 1925, even though industrial output and grain harvest were below 1913 levels, infant mortality had fallen to half of the pre-Revolutionary level (20). This progress, when compared with that of the West, has now been lost, as can be seen from Table 2. Today, mortality rates for infants and adults compare very unfavourably. There were 27.8 infant deaths per 1000 live births in the whole of the USSR in 1975 and 19.2 per 1000 in the Ukraine Republic, compared with 15.7 in Britian in 1978. Infant mortality actually rose from 1971, when it was 22.9 per 1000, to 27.9 per 1000 in 1974 (20). Life expectancy was 66.5 years for males and 74.3 years for females for 1970-1975, compared with 70.2 and 76.3 for Britain in 1977. There is evidence that life expectancy for adult males began to decline in the mid 1960s. Age-adjusted death rates for adults rose from 861 per 100,000 in 1965-1966 to 955 per 100,000 in 1972-1973. The largest increase in mortality has been in the 40-59-year category (20). The absence of morbidity and mortality data analysed by social class does not permit any assessment as to whether there has been greater equalisation in longevity and mortality.

An analysis of the diseases Russians now suffer and die from also provides a disturbing commentary: "As the death rates from infectious disease have fallen in the Soviet Union, mortality from cardiovascular diseases and cancer has risen, both relatively and absolutely. The force of these modern epidemics has been sufficient to *raise* [the] age adjusted death rate by 18 per cent over the last decade" (20). Cooper and Schatzkin (20) comment that "social environment... typical of capitalist society... can be shown to be responsible for these mass diseases." The first Commissar of Health in the USSR said: "There is no interest in concealing the social character of these diseases... the social causes of diseases among working people are found out in order to remove them." But Cooper and Schatzkin (20) conclude: "The opposite [now] appears to be the case: disease is promoted, its social character is obscured and avoidable hazards are not removed."

Control of Medical Care

The early days of the socialist experience in Russia (1917-1921) provide perhaps some of the most potent examples of the possibilities of socialist medical care policy in terms of formal control over medical care policy and institutions. The direct confrontation in the 1920s between the medical profession's Pirogov Society and the Bolsheviks, which was won by the Bolsheviks with the aid of the health workers' union, should be noted. This struggle curtailed the special privileges of the profession and the control it had over medical care institutions at that time. This early period of Russian history provides us with the best practical examples of how the important issue of control of health service and other welfare institutions will be raised under socialism. The debate, which is also recalled by Navarro (17), between those who favoured control by the workers in health service institutions and those who favoured control by soviets or delegates of workers in a locality, is one which poses for us now the question of what form democratic control should take in any future socialist society. In this example, the form of administration chosen was one in which doctors, as state-salaried employees, had no special professional access to power, with the day-to-day management of health service institutions invested in a nominee of the local soviet, who would be advised by an elected committee of health service workers. Those who favoured control of each institution by a democratically elected committee of workers of that institution were criticised for not understanding the needs of overall planning and were defeated.

With the eventual erosion of any active life in the local soviets and as soviets became empty conduits for the rule of an increasingly centrally controlled and Stalinist Communist Party that determined even local policies through the national budget, any vestiges of active worker participation in—let alone control of—health service institutions disappeared. At the same time, the initial decline in the power of the medical profession was reversed. The Ministry of Health has relied heavily in more recent years on the advice of the increasingly institutionalised medical profession, and it has become the practice for all directors of health service institutions to be qualified doctors. The ratio of income between doctors and nurses is now as large as 10:1 (17). Indeed, George and Manning (1) conclude that, nowdays, "Soviet health care [is] centrally controlled to meet the requirements of industrialisation and the academic interests of medical scientists." However, despite this heavy reliance today on medical personnel to run the health service centrally and locally, a large proportion of these administrators are Communist Party cadres and are, of course, in the last analysis, responsible to the Central Committee of the Party (17). The socialist notion of political control of policy through the active involvement of party cadres at all levels of administration is theoretically maintained; however, from the point of view of an ideal socialist medical care policy, the ideas and

practice of these cadres leave much to be desired. They no longer appear to favour—if they ever did—the genuine mass involvement in health matters which should be the hallmark of communist medicine.

Agency of Provision of Services

The main agency of provision of health care in Russia is the state. Hospitals polyclinics, feldsher outposts, and so forth are all run on behalf of the state by local councils, but there is scant evidence of mass participation in, or democratic election to, the local bodies which run these institutions. The workplace features quite significantly in the system of provision. Under the Stalinist industrialisation policy, a large number of health centres were established in industrial enterprises. There ranged from 100-bed hospitals to the provision of a nurse. They were organisationally separate from the Soviet-run health services and were part of a policy of giving priority to preventing loss of industrial production. The demands of industrialisation and the needs of workers coincide to some extent here, but it is not easy to determine how far these services give priority to the latter over the former when it comes to a direct conflict between them. The scarcity of Russian data on disease and death analysed by social group, and the nonpublication of accident data, is perhaps indicative of which priority is uppermost. There is further evidence of the priority given to workers in Russia by the development of separate health service institutions run by and for railway workers and the wide provision of rest cure and convalescent homes and holiday villas by trade unions for their members.

The private market is an important provider of medical care services in the Soviet Union, although there is some legal and some illegal private practice. Abortion constitutes on example. Additionally there are autonomously financed medical institutions, or "paying polyclinics" (*platnaya poliklinika*), in Moscow and other big cities where patients pay a small sum for prearranged appointments with specialists. Like the nonpaying polyclinics, these are run by the local authority and are not really examples of the operation of a competitive market in medicine. They provide, however, a commentary on medical care rationing procedures used. If you can pay, you get better treatment. Although it is discouraged, payment for treatment is also made on a regular basis to doctors and nurses in ordinary state hospitals. In the 1960s the table of customary payments ranged from 5-25 roubles for attention in hospital to 500 roubles for a course of treatment for venereal disease by a senior specialist (18). Women in the family still provide a large amount of medical care in terms of nursing the sick and elderly. This is institutionalised in the provision made for women (not men) to receive state grants for time off work to look after sick children.

Relationships Involved in Medical Care

Turning now to the various aspects of the relationships involved in medical care, we must remember that the status of the medical profession in the Soviet Union is lower than in the West. The division of medical labour is similar, however. The only exception is the feldsher system of partly trained nurses-midwives-practitioners who practise in rural areas. This is a socialist innovation, but one inherited from pre-Revolutionary days. Indeed, early Bolshevik policy, later abandoned, was to get rid of these "second-class doctors."

Whether or not Bolshevik policy initially understood that socialist medicine must redefine the practice of medicine, in such a way that a change in the division of labour takes place in both the vertical and horizontal senses, there is no evidence that this policy was pursued in later years. Indeed, the absence of a family doctor system brings specialisation and mechanistic medicine even into the diagnostic stage of the polyclinics. George and Manning (1) write:

> For example, the Ministry of Health recently stated that "it is impossible to conceive th[illegible]ly a single doctor with a broad background co[illegible]arantee highly qualified care for patients suffering from a variety of illnesses which are frequently complicated to diagnose and treat." Such a view in contrast to the major incidence of relatively simple and self-limiting illnesses brought to primary-level physicans, clearly indicates the interest and perception of medicine oriented towards academic specialisation rather than patient needs.

There is also the practice of tipping doctors, which reflects the esteem in which doctors are held by patients. There are no adequate independent complaint procedures against doctors. There is no free choice of doctors by the patient. These points contribute to the conclusion that there has been no sustained challenge to the relationships involved in the capitalist practice of medicine in the Soviet Union. Navarro (17) is convinced that the Soviet system of health care is dominated, as in the West, by what he terms technologicalisation, depoliticisation, hospitalisation, and urbanisation.

Rationing Procedures

Does Russian medical care embody socialist aspirations in its system of distribution and rationing? There is evidence (1) of a sustained attempt to provide for a reasonable degree of territorial justice between different regions of the USSR in terms of doctors and hospitals, although the quality of service probably varies geographically more than the quantity. The emphasis on central planning has enabled this achievement to be registered. Within each region of the country, however, resources are concentrated in the urban areas. For example, Moscow in 1972 had 76 physicians per 10,000 inhabitants compared with 28.3 for the country as a whole (17). There does not appear to be a larger number of feldshers to compensate for this in the underprovided-for rural areas.

It is more difficult to be precise about the allocation of services between social classes and groups. The urban concentration of resources, taken together with the development of workplace-based health services, reflects a concentration of provision in favour of the urban working class as opposed to the peasantry. There is, however, no hard evidence about health service usage by social class, or even, as we saw earlier, health outcomes by social class. Nor is the impact of any differential usage on health known.

The fact that polyclinics are, for example, open on Sundays for all services is a reflection of an overt policy to make services available in a way that fits the needs of working people. Against this, however, has to be set the existence of closed-access clinics and hospitals such as the colloquially termed *Kremlouka* for senior state and party officials. There is also a special polyclinic for scientists with a doctorate. Furthermore, the people who have privileged access to these facilities are the ones who are likely to be able to purchase pharmaceutical preparations, not otherwise readily available, in closed-access shops (*Zakryfie raspredeleti*) (18).

The medical care services are for the most part free, with the exception of the paying polyclinics described earlier. Price is generally as a rationing device only in relation to drugs, dentures, spectacles, and surgical appliances, and there are the exemptions for the young and the disabled. About 30 per cent of the cost of drugs in 1970 was recoverable by charges, which compared with 50 per cent in Britian (18). How services that are free are actually rationed informally between competing consumers is again not known. Waiting lists and queues clearly operate, but there is no discussion of the impact of these informal *ad hoc* rationing devices on usage by class, age, or sex in the literature reviewed.

Sexual Divisions

There are two aspects to the impact of the Russian health service on women: first, the extent of and nature of female involvement in health service employment; and second, the degree to which the practice of medicine is sexist in its content. There is no doubt that women have been recruited to all ranks of the medical and nursing professions and to ancillary employment in the health services in far larger proportions than in equivalent Western health services. Ninety per cent of primary care physicians, 70 per cent of nonprofessional workers, and 50 per cent of managers and administrators are women. Eight-five per cent of the total health labour force is female (17). (It must be remembered that the status of even senior professional health service employees is lower in Russia than in the West.) Women moreover occupy a small proportion of the more senior posts. Only 20 per cent of medical professors are women. There is also some evidence that, as the status of doctors increases, the employment of women in this sphere is declining. Only 54 per cent of those now embarking on medical training are women, and men are admitted into medical studies with lower grades than women (21).

Evidence to allow any firm conclusions to be drawn about health care as it affects female consumers is far more patchy. The right to abortion has sometimes existed in Russia and at other times, especially from 1936 until the 1960s, has been expressly removed (26-28). The demographic needs of the country have, in later years, played the most important part in influencing this policy. Childbirth nearly always takes place in hospitals. In so far as medical care and allied childcare facilities have been developed with the extra express "needs" of women in mind (e g, their right to paid time off to nurse a sick child in hospital), it has been argued that they have been predicated on the twin requirements of women as workers and as mothers. The emphasis on the role of women in Russia as mothers, despite their role as workers, is well-known and, some would argue (29), was even present in the work of Alexandra Kollontai in the 1920s. Indeed, it would appear that there is resistance among some Russian women to the demands of this double burden, so that genetic and psychological counselling is now a service being provided in Moscow to encourage childbirth and happy marriage (21). Lapidus (23) concludes:

> Soviet sociological analyses show no sensitivity to the distinction between reproduction—a biological fact—and child rearing or housekeeping—socially learned roles whose relationship to biology is not given but requires explanation. The equation of femininity, maternity and domesticity is virtually universal, and the recognition that roles might be socially assigned rather than endowed by nature is largely absent.

Although Lapidus does point later to emerging Russian examples of critical literature that attempt to challenge this idea (literature that goes so far as to present the case for reduced working hours for men to overcome the sexual division of labour), it is more than likely that medical care texts, education, and practice in this area are predicated on conservative and antifeminist assumptions. A feminist analysis of Russian medical textbooks and medical practice is awaited.

It is possible now to go some way toward determining whether any or all of the 16 expectations of socialist or com-

Table 3

Extent to which Socialist and Communist Medical Care Expectations have been Realised in Existing Socialist Societies

Aspect of medical care policy[a]	Soviet Union	Russia, 1917-21	Hungary	Poland	(Solidarity's proposals)
1. Outcomes in terms of health	No[b]	No	No	No	(Soc)
2. Resources in terms of money	No	No	No	No	(Soc)
3. Resources in terms of person-power/facilities	Soc[b]	Soc	½ Soc	No	(Soc)
4. Priorities in terms of cure, care, prevention	No	Soc	No	No	(Soc/Com)[b]
5. Central control	Soc	Soc	Soc	Soc	(Soc/Com)
6. Local control	No	Soc	No	No	(Soc/Com)
7. Control of medical technology industry	½ Soc	½ Soc	½ Soc	½ Soc	(Soc/Com)
8. Agency of provision	Soc	Soc	Soc	Soc	(Soc/Com)
9. Status of doctors	Soc	Soc	Soc	Soc	(N.A.)[b]
10. Division of labour in medicine	No	No	No	No	(N.A.)
11. Nature of medical technology	No	No	No	No	(N.A.)
12. Status of patients	No	No	No	No	(Soc)
13. Region and class access	No	No	No	No	(Soc)
14. Rationing procedures	½ Soc	½ Soc	½ Soc	No	(Soc)
15. Sexual division in employment	Soc	Soc	Soc	Soc	(Soc)
16. Sexist content of medical practice	N.A.	N.A.	N.A.	N.A.	(N.A.)
Number of socialist expectations realised	6	8	5½	4½	(12)
Number of communist expectations realised	0	0	0	0	(5)

Notes: a See Table 1 for an explanation of criteria used in this table.

b Abbreviations: N.A., inadequate information available to enable judgement to the made; No, the socialist or communist expectation has not been realised; Soc, the socialist expectation has been realised; Soc/Com, the aspect of the service could be attributed to the realisation of either socialist or communist expectaion; ½ Soc, in some respects but not all, socialist expectation has been realised.

munist medical care delineated in Table 1 have been realised in the Soviet Union. The results are tabulated, along with those for the other countries to be reviewed in this article, in Table 2. For only five of these indicators is it felt appropriate to claim unqualified socialist achievement in contemporary Russia, with some indication of this in a further two. The five relate to the level of service provided (more doctors and beds), the nature of the central control of the health services (political), the agency of provision of medical care (state and workplace), the status of physicians (lower), and the position of women as employees of the service (large percentage). Even some of these have to be qualified, however, and, importantly, there is evidence of recent reversal. The status of doctors appears to be rising, the position of women in the profession declining, and the influence of medical expertise on central policy increasing.

It is, of course, possible to interpret even these five indicators of socialist medical care policy in a different light. It could be argued that these aspects of the service are compatible with, and necessary to, the needs of an exploitative state capitalist or state bureaucratic ruling class. Their apparently socialist character may conceal other reasons for their existence. A society in which the accumulation needs of the ruling group took precedence over the consumption needs of the working class would quite likely adopt tight central control over health planning, develop a workplace-based system of health care to ensure productivity, limit the independent influence of doctors (and be more successful at this than a capitalist ruling class operating in conditions of parliamentary democracy), and pull all women into the labour force. Indeed, such a state capitalist or state bureaucratic class, while adopting these measures, would equally not adopt many of those measures which we have associated with socialist medical care but which Russia does not exhibit. Such a class would not spend much on health, would not allow a democratic form of control over its institutions, would not encourage preventive measures which clashed with accumulation needs, and so on.

There is certainly no evidence of communist achievement in Russian medicine. Paradoxically, however, in the early days of Revolution there was some such evidence in, for example, the democratisation of the service at a local level. This development has long since been reversed. There was also an important stress earlier, at least in official pronouncements, on preventive medicine. Russian medical care, then provides us with very few concrete examples of our conception of ideal socialist medical care, and none of communist medical care.

One final cautionary note. It was stated earlier that in one particular way the table of expectations of socialist and communist medical care (Table 1) underemphasised the fundamental break with capitalist medicine that communist medicine entails. Communist medicine would involve itself with all aspects of social and productive life (working conditions, living conditions, eating habits, relationships) in so far as they affect health. This review of Soviet medical care has only noted such wider aspects in small ways, and then negatively, e g, in relation to the pattern of disease, which is similar to a capitalist one. It is most unlikely that all aspects of social life in the Soviet Union are evaluated in terms of their impact on health. The conclusions drawn therefore probably overemphasise the socialist nature of Soviet medical care policy.

Hungarian Medical Care Policy

I do not intend to provide as exhaustive a review of medical care services in Hungary or Poland. Both countries occupy similar positions as members of Comecon and are, as we shall see, modelled in many ways on the Soviet experience, with the important difference that they had this experience imposed on them after the Second World War.

There is a limited secondary literature available on the Hungarian health service. The main sources used here are Kaser (18), Ferge (30), and World Health Organisation (WHO) publications (31), which are supplemented by personal observation and by discussions with the small group of social analysts working within the Institute of Sociology in Budapest.

Health care is universally available in Hungary and largely free at the point of consumption; however, this universality was finally achieved only in 1975. The insurance basis of the scheme excluded about 15 per cent of country dwellers, in 1960, but this was reduced to about 1 per cent by 1972 as a result of the collectivisation of agriculture that took place between 1958 and 1962. Those excluded were helped on a means-tested basis with medical fees by the social aid committees of local councils. Before the Communist Party came to power after the war, a large proportion of the population was excluded from coverage—except for the 133 days of Hungarian Soviet Republic of Bela Kun in 1919, a genuinely Hungarian-born revolutionary workers' council type of government, under which medical care was in principle provided free to all. (This regime was crushed and replaced by an authoritarian right-wing regime.) The system of health care in Hungary is remarkably similar to that in Soviet Union in a large number of aspects, although there is less factory medicine, more private medicine, and no use of feldshers.

The overall conclusions about Hungarian medical care are summarised in Table 3. They are remarkably similar to those for the Soviet Union, except that whereas the socialist nature of aspects of Soviet health care was in some doubt because of non-availability of data, the availability of such data for Hungary defines these aspects more clearly as nonsocialist. This is particularly the cause in the matter of inequality of morbidity and mortality by social class. Hungary differs from the Soviet Union only in not ever having experienced the brief democratisation of the health services that Russia did in the early years of the Revolution.

Polish Medical Care Policy

The purpose of including Poland in the survey is to examine whether the working-class uprising led by Solidarity in 1980 and 1981 might have made medical care policy more genuinely socialist had it not been suppressed. In the discussion of Soviet and Hungarian medical care polices, little mention was made of the existence of any social forces struggling against the current form of provision. This was mainly because there are none at present having much impact. Poland, by contrast, provides us with a modern laboratory in which to test out the theory that working-class struggle against the existing form of socialism contains within it the seeds of a struggle for a more genuine type of democratic socialism. Clearly Solidarity drew into its wake all manner of ideas, themes, and groupings whose aims may not have been the better development of socialism; however, these counter-revolutionary tendencies were insignificant (32).

More interesting is whether the end result of the struggle for socialism by Solidarity might have led to a pluralistic conception of socialism in which self-managed enterprises became increasingly subject to market forces to the possible detriment of the overall socialist objective. For our purposes here, we focus on the demands and the forms of struggle that arose in the course of the life of Solidarity as far as medical care is concerned.

In almost all respects, Polish medical care policy is like that of the Soviet Union and Hungary. Data on health expenditure and medical care outcomes are included in Table 2. The number of doctors and hospital beds per head of population is small compared with both the other Eastern European countries studied and Western Europe. A full account of medical care policy in Poland can be found in Millard (33,34) and Kaser (18). Millard (34) summarises his findings as follows:

> The health service has remained in a state of crisis, currently worsening as a result of mounting economic dislocation and political tension. Inadequate access to treatment, lack of continuity of care, poor quality of care, profound shortages of drugs and supplies, and the absence of preventive medicine are some of the manifestations of this crisis. Its main causes lie in the political weakness of the Ministry of Health, with consequent underfunding and the non-fulfilment of its plans. This situation is exacerbated by continuing organisational fragmentation, the neglect of primary care, existence of conflicting aims in health policy, and the dominance of an ideology of clinical specialism.

Rather than reviewing the Polish health service systematically in terms of the six questions and 16 criteria applied to the Soviet Union and Hungary, I shall concentrate on three aspects of policy which, taken together, indicate just how far the Polish health service had reached a state of crisis even worse than in other Eastern European countries surveyed. As we shall see later, it was precisely to these aspects of medical care policy that Solidarity paid most attention in its proposals for fundamental change in Polish society. The three aspects are the failure of the central planning system, the inequalities of access and corruption involved in access to decent health services, and the neglect of preventive medicine. The summary Table 3 does, however, evaluate the Polish medical care service in terms of all the criteria established earlier.

Crisis of Planning

Central planning of medical care and the implementation of the plan at the local level are in the hands of people placed in position through the system of *nomenklatura*. This party control of key positions extends as far as directors of important medical establishments (32). It was described in the critical report prepared by members of the Experience and Future Discussion Group (DiP) (35) in Warsaw in 1980 as "the personal merry-go-round," which enables a person listed to be appointed to a post conferring equivalent or even higher status after having bungled a previous job. The tendency in this situation is for particular aspects of plan fulfilment to be nominally achieved even by cheating or misrepresenting data, and for plans to be politically constructed to accommodate the interests of those engaged in their nominal fulfilment. Those whose jobs rest on paper fulfilments have no interest (unless pushed from below) in real fulfilment of plans, especially if, as we shall see later, their particular material interests are separately catered to. Only the democratic association of actual producers has a genuine interest in real plan fulfilment. These tendencies found expression in the Polish health services in terms of, for example, extending the stay of certain patients in hospital who no longer needed treatment to bring down the average cost of treatment of patients registered in that hospital to the norm in terms of cost per patient per day. Another example is that certain units did not provide access to diagnostic equipment for other units since they did not want to bear the cost. A further example is where construction enterprises concentrated on fulfilling easier components of their building programme than those represented by hospital construction. In so far as problems arising from these practices were identified by the Polish government, the solution was always seen in terms of improved administration rather than a political challenge to the structural aspects of the system that led to these practices (34).

Inequality of Access

The other side of this coin of bad management is that the managers can afford to be protected from its worst aspects by virtue of their privileged access to special clinics, or their ability to bribe their way past the access barriers of the state service. The following account drawn up by the Experience and Future Discussion Group (35) portrays this graphically:

> The state of the municipal and general hospitals is catastrophic: hospital wards are overcrowded, and cases of death among patients left in hospital corridors are not uncommon. Conditions created by chronic under-investment in health services fully warrant the assertion that access to treatment, hospitals, good doctors and medical equipment has become very difficult to obtain for the majority of the public. At the same time, the privileged few have special enclaves of luxury closed to people who do not belong to that group. A glaring example is the Ministry of Health clinic at Anin.
>
> Free health care for the vast majority of the population was once considered an achievement of People's Poland. But unfortunately, today the situation is completely different. Irregularities and deficiencies in health care have meant that medical treatment now requires money, quite a bit of money, as well as connections and pull. They have led to a distressing situation—if one does not bribe the nursing staff, one does not get decent attention, and if one does not bribe the doctor his care will be marginal. One now pays to get a bed in a hospital or an operation, to say nothing of medicine. Gradually the public is being divided into two categories: those who can afford proper medical care and those who cannot. If the situation does not improve substantially, the latter group will get even larger. If we are to compare incomes to the real costs of obtaining treatment by a specialist, we would probably find that at least half the public could not afford it today. This situation is alarming in the extreme.

It has been estimated (36) that the money allocated recently to create 120 places for the privileged elite at the Anin Clinic could have added 1,100 places for ordinary patients. This privileged access to special hospitals is not restricted to the managerial and bureaucratic elite, but is available also to paid officials of the Trade Union Central Committee. The TUCC has its own polytechnic "which has the advantage of referral for inpatient treatment to the Hospital of the Ministry of Internal Affairs" (18). No doubt this was one of the reasons for the rapid desertion from the official trade-union movement to Solidarity once it was formed.

Neglect of Preventive Medical Care

The lack of attention to preventive medicine in Poland involves the continuation of dangerous working processes, the

pollution of the atmosphere and rivers, and the production of carcinogenic foods. On the first point, a Solidarity spokesman (32) stated:

> Health and safety has been one of our greatest problems for many years. The health and safety representatives of the old unions were too close to management. The health and safety councils were worthless. Production had to be kept up at all costs.

Something of the consequences of this situation can be judged by an analysis of work days lost in Poland. In 1974, accidents, poisoning, occupational and nonoccupational injuries were reported to be the cause of 20 per cent of all days lost from work (18). On the question of atmospheric pollution, the Experience and Future Discussion Group (35) commented:

> Industrial enterprises emitted 3,439 million tons of gases [in 1977] into the atmosphere but trapped only 667,000 tons. If one adds to this that the majority of stack filters are almost always shut down because of the energy shortage, it must be concluded that Poland is one of the few countries in the world in which emission of industrial gases and particles into the air is not subject to control.

On the question of harmful foods, the same report (35) asserts that "25 per cent of the food products on sale have characteristics that are to some degree harmful to health, to say nothing of the many food products that are commonly adulterated by producers." Added to this must be the chronic alcoholism in Poland.

Table 3 summarises the position as far as the socialist status of its health services is concerned. Even allowing for the corrupt system of party *nomenklatura* to be classed as socialist cadre control, Poland scores still worse than its socialist neighbours. The second column indicates the extent to which the demands of and forms of struggle adopted by the Solidarity movement during its brief life, if implemented or adopted permanently, would have led to the health service becoming more genuinely socialist or even communist.

Solidarity and Medical Care Policy

Clearly a number of different political currents were present within the Solidarity movement. Those who propounded an explicit commitment to a Marxist analysis were probably in a minority, and argued with others who held a perspective of a pluralist socialism in which decentralised self-management enterprises operated to meet needs in the context of market demand. Nonetheless, it was impossible to perceive a fairly consistent line emerging from Solidarity on the question of health policy. This policy can be deduced from the reports of the Experience and Future Discussion Group (35), the text of the charter of Workers' Rights published in September 1979 (32), from the Gdansk agreement itself in August 1980 (37), and from *ad hoc* reports that emerged from Poland before the imposition of martial law in December 1981. These reports indicated that more resources should be found for health care and greater priority should be given to preventive medicine. This was usually expressed in the more limited terms of occupational safety, but a general concern for "the pillage and devastation of the natural environment" was present. In common with all other parts of the economy, the centralised planning system should be replaced by a system of workers' self-management. Medicine should be free (at least, and this reflects a certain sectionalism in the union's demands; to health service workers). Privileged access to medical care should be abolished and a fairer democratic rationing procedure for allocation to, for example, holiday homes, should be worked out. Early retirement (age 50 for women and 55 for men, or after 30 and 35 years' work, respectively) was a further health-related demand. Missing from the analysis of issues and list of demands was any real confrontation with the existing horizontal technical division of labour in medicine or with the form of technology and curative procedures used, although, in general transformed social relationships were at the heart of the methods and goals of Solidarity. The statements on the status of the medical profession were equivocal on this point. Also absent was any concern for the sexist content of medical practice. Indeed, spokespeople involved with the self-management movement often expressed quite conservative views on the issues of central concern to Western socialist feminists. The Experience and Future Discussion Group (35), for example, concluded: "Family policy ought to be as solicitious of the material well being of the family as of its moral status, which requires better preparation for family life, safeguarding the stability of the family, and the efforts to control the mass spread of abortion." The October 1981 Solidarity conference resolved, in a section dealing with family policy, to urge the creation of decent living conditions for unmarried mothers in order to discourage abortions. However, by November 1981, one month before the demise of Solidarity, the *Guardian* (38) could report the existence of a Women's Forum in Warsaw which listed among its areas of concern the need to dispel stereotyped images and harmful myths about women in society, to ensure teaching about and improvement of birth control techniques, and to overcome the situation where arguments about abortion are "distinctly naive."

While a number of such general goals of medical care policy were emerging during the life of Solidarity, sectional demands were also being put forward of interest only, for example, to the workers in the health service. The demand that salaries of all health service workers be increased, and that additional payments be made for handling patients with infectious diseases, are two of these. The latter embodies the idea of hazard pay, which could be criticised from a socialist perspective.

Solidarity, in the form that gave rise to these demands, is now repressed. This, itself, is a commentary upon the nature of Polish socialism. However, even in its short life, and before it had time to work out a strategy for the successful implementation of workers' democracy in Poland, it accomplished some achievements in the health field. These included: the change of use of administrative buildings to health use, the sacking of certain incompetent and corrupt health officials, the closure of an aluminium plant in Silesia because of the effect it was having on the local environment, and the direct control by workers of the distribution of medical equipment in short supply.

Thus, while Millard (33), writing even before the demise of Solidarity, was partly correct in his interpretation that "there is no cause for optimism as the Poles struggle with the problems of years of under-funding, a cumbersome and inadequate planning system, a weak ministry, and a hierarchy of organisation and status which favour clinical specialism to the detriment of a widely conceived primary care sector unifying curative and preventive medicine", he was also partly wrong in not seeing the potential, albeit not realised, for the socialist transformation of the health service that was surely there in the ideas and programme of Solidarity.

Conclusions

This survey of medical care policy in existing socialist societies has led to one inescapable conclusion: In the economically advanced socialist societies of the Soviet Union and Eastern Europe there is very little evidence of socialist, let alone communist, forms of medical care policy. Mortality data from these countries, which are a measure of health policy as distinct from medical care policy, also compare unfavourably with data from equivalent capitalist countries.

It has been argued that the few characteristics of Eastern European medical care policy that have been described as socialist (e g, the state's role as major provider, the lower status of doctors, the employment of women in the health sector) may be attributed, for example, to the fact that these societies are dominated by a state bureaucratic or a state capitalist ruling class. Such a class is able to exercise more effective control over employment policies and levels of pay unhindered by the independent health trade unions and professions that are a factor in the West.

The accounts have not revealed a static picture of policy. There was evidence in the early days of the Russian Revolution of radical experiments in medical care policy. These seem to have given way over the years to a more orthodox capitalist-like view of what constitutes good medical care. Hungary and Poland never experienced such radical experiments. The possibility, once again for the moment repressed, of a new leap forward toward a more genuine socialist and even communist medical care and health policy in Poland has been described.

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Obstetrician on Trial

AFTER a 10-month suspension from all clinical and lecturing duties, obstetrician Wendy Savage is in the midst of a month-long inquiry into the management of five women during childbirth at the London Hospital. She is accused of professional incompetence, a charge usually reserved for alcoholic, drug dependent or similarly incompetent doctors.

The barrister representing the local health authority which brought the charges said the case was being presented as if it were a contest between the male establishment and the women's movement, and between the impersonal imposition of technology and a woman's freedom to decide how she gives brith. While he does not see the case in this light, the women's health movement in Britain is convinced it is precisely that.

Wendy Savage is the only obstetrician at the hospital who does home visiting for ante-natal care, and she involves women fully in decisions as to how they give birth. She is at odds with other doctors in the hospital over the politics of obstetric practice, and has fought to keep the abortion unit open when others would like to close it. There has been evidence during the inquiry that the head of obstetrics intended to try and oust her from the time he took over his job. The previous head of the department, who had set the principles and standards which Ms Savage also follows, also faced a great deal of hostility until he left.

What the local health authority probably did not expect was for the case to get such wide public attention. The inquiry has been held in public at Ms Savage's request, accompanied by constant media coverage and public discussion. Whatever the outcome, the practice of obstetrics is bound to be affected, as so many women have heard the arguments for women's choice in childbirth.

—Women Global Network on Reproductive Rights