and "successfully" this mode functions, in reducing mortality and morbidity, the more is its success in empowering the state at the cost of the people.

Illusions created by the "public-private contradiction" have made many communist parties and otaer marxists think that the growth of the state sector is something progressive and going nearer to socialism. But the *health system* will not radically change to become a liberative process if the new arrangement only subtracts the bourgeoisie and replaces it with experts and bureaucrats while organising a better distribution of the existing type of facilities. We have to break from the prevalent concept of health forced upon us by centuries of the health establishment and society — and to understand a health system as itself a process of liberation.

Finally, after defining the "central strategic problem for activists," Waitzkin concludes by describing what they are doing. But this can be extremely misleading, for of the three trends he more or less classifies as those advocating a "vanguard party", a "mass party" or "counterhegemonic" work, only a very small minority hold the mechanical view of taking control of the state which he puts forward in the article. To say that "Party building is now taking place throughout the United States (1.1.)" is an inaccurate, to say it most kindly, depiction of the innumerable mass movements the US has seen.

If we look back at Waitzkin's own bibliography of 260 references, there is hardly any marxist critique of health before 1970 in the USA. The reason seems to be that it was the struggles of blacks, women youth and others that transformed the earlier sterile attitudes towards health and stirred them up. It is sad that Waitzkin, instead of starting from the reality of the movements, reverses this process by trying to fit the creative activism of the people into the "work of Party builders" and into such an authoritarian and narrow concept of Marxism. In the end, his type of "marxist view" raises the question, what was Marx's view? Marx vigorously supported movements against exploitation and oppression and tried to learn from them. In his openness to learn from rebellions he was ready to throw away much of his earlier views. This, and not narrow theoretical preconceptions, we think, should be the "marxist view."

Need for Analtyical Rigour

Imrana Quadeer

SHR's effort to provide a platform for discussions and interaction between activists in the field of health and its focus on the process of distilling the truth from various trends within the marxist movement is most welcome. However, the fact that health and medicine cannot be separated from the problems of the wider social order, underlines the dilemma that no serious analysts of health and medicine in India can afford to take for granted the issues within this wider social order. A theory of health and medicine is not possible in isolation. Those who try to build such a theory would be required to develop an analysis of society as well. SHR has circumvented the problem by leaving this task to other forums and have presumed that readers will either know the debates on these issues or will accept the views that contributors present. An easy way out perhaps, but not one that is conducive to constructive debate on either the specific theory of radical health action or general theory of radical political action. For example, when we talk of "political economy of health", "articulation of medicine within a mode of production" or "class structure in health system" without specifying our understanding of the terms used, we not only fail to communicate but often create confusion.

It seems to me that a debate concentrating on health and medicine alone, however rigorous, tends to treat these generel concepts superficially. Thereby, hampering the very purpose that it set for itself, that is, understanding the relationship between health and society. I would plead therefore, that even if SHR is interested in a very restricted readership of the aware converts, it still needs to handle the wider social system with much greater rigour. However, if SHR is interested in a readership, of doctors and other health workers who were attracted to marxism because in it we found a better approach to handle our own contradictions and for relating ourselves to the wider society, then SHR's policy becomes a major handicap. For us, the study of health, medicine and health services in India has not only been instrumental in deciding our professional roles but it is also a tool for understanding the society we live in. SHR does not seem to be interested in that window.

I would infact argue that this neglect leads SHR into an uncritical acceptance of certain general formulations which might sound very radical but which do not stand the test of scrutiny. The mere quantum of the so-called marxist analysis of health, done in the west has so impressed us that we have literally lifted their formulations and transplanted them on the Indian scene, without even thinking whether they are applicable. Further, in our hurry to fill in the gaps in our knowledge, we have concentrated on theory of health and medicine. That theory however, has been sought by filling the accepted theoretical constructs with Indian data and developments rather than beginning with health and health services itself to test the assumptions as well as the theoretical constructs. Such an approach creates many conceptual and merhodological problems. Another weakness has been our definitions and terms and the lack of empirical analysis and date base.

Let me take the first issue of SHR to illustrate my points. I would treat. Amar and Padma's[1] as the central paper and touch upon others when needed.

The Use of Concepts

An important assumption of the analytical framework is that mode of production in a society determines directly its health care as well as patterns of illness but it has never been proved and often negated. According to the authors, the socioeconomic structure even after independence remained more or less intact, the bourgeoisie dominated the scene and till today capitalism remains the dominant mode of production. If that be so, then there should be no change in the basic pattern of modern medicine. The authors in fact demonstrate to the contrary that there has been a major shift from "scientific medicine" to "community medicine." Furthermore, it is argued that the major factor which influenced changes in health care were the notion of welfare state, planned development, pressures of world capital class conflicts and project optimisation. It appears then that

(a) the period covered in the main article is not sufficient to use the analytical category of mode of production.

(b) within a mode of production also, patterns of health care may vary depending upon the prevailing social relations.

The other theoretical construct that is assumed as proven and asserted vigorously to make a point instead of empirical data, is the concept of health as labour power. On this is based the understanding that input in health care by the state has an economic basis because it is necessary in the creation of surplus value. Even the fact that in India 90 percent of the industries belong to the unorganised sectors whose workers are provided no facilities for health care, agricultural producers who contribute 45-50 percent to the GNP have little access to health services and the existing health care facilities of the country are utilised by the elite and the middle class not the labouring classes has not provoked us. Could it be that the existence of a large reserve of surplus labour and the nature of technology combined with organisational forms like "contract labour" and "casual labour" devalue this concept in the Indian setting?

Related to this question is yet another formulation which needs to be looked into and that is "commodification of health care in capitalism". The authors argue, "it is immaterial whether the surplus value is realised directly through the productive activities in the clinic and hospitals owned by the capitalist or indirectly through the provision of services by the state ....". In either case, the maintenance of productive capacity of labour is central in the creation of surplus value. It is assumed then that in commodity "health service", the surplus is not generated in the process of commodity production but outside it! A strange view of Marx's "surplus value". The confusion has perhaps arisen because we do not make the distinction between the 'service' and 'material' outputs (like drugs, instruments, equipment etc) of the health industry. The later like any other commodity, generates surplus value and therefore profits. In the service component of the output, things are quite different. The surplus in clinics and hospitals or any other medical care institution comes from the exploitation of the health workers who are paid wages. They are paid for their subsistence (socially determined) whether they are in a private hospital or a public hospital. It is this that must be understood to appreciate why in capitalism, welfare is not an economic proposition. The services though in the name of the poor and the labouring go to the unproductive sections of population and hence in reality, there is relatively little investment in the labour power of the industrial or agricultural workers. At the same time the socially determined subsistence for doctors — the pillars of health services — are undesirably high.

It must also be realised that a practitioner even in a capitalist formation continues to provide service (commodity) without creating any surplus value for he is charging for his hours of labour and not

his subsistence. That is why a private practitioner earns even more than a doctor who is paid wages even though he may be of the same status. It appears then that the production of surplus value is not as intimately associated with profits in the provision of health services as it is assumed. Hence the economic reason for the state to run health services becomes less tenable.

Yet another formulation that needs to be corrected is that "modern medicine and hospital systems reproduce the social structure of bourgeois society." I would think that the two may replicate or mirror bourgeois relations or structures but can not reproduce it. If they could, then, the sheer presence of hospitals and modern medicine in Russia, China, Cuba, and Vietnam would be a threat to their present social systems. A proposition which is just as ridiculous as it sounds. Also in Dalli Rajhara, the hospital workers would not be able to practice modern medicine and at the same time attempt to evolve a new set of social relations. In other words there is a need to realise that a system based on division of labour and controlled by a collective is different from one where division of labour as well as ownership is a function of class.

Need for analytical rigour

The above discussion brings us to the question of class analysis and its relevance for the understanding of "political economy of health.' At this point I would not go into the question what this term denotes but assume that the effort is to see how class configurations influence patterns of health care. To approach this question, the authours go in great details of the industrial and agricultural growth pattern and the emergence of various classes. In tracing the evolution of the peasantry though, no mention is made of the rich peasants' role in the green revolution areas as well as those where green revolution did not happen. We are told that the marginal and small peasants did well in both these areas. This is unconvincing as it neither explains the increasing numbers below the poverty line since 50's nor does it explain the process of proletarianisation and pauperisation of the peasantry. Secondly, though the emergence of these classes is traced, the differences in health needs of these classes are never discussed. We are at a loss then to see if that too played any role in shaping the health services. Thirdly, in their attempt to establish causalty between health service development and changing balance of class alliances and class conflicts, they make some weak propositions and offer scant data to substantiate their arguments.

(i) It is argued that bourgeois radicalism "can best be viewed as concessions gained by working class militancy". Hence all expansion in services is projected as a result of protest and struggle. We therefore fail to make the crucial distinction between a conscious demand (or protest) for health and socio-economic unrest or instability which is often appeased by offers of bonuses and concessions in welfare services. In the former the ruling classes are forced to give in, in the latter they provide health services by choice and refuse what is really needed. Apart from this strategy of appeasment, the ruling classes also provide services because of their own direct interests economic, political, ideological [2] and physical. Also they use both preventive and curative services not just curative as the authors tend to believe. It is then necessary that to establish that expansion of services ("implementation of various reports") was a result of struggle, we locate those struggles specifically and show that provision of health services was one of their demands.

(ii) In their analysis of the 70s, they say that the emphasis on rural inputs and family planning was an attempt to postpone 'the crisis'. Without identifying the full nature of the crisis (a part of which was industrial stagnation) they further argue that the rationale of the Indian bourgeoisie in adopting a massive family planning (FP) drive was a means of controlling labour supply to suit the expansion of more capital intensive modern industries. Firstly how a capital intensive expansion of industry can be possible when there is a glut and how is it going to remove industrial stagnation or the crisis is not indicated. Secondly, despite the fact that they mention expanding numbers of unemployed people, increasing population and imperialist pressure as factors influencing acceptance of F.P.P, why they consider "controlling labour supply as "the rationale" of the bourgeoise" is never clarified.

The questions regarding the nature and resolution of the crisis can only be answered by taking up the nature of the state and the problems of surplus accumulation in India. I will not go into them, but to analyse the rationale of F.P.P. we should have certainly made some efforts. The facts are,

a) that the emphasis on F.P.P. came in the 3rd plan itself when the investments in F.P rose from 30 million to 26.97 million rupees.

b) that though it is true that in 70's the population growth rate was high, it is not adequate to

say that "the population went on rising, hence the labour force continued to expand". The rates of expansion of these two are not equal. Since the labour force increases only by new enterants into it (young people) who were born at least 10 years back. Therefore, labour force increases at a rate which is equal to growth rates of population 10 years back which in our case was much lower (22.2 in, 70s, 18.9 in, 60s and 12.5 in, 50s).

It appears then that the control of numbers of labour force alone could not be the main rationale for accepting the F.P.P One expected that instead of treating F.P.P as a welfare programme, its real nature would be exposed (where compulsion and force made their appearance as early as 1966-67). and its class orientation made explicit. F.P-P neither came as a concession to the growing political clout of the middle farmers nor it ever lost its ideological value for the classes for which it was meant. That is why it still survives in almost the same form as it did a decade ago.

(iii) Throughout it is argued that the model of 'scientific" medicine (with all its social relations and economic possibilities) was suited to the Indian bourgeoisie, and therefore it expanded. The working class continued to extract more and more through its struggles (or so we would like to believe) and the rise of the peasantry created additional pressures Suddenly however, we are told that by the second half of the, 70s this specific model, "no longer performed either this ideological role or achieved their socio-political objectives". In fact, "it was no longer a good economic option". Hence a shift in strategy by the bourgeoisie from "scientific" medicine to "community" medicine. Why all of a sudden welfarism lost its value, why health services started eating into the surplus and why they no longer performed their legitimising role, are questions left unanswered.

I suspect that the idea of failure of the western model is located in our minds and is strengthened by the "radical bourgeois documents" which are forever crying their hearts out. Our susceptibility leads us into accepting their logic rather than exploring the truth. Let us answer the following questions. For which classes, hospitals and the PHC complex are no more the answers to their health problem? Even when they get nothing out of the government health institutions, do they not go to the private clinics of the same doctors for better scientific medicine? Given the choice will people prefer a community health worker or a doctor?

The answers tell us that in India as yet, modern medicine faces no crisis. The crisis is of the bourgeoisie, who even if they wanted, can not provide it to the people and therefore must create blinkers. The authors have themselves shown that the present policy paper is nothing but an effort at streamlining health services in a way that the old model remains its core and is assisted by the so called "community medicine" component to create profits, provide political legitimisation an ideological domination. Secondly, the argument that "there had not been any large scale improvements in health indicators in the past years" is also not adequate to locate the crisis of health care in late 70s. These indicators are neither indicative of health status of classes nor do they show overall worsening (death rates for '50s, 60s & 70s were 22.8, 19.0 and 14.8).

While Amar and Padma make one think about all these questions, Waitzkin in his article creates much confusion on the very subject of class analysis of medicine. Having located the structural source of exploitation in the process of surplus production, he introduces the notion of "persistence or reappearance of class structure usually based on expertise and professionalism in countries where social revolutions have taken place", without, even going into the definition of 'class' used by Bettelheim and Ehrenreich. At the same time he takes great pains to tell us about Alford's research which talks of "interest group" analysis without any comments on the value of this analytical category vis-a-vis 'classes' understood by marxists.

Waitzkin not only indulges in such 'innocent" confusions but also misleads. For example, he introduces the concept of "social imperialism of the USSR" and attributes it to Navarro who in fact though critical of the "party domination" and "managerialism" in Soviet Union, has never used this concept. In the book quoted by Waitzkin, Navarro has actually argued against the theory of convergence and criticised those Western scholars who project managers, administrators, and technocrats as a "new class" of controllers of the system. He underlines the fact that supermacy of the political party over these groups is distinct in the Russian society.

Need for better empirical basis

Yet another methodological point that needs to be repeated is the need to validate arguments and proposition. The practice of making conjectures which are not substantiated must be avoided at all

costs. For example, when we say that "by the 60 s increasing urbanisation with a 40 percent increase of urban population, inadequate housing and living conditions, low availability of food and impoverishment and unemployment has pushed up disease incidence, "we have neither data nor logic on our side. Disease incidence rates or morbidity data for the country simply don't exist and logic says that if people are migrating from villages to urban areas they must have good reason to do so. Will they move from better into the worse ? Similarly, whie talking of the early '50s, it is said, "recent series of famine and draught, increased exploitation of wars, further deterioration of the abysmal public health services the post partition exodus had resulted in a labour force ,which obviously could not contribute its best in terms of productivity". Here again the emphasis on health which seems so obvious to the authors, is never really validated. Unless we explore all the factors which were responsible for the disruption of industrial production or for its low performance, (investments, technology, social situation) to isolate poor health of the worker is to blame him for non-performance.

Use of dialectical approach

In outlining the political econmy of health, the authors repeatedly use the terms "western medicine" "scientific medicine" "allopathic medicine" and "modern allopathic medicine" interchangeably and then criticise scientific medicine because it developed in a capitalist setting and was moulded by it. It becomes difficult to judge therefore, whether they are critical of the allopathic system's body of knowledge (of which preventive medicine is a part) or its organisation in a capitalist setting or both. Specially because, despite their ideological criticisms, they do not deny that the increase in the number of health personnel and institutions was necessary or useful[3]. The problem is further confounded when talking about the '50s they claim, "if the recommendations of Chopra Committee were implemented at that time they would have resulted in a drastically different system of medicine". Firstly, why a system of medicine that developed in a feudal society would offer a better alternative to the set of social relations imbued in "scientific medicine" is not argued. Secondly, even at the level of ideology why ayurveda as practised in the British period was less class-based, sex-biased and individualistic than allopathy (not to mention its dependence on obscurantism and mystification) is never explained and thirdly, why indigenous medicine would not be just as easily ammenable to capitalist commodity production and absorption in the capitalist system like other feudal institutions is never clarified.

If we agree that the indigenous systems were more widespread and culturally more suited then, we should also grant the bourgeoisie the intelligence to see the profits of a wider market and easy profits of indigenous medicine. However, our intense dislike of the bourgeoisie never really allows us to explore what could have been their other reasons for rejecting indigenous medicines[4]. The problem is, lack of appreciation of the dialectical nature of medicine (allopathic or ayurvedic) which alone can help us to trace the roots of an alternative medical science and technology and an alternative basis for organisation of medical care. Waitzkin does mention a different kind of 'modern medicine' which was practiced by Virchow. However, he does not explore the reasons why the germ theory instead of strengthening actually undermined both epidemiology and public health and what role these disciplines played in the 18th and 19th century.

A much discussed subject is reformist and non-reformist reforms. Every one seems to agree that the former is bad and the latter good because non-reformist reform alone can lead to revolution while the former only strengthens the system. What we tend to forget is that implimentation of reforms is a tool for survial for the bourgeoisie and not the function of a revolutionary movement. The latter extracts reforms, struggles for it but does not implement it. Lessons from history teach us that the essence of a reform is in the change that it introduces in the structure of the bourgeois society and not the material benefits (though they are very important at that point of time). Reform has its own dialectics, it may diffuse a struggle but it also heightens the contradictions within the bourgeois structure. In other words, it sows the seed of change in the objective reality of social structure and not in the subjective reality of working class consciousness. That is the role of revolutionaries.

To say that experiments which help leaders of a working class movement in increasing class consciousness is reform (even if it is called radical) or to claim unimplemented drafts of the opposition as radical reforms (they are demands for reform not reform) is not only wrong but misleading. Misleading because it tends to divert attention from the essence of reform (structural change) and confuses it with either "mobilisation of political support" as claimed by Waitzkin or with strengthening of a union as Binayak and Ilina do. They ignore the fact

that a politicalised union as strong as Chhattisgarh Mukti Morcha is not making provision of health services a part of its demands and extracting it out of the management, instead, it is providing these out of the wage of workers (same as the bourgeoisie) ! In doing so it leaves the health structure created by the bourgeosie intact and therefore is not struggling or extracting reforms at all. The step might be radical but there certainly are no reforms.

The issue whether a revolutionary union is justified in running its own hospitals, schools and industries is a separate issue all together and I won't go into it. But I would like to point out that Binayak and Ilina tend to confuse "reforms" with "reformism". The former is a visible change in the objective reality, the later an approach, a subjective component of ones ideology. A reformist (whose ideology may be reformism) may attempt to "suppress emerging class antagonisms" through reforms and might "need to derive strength" from wherever but the reform is innate (it cannot be vitally conscious of itself) and is the seed of change for it has the potential of hightening contradictions and weakening the very system which the reformist tries to save.

Unless we appreciate this dialectical nature of reform (and all other phenomenon) we would never grasp the meaning of the quotes that we quote. We would continue to make the mistake of rejecting things in toto — whether it is "text book epidemiology" or "operation research rooted in capitalist culture" and not apprehend the elements of a revolutionary alternative which exist not outside but within the bourgeois society.

If we agree that the basic assumptions which we started need to be reexamined in our given context, then we might also agree that perhaps the way to make a beginning is to attempt detailed analysis of the contradictions within the health system and their manifestations. For example a study of contradictions in health care policy and practice (one professes service to all, the other provides for some, one eulogises free medical care the other promotes private service, one emphasises preventive the other curative medicine and promotes technology to solve social problems) will help us locate the relevance of what was mentioned in passing in the main article as "constraints" to bourgeois "options". These "constraints" of foreign capital intervention, class pressures and class conflicts and a policy of welfarism in absence of adequate capital accumulation are actually the links between health planning and the wider socio-political and economic frame of the society. Links which need to be further studied with references to health as well as the Indian social formation.

The challenge that SHR faces is to build up a theory rooted in Indian reality. For this four things are necessary. One, that the frame-work that we use must be first critically evaluated. Second, that our analysis must concentrate on trends emerging from the available information and data on health. Third, we must attempt at collecting data where it is necessary. Lastly, if our study demands an exploration of the wider social system then that must be attempted. Towards this I join you in solidarity.

Notes

1. I hope they would not mind my use of first names. My effort is not to score points but to share with them what I think and first names make it easier.
2. Liberalism is very much a part of bourgeois ideology which reflects the positive forces within it.
3. Even if they really consider it futile then their rejection of modern medicine is clear and my argument does not change.
4. I do not mean that indigenous medicine is to be rejected. My plea is that the same analytical framework should be used for indigenous medicine if is to be compared with modern medicine.

WORK HAZARDS : WHAT CAN WORKERS DO ?

The best devices for detecting hazards in your workplace :

Nose : To smell foul odours as a tip off to hazards and to stick where management says it doesn't belong !
Ears : To listen to the complaints of the workers
Eyes : To spot hazards and poor work conditions
Mouth : To argue the worker's point of view
Guts : To have a gut level reaction about what's right and what's wrong and to have the strength to stand up and get the hazards corrected
Brain : To be imaginitive in building the union's safety programme