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TOWARDS A REVOLUTIONARY APPROACH TO HEALTH

Sometime during the last year, some of us working in the field of health realised that there was a need for a separate periodical which would analyse and discuss health issues from a broadly marxist perspective. *Socialist Health Review* (SHR) is being published with a conviction that it would fulfil this need by acting as a platform for discussion and helping the propagation and development of a marxist analysis of health (i. e. determinants and dynamics of health and disease) and medicine (i. e. medical technology as well as systems of medical care).

It may well be asked as to what the necessity is of a separate periodical when there exists a plethora of journals devoted to both marxism as well as health. Since the 70's various groups and individuals with different ideological positions have been working in the field of health. Many health workers, and doctors have, through their exposure to people's struggles to change the oppressive social reality, been attracted to the left movement and specifically to marxism. They have come to realise the need for a substantial, radical critique of health and medicine. Moreover, most marxist doctors, health workers in India are more or less ignorant about marxist analysis of health and medicine. But with the growth of the health and science movements in India, we have all increasingly felt the need to know and to develop a marxist analysis of health and medicine. At the same time, many political activists and social workers too, as a result of their exposure to health problems have realised the relevance of such an exercise. The growth of people's science movements in the country (e. g. Lok Vignyan Sangathana in Maharashtra, Kerala Shastra Sahitya Parishad, Kerala) has also contributed to this awareness. Activists of these movements have been exposed to, and have also challenged the existing health and medical care system and consequently, have realised the need for analysing them. All these developments have resulted in generating an awareness amongst medicos, social workers and political activists of the relevance of radical health praxis to the left movement.

Such an analysis not only advances the general theory of radical political action — which we believe to be critical for any fundamental change in the health situation — but also provides a specific theoretical direction for radical health action. As of today, in India, there is little understanding of various theoretical questions related to health and medicine: the political economy; the bourgeois, male dominated ideological positions; underlying positivist outlook etc. As argued earlier, the need to develop such a theory through mutual discussions and debates does exist. Given the geographical distances that separate us, the best solution the situation offers is a periodical.

Now, it could be argued that existing forums like the *Medico Friends Circle Bulletin* could be utilised for this purpose. We feel that periodicals like these have played and will continue to play the very purposeful role of exposing socially conscious individuals to concrete alternatives and in developing a radical democratic critique of health and medicine. But, they have an inherent limitation in that the divergent or sometimes equivocal ideological commitments of their readership makes a discussion from a particular ideological standpoint, especially the marxist one, a a futile affair. Even when it does take place, much of the rigour is lost.

Periodicals like the *EPW, and Social Scientist*, while publishing marxist analyses of society have an obvious limitation in that they cover a wide field and therefore, they cannot become platforms for continuous debates on health and medicine only.

This in short, is the *raison d'etre* of a separate periodical devoted to propagating and developing a marxist theory of health and medical care, a task which SHR proposes to undertake.

Editorial Policy

As stated earlier SHR will function as a forum for propagating and developing a marxist approach to health and medicine. By a marxist approach we mean that analytical approach which takes a historical materialist and dialectical view of the health of a people and the medical care system in a given social order. From a marxist standpoint, health can be considered as a part and consequence of economic, political and socio-cultural development of society. The problems of health and the health care system reflect the problems of the dialectic of production forces and production relations and the broader social order based on it. They cannot be separated from the problems of this broader social order. As health care and medicine operate today

through public institutions and private clinics, insights into who controls them and how this control operates is significant for such an approach. The role played by these institutions in social control and reinforcement of the existing ideology would be the focus of such an analytical approach.

The editorial policy will aim to present the various currents which have contributed to the development of such an approach to health and medicine. It must be emphasised here that in our opinion, there does not exist one single, marxist analysis — an all correct perfect 'line' so to say, of health and medicine. Only a continuous interaction at the level of praxis amongst the different trends within the marxist movement can lead to the process of distilling the truth. Therefore, SHR will contain articles and viewpoints reflecting this diversity in marxist thought albeit with the limitations spelt out later.

We believe that the women's health movement has added a new dimension to the critique of the organisation and contents of medicine. Therefore, SHR will also contain reflections mainly of the marxist-feminist viewpoint — and sometimes even of the non-marxist ones — directed towards the exposure of the ideological substructure of the developments in medicine.

The Illichian trend is characterised by its criticism of the bureaucratising and centralising tendency of modern health care systems, while overlooking the class basis of these tendencies. It has nevertheless contributed to the critical views on medical care in bourgeois society. This is despite the fact that this criticism arises from within the bourgeois ideological standpoint. Occasionally, this current may, too, find a place in this periodical.

These three points of view have one common direction : they oppose the existing ideological position dominant in the sociology of medicine, one rooted in the structural-functional school. This school assumes the neutrality of medicine (and all sciences) and examines the health care systems without reference to the character of society. It refrains from a political analysis of the medical system and places great emphasis on the social factors affecting health without enquiring into the root cause of their existence, the economic base of society.

It is this commonality that forms the justification for including them together in this periodical.

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In addition to these main articles, SH also contain features like news, book reviews reports, letters to the editor and so on.

SHR's relation to the left movement

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Of late, there has been a spurt in the literature on the marxist analysis of health and medicine in the US and other western countries. Many of us are not exposed to these, as not all of us have an easy access to the relevant reading material. Therefore, the periodical will contain reproductions of such articles with introductory comments whenever necessary.

In order to develop a 'concrete analysis of the concrete situation', SHR would encourage publishing of original articles pertaining to the Indian situation and debates and comments thereupon. We hope that in a short time, original articles will form the bulk of the periodical.

Keeping in view the development of the Indian marxist movement in general, the following, in our view, must be strictly observed while writing original articles:

1. The central propositions of the articles must be worked out logically with supporting empirical evidence.

2. Subsidiary propositions and other general statements regarding the economic and political situation, for example, the nature of mode of production in India, strategies of revolution etc. must have a direct bearing on the central propositions. This is imperative in order to avoid a debate on these issues on the pages of this periodical (though these are obviously essential for political activists) and to prevent irrelevant generalisations.

In addition to these main articles, SHR will also contain features like news, book reviews, field reports, letters to the editor and so on.

SHR's relation to the left movement : SHR being a periodical devoted to theoretical aspects of health and medicine does not propose to become an action-oriented periodical in the sense of an organiser of an action group. We believe that the formulation and clarification of these theoretical issues are essential for successful, politically relevant action and in that way, the periodical would facilitate effective health action, in the manner after journals like *Monthly Review* or *Social Scientist*.

We feel that the very fact of the need for such a periodical having been felt indicates that the health movement within the broad left movement has reached a stage of maturity though not of a level necessitating a formal organisation. But, this does not and cannot, preclude the possibility of formation of such an organisation in future.

At present, SHR would contribute to the general fund of marxist analyses which is particularly deficient in this respect in India. We consider this

deficiency, even mistakes and distortions within the left movement, as **our** deficiency, mistakes and distortions. And if they have to be criticised — which of course, they **need** to be — the criticism should be a **self**-criticism, with a view to improve upon the past and the present so that the movement proceeds with unity, strength and on a politically correct path towards its historical goal. Let me make it clear that we do not stand for a goody-goody, come-what may-we-shall-stay-united type of left unity but we certainly oppose the kind of sectarianism that leads us to mutual mud-slinging while the enemy without goes unexposed and unchallenged.

In this issue

To drive home the point made above regarding the relationship of the problems of health and medicine with those of society in general, we open our publication with an overview of Health and Politics.

In any class society, and by the same logic, in bourgeois society, every institution is controlled by a class/classes to further its/their own interests **against** certain other class/classes. Under the hegemony of the bourgeois, health has become a commodity and consequently, there has been a proliferation of health 'producing' institutions and businesses. And according to the same logic, they are controlled by the bourgeoisie to perpetuate and justify their hegemony. The articles appearing in this inaugural issue set the keynote of the marxist approach to health and medicine.

Howard Waitzkin in his article (a reproduction) *A Marxist View of Medical Care* reviews marxist literature on health and medicine. The article shows how the present health system reflects the class structure of captalist society and how this class structure manifests itself in various ways: control over health institutions, stratification of health workers, health policy etc. He goes on further to show the penetration of monopoly capital into the 'medical-industrial complex'. The article deals briefly with the concepts of historical materialist epidemiology focussing on the effects of economic cycles, social stress, working conditions and sexism on health.

Amar Jesani and Padma Prakash in their article *Political Economy of Health Care in India* select one aspect of the relationship of health and politics and put it in the Indian perspective. They lucidly trace the connection between the economic base of Indian society and health system.

Binayak Sen's article focusses on areas which have either been dealt with only superficially in Waitzkin's article or not at all.

Anant Phadke introduces the book *Cultural Crisis of Modern Medicine* edited by John Ehrenreich, with his critical comments thereupon.

From this issue onwards, each issue will be devoted to one aspect of health and medicine.

An Appeal

Our reader friends would agree that building up a platform for the task envisaged by SHR requires a lot of collective effort. We appeal to our comrades to accept this challenge and extend their fraternal support to this venture. There are several ways in which SHR could be helped:

As with any other publication of this type, SHR too, badly needs financial support. Although several friends have promised to collect funds, the total amount would just be barely sufficient for the first few issues only. Financial support for SHR could be enlisted by either enrolling subscribers or collecting donations.

In case, you are unable to contact a person whom you know would be interested, his/her address could be sent to us. We would send the first issue with an appeal for subscription/donation.

Original articles or reproductions including theoretical analyses, relevant research papers, reports of alternatives in health care, reports of health care in post-revolutionary societies, book reviews etc. could be sent to us for publication. (See back cover).

SHR is a platform of discussion. Hence opinions of the readers regarding the production of the periodical material published and of course, the views presented here are welcome — nay, necessary for the growth of this periodical.

If one goes by the enthusiastic response we have received so far it would not be too much to hope that the Socialist Health Review in a short time, would become a leading theoretical organ of the growing health movement within our country and would contribute significantly to the general fund of marxist literature.

Dhruv Mankad

A MARXIST VIEW OF MEDICAL CARE

howard waitzkin

Marxist studies of medical care emphasise political power and economic dominance in capitalist society. Although historically the marxist paradigm went into eclipse during the early twentieth century, the field has developed rapidly during recent years. The health system mirrors the society's class structure through control over health institutions, stratification of health workers, and limited occupational mobility into health professions. Monopoly capital is manifest in the growth of medical centres, financial penetration by large corporations, and the "medical-industrial complex." Health policy recommendations reflect different interest groups' political and economic goals. The state's intervention in health care generally protects the capitalist economic system and the private sector. Medical ideology helps maintain class structure and patterns of domination. Comparative international research analyses the effects of imperialism, changes under socialism, and contraditions of health reform in capitalist societies. Historical materialist epidemiology focuses on economic cycles, social stress, illness-generating conditions of work, and sexism. Health praxis, the disciplined uniting of study and action, involves advocacy of "nonreformist reforms" and concrete types of political struggle.

This review surveys the rapidly growing marxist literature in medical care. The marxist viewpoint questions whether major improvements in the health system can occur without fundamental changes in the broad social order. One thrust of the field, an assumption also accepted by many non-marxists, is that the problems of the health system reflect the problems of our larger society and cannot be separated from those problems.

Marxist analyses of health care have burgeoned in the United States during the past decade. However, it is not a new field. Its early history and the reasons for its slow growth until recently deserve attention.

Historical Development of the Field

The first major marxist study of health care was Engel's *The Condition of the Working Class in England* (1), originally published in 1945, three years before Engels coauthored with Marx *'The Communist Manifesto'* (2). This book described the dangerous working and housing conditions that create ill health. In particular, Engles traced such diseases as tuberculosis, typhoid and typhus to malnutrition, inadequate housing, contaminated water supplies and overcrowding. Engels' analysis of health care was part of a broader study of working class conditions under capitalist industrialisation. But this treatment of health problems was to have a profound effect on the emergence of social medicine in Western Europe, particularly the work of Rudolf Virchow.

Virchow's pioneering studies in infectious disease, epidemiology, and "social medicine" (a term Virchow popularised in Western Europe) appeared with great rapidity after the publication of Engels' book on the English working class. Virchow himself acknowledged Engels' influence on his thought. In 1847, at the request of the Prussian government, Virchow investigated a severe typhus epidemic in a rural area of the country. Based on this study, Virchow recommended a series of profound economic, political, and social changes that included increased employment, better wages, local autonomy in government, agricultural cooperatives, and a more progressive taxation structure. Virchow advocated no strictly medical solutions, such as more clinics or hospitals. Instead, he saw the origins of ill health in social problems. The reasonable approach to the problem of epidemics, then, was to change the conditions that permitted them to occur. (4,5.)

During this period Virchow was committed to combining his medical work with political activities. In 1848 he joined the first major working-class revolt in Berlin. During the same year he strongly supported the short-lived revolutionary efforts of the Paris Commune (6-8). In his scientific investigations and in his political practice, Virchow expressed two overriding themes. First, the origin of disease is multifactorial. Among the most important factors in causation are the material conditions of people's everyday lives. Second, an effective health-care system cannot limit itself to treating the pathophysiologic disturbances of individual patients. Instead, to be successful, improvements in the health care system must coincide with fundamental economic, political and social changes. The latter changes often impinge on the privileges of wealth and power enjoyed by the dominant classes of society and thus, encounter resistance. Therefore, in Virchow's view, the responsibilities of the medical scientist frequently extend to direct political action.

After the revolutionary struggles of the late 1840s suffered defeat, Western European governments heightened their conservative and often

repressive social policies. Marxist analysis of health-care entered a long period of eclipse. With the onset of political reaction, Virchow and his colleagues turned to relatively uncontroversial research in laboratories and to private practice.

During the late nineteenth century, with the work of Ehrlich, Koch, Pasteur, and other prominent bacteriologists, germ theory gained ascendancy and created a profound change in medicine's diagnostic and therapeutic assumptions. A unifactorial model of disease emerged. Medical scientists searched for organisms that cause infections and single lesions in non-infectious disorders. The discoveries of this period undeniably improved medical practice. Still, as numerous investigators have shown, the historical importance of these discoveries has been overrated. For example, the major declines in mortality and morbidity from most infectious diseases preceded rather than followed the isolation of specific etiologic agents and the use of antimicrobial therapy. In Western Europe and the United States, improved outcomes in infections occurred after the introduction of better sanitation, regular source of nutrition, and other broad environmental changes. In most cases, improvements in disease patterns antedated the advances of modern bacteriology (9-17).

Why did the unifactorial perspective of germ theory achieve such prominence ? And why have the investigational techniques that assume specific etiology and therapy retained a nearly mythic character in medical science and practice to the present day ? A serious historical reexamination of early twentieth century medical science, which attempts to answer these questions, has begun only in the past few years. Some preliminary explanations have emerged; they focus on events that led to and followed publication of the Flexner Report (18).

The Flexner Report has been held in high esteem as the document that helped change modern medicine from quackery to responsible practice. One underlying assumption of the report was the laboratory based scientific medicine, oriented especially to the concepts and methods of European bacteriology, produced higher quality and more effective medical practice. Although the comparative effectiveness of various medical traditions (including homoeopathy, traditional folk healing, chiropractic, and so forth) had never been subjected to systematic test, the report argued that medical schools not oriented to scientific medicine fostered mistreatment of the public. The report called for the closure or restructuring of schools that were not equipped to teach laboratory-based medicine. The report's repercussions were swift and dramatic. Scientific, laboratory-based medicine became the norm for medical education, practice, research and analysis.

Recent historical studies cast doubt on assumptions in the Flexner Report that have comprised the widely accepted dogma of the past half century. They also document the uncritical support that the report's recommendations received from parts of the medical profession and the large private philanthropies (19-27). At least partly because of these events, the marxist orientation in medical care remained in eclipse.

Although some of Virchow's works gained recognition as classics, the multifactorial and politically oriented model that guided his efforts has remained largely buried. Without doubt, marxist perspectives had important impacts on health care outside Western Europe and the Untied States. For example, Lenin applied these perspectives to the early construction of the Soviet health system (28). Salvador Allende's treatise on the political economy of health care, written while Allende was working as a public health physician, exerted a major influence on health programmes in Latin America (29). The Canadian surgeon, Norman Bethune, contributed analyses of tuberculosis and other diseases, as well as direct political involvement, that affected the course of post-revolutionary Chinese medicine (30-32). Che Guevara's analysis of the relations among politics, economics and health care — emerging partially from his experience as a physician — helped shape the Cuban medical system (33,34).

Perhaps reflecting the political ferment of the late 1960s and widespread dissatisfaction with various aspects of modern health systems (35), serious marxist scholarship of health care has grown rapidly. Recent work began in Western Europe (36,37) and spread to the United States with the publication of Kelman's path-breaking article in 1971 (38). The following sections of this review focus on current areas of research and analysis.

Class Structure

Marx's definitions of social class emphasised the social relations of economic production. He noted that one group of people, the capitalist class or bourgeoisie, own or control (or both) the means of production : the machines, factories, land, and raw materials necessary to make products for the market. The working class or proletariat, who do not own or control the means of production, must sell their labor for a wage. But the value of the product that workers

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produce is always greater than their wage (39). Workers must give up their product to the capitalist; by losing control of their own productive process, workers become subjectively "alienated" from their labor (40). "Surplus value", the difference between the wage paid to workers and the value of the product they create, is the objective basis of the capitalist's profit. Surplus value also is the structural source of "exploitation"; it motivates the capitalist to keep wages low, to change the work process (by automation and new technologies, close supervision, lengthened work day or overtime, speed-ups and dangerous working conditions), and to resist workers' organized attempts to gain higher wages or more control in the workplace (41).

Although they acknowledge the historical changes that have occurred since Marx's time (52-51), recent marxist studies have reaffirmed the presence of highly stratified class structures in advanced capitalist societies and Third World nations (52-54). Another topic of great interest is the persistence or reappearance of class structure, usually based on expertise and professionalism, in countries where socialist revolutions have taken place (55,56); a later section of this review focuses on that problem. These theoretical and empiricial analyses show that relations of economic production remain a primary basis of class structure and a reasonable focus of strategies for change (57-59).

Miliband's (59) definitions of social class have provided a framework for marxist research on class structure in the health system. This research has shown that the health system mirrors the class structure of the broader society (60-63).

The "corporate class" includes the major owners and controllers of wealth. They comprise 1% of the population and own 80% of all corporate stocks and state and local government bonds; their median annual income (1975 estimates) is 114000 dollars to 142000 dollars. The "working class", at the opposite end of the scale, makes up 49% of the population. It is composed of annual laborers, service workers, and farm workers, who generally earn 8500 dollars per year or less. Between these polar classes are the "upper middle class" (professionals like doctors, lawyers, and so forth, comprising 14% of the population and earning about 25600 dollars; and middle-level business executives, 6% of the population and earning about 22700 dollars; and the "lower middle class" (shopkeepers, self-employed people, craftsmen, artisans, comprising 7% of the population, earning about 12000 dollars and clerical and sales workers, 23% of the population, earning about 9200 dollars per year). Although these definitions provide summary descriptions of a very complex social reality, they are useful in analysing manifestations of class structure in the health system.

Control over Health Institutions

Navarro (60-62) has documented the pervasive control that members of the corporate and upper middle classes exert within the policy-making bodies of American health institutions (Table 1). These classes predominate on the governing boards of private foundations in the health system, private and state medical teaching institutions, and local voluntary hospitals. Only on the boards of state teaching institutions and voluntary hospitals do members of the lower middle class or working class gain any appreciable representation; even there, the participation from these classes falls far below their proportion in the general population. Local research has documented corporate control of health institutions in many parts of the United States. Navarro has argued, based partly on these observations

Table 1 : Social Class Composition of U.S. Labor Force and Boards of U.S. health institutions

	Class* (%)			
	Corporate	Upper middle	Lower middle	Working
U.S. labor force	1	20	30	49
Board members				
Foundations	70	30	—	—
Private medical teaching institutions	45	55	—	—
State medical teaching institutions	20	70	10	—
Voluntary hospitals	5	80	10	5

*See text for definitions : source, Navarro V; Social policy issues : an expalanation of the compositi nature, and functions of the present health sector of the United States. Bull NY Acad Med 51:199-234, 19 (Reference 60).

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Although they acknowledge the historical changes that have occurred since Marx's time (52-51), recent marxist studies have reaffirmed the presence of highly stratified class structures in advanced capitalist societies and Third World nations (52-54). Another topic of great interest is the persistence or reappearance of class structure, usually based on expertise and professionalism, in countries where socialist revolutions have taken place (55,56); a later section of this review focuses on that problem. These theoretical and empiricial analyses show that relations of economic production remain a primary basis of class structure and a reasonable focus of strategies for change (57-59).

Miliband's (59) definitions of social class have provided a framework for marxist research on class structure in the health system. This research has shown that the health system mirrors the class structure of the broader society (60-63).

The "corporate class" includes the major owners and controllers of wealth. They comprise 1% of the population and own 80% of all corporate stocks and state and local government bonds; their median annual income (1975 estimates) is 114000 dollars to 142000 dollars. The "working class", at the opposite end of the scale, makes up 49% of the population. It is composed of annual laborers, service workers, and farm workers, who generally earn 8500 dollars per year or less. Between these polar classes are the "upper middle class" (professionals like doctors, lawyers, and so forth, comprising 14% of the population and earning about 25600 dollars; and middle-level business executives, 6% of the population and earning about 22700 dollars; and the "lower middle class" (shopkeepers, self-employed people, craftsmen, artisans, comprising 7% of the population, earning about 12000 dollars and clerical and sales workers, 23%of the population, earning about 9200 dollars per year). Although these definitions provide summary descriptions of a very complex social reality, they are useful in analysing manifestations of class structure in the health system.

Control over Health Institutions

Navarro (60-62) has documented the pervasive control that members of the corporate and upper middle classes exert within the policy-making bodies of American health institutions (Table 1). These classes predominate on the governing boards of private foundations in the health system, private and state medical teaching institutions, and local voluntary hospitals. Only on the boards of state teaching institutions and voluntary hospitals do members of the lower middle class or working class gain any appreciable representation; even there, the participation from these classes falls far below their proportion in the general population. Local research has documented corporate control of health institutions in many parts of the United States. Navarro has argued, based partly on these observations,

Table 1 : Social Class Composition of U.S. Labor Force and Boards of U.S. health institutions

	Class* (%)			
	Corporate	Upper middle	Lower middle	Working
U.S. labor force	1	20	30	49
Board members				
Foundations	70	30	—	—
Private medical teaching institutions	45	55	—	—
State medical teaching institutions	20	70	10	—
Voluntary hospitals	5	80	10	5

*See text for definitions : source, Navarro V; Social policy issues : an expalanation of the composition, nature, and functions of the present health sector of the United States. Bull NY Acad Med 51:199-234, 1975 (Reference 60).

that control over health institutions reflects the same patterns of class dominance that have arisen in other areas of American economic and political life.

Stratification within Health Institutions

As members of the upper middle class, physicians occupy the highest stratum among workers in health institutions. Composing 7% of the health labor force, physicians receive median net income (approximately 53900 dollars in 1975) that places them in the upper 5% of the income distribution of the United States. Under physicians and professional administrators are members of the lower middle class: nurses, physical and occupational therapists, and technicians. They make up 29% of the health labor force, are mostly women, and earn about 3500 dollars. At the bottom of institutional hierarchies are clerical workers, aides, orderlies, and kitchen and janitorial personnel, who are the working class of the health system. They have an income of about 700 dollars per year, represent 54% of the health labor force, and are 84% female and 30% black (60,63).

Recent studies have analysed the forces of professionalism, elitism, and specialisation that divide health workers from each other and prevent them from realising common interests. These patterns affect physicians (64), nurses (65, 66), and technical and service workers who comprise the fastest growing segment of the health labor force (67-72). Bureaucratisation, unionisation, state intervention, and the potential "proletarianisation" of professional health workers may alter future patterns of stratification (73).

Occupational Mobility

Class mobility into professional positions is quite limited. Investigations of physicians' class background in both Britain and the United States have shown a consistently small representation of the lower middle and working classes among medical students and practising doctors (23, 24, 74, 75). In the United States, historical documentation is available to trace changes in class mobility during the twentieth century. As Ziem (23, 24) has found despite some recent improvements for other disadvantaged groups like blacks and women, recruitment of working class medical students has been very limited since shortly after publication of the Flexner Report. In 1920, 12% of medical students came from working class families, and this percentage has stayed almost exactly the same until the present time.

Emergence of Monopoly Capital in the Health Sector

During the past century, economic capital has become more concentrated in a smaller number of companies, the monopolies. Monopoly capital has emerged in essentially all advanced capitalist nations, where the process of monopolisation has reinforced private corporate profit (70, 76, 78) (In a much different form monopolisation also occurs within socialist countries, where the state owns major capital assets and strongly limits private profitability). Monopoly capital has become a prominent feature of most capitalist health systems and is manifest in several ways.

Medical Centers

Since about 1910, a continuing growth of medical centers has occurred, usually in affiliation with universities. Capital is highly concentrated in these medical centres, which are heavily oriented to advanced technology. Practitioners have received training where technology is available and specialisation is highly valued. Partly as a result, health workers are often reluctant to practise in areas without easy access to medical centers. The nearly unrestricted growth of medical centers, coupled with their key role in medical education and the "technologic imperative" they encourage, has contributed to the maldistribution of health workers and facilities throughout the United States and within regions (38, 64).

Finance Capital

Monopoly capital also has been apparent in the position of banks, trusts and insurance companies, the largest profit making corporations under capitalism. For example, in 1973, the flow of health-insurance dollars through private insurance companies was 29 billion, about half of the total insurance sold. Among commercial insurance companies, capital is highly concentrated; about 60% of the health-insurance industry is controlled by the 10 largest insurers. Metropolitan Life and Prudential each control more than 30 billion dollars in assets, more than General Motors, Standard Oil of New Jersey, or International Telephone and Telegraph (60).

Finance capital figures prominently in current health reform proposals. Most plans for national health insurance would permit a continuing role for the insurance industry (79,80). Moreover, corporate investment in health maintenance organisations is increasing, under the assumption that national

health insurance, when enacted, will assure the profitability of these ventures (81.)

The "Medical-Industrial Complex"

The "military-industry complex" has provided a model of industrial penetration in the health system popularised by the term, "medical-industrial complex." Investigations by the Health Policy Advisory Center (82,83) and others have emphasised that the exploitation of illness for private profit is a primary feature of the health systems in advanced capitalist societies (64). Recent reports have criticised the pharmaceutical and medical equipment industries for advertising and marketing practices (82-86), price and patent collusion (87), marketing of drugs in the third world before their safety is tested (88-89), and promotion of expensive diagnostic and therapeutic innovations without controlled trials showing their effectiveness (13,90-93).

In this context, "cost-effectiveness" analysis has yielded useful appraisals of several medical practices and clinical decision-making, based in part on analysis of cost relative to effectiveness (94-100). Although recognising its contributions, marxist researchers have criticised the cost-effectiveness approach for asking some questions at the wrong level of analysis. This approach usually does not help clarify the overall dynamics of the health system that encourages the adoption of costly and ineffective technologic innovations. The practice evaluated by cost-effectiveness research generally emerges with the growth of monopoly capital in the health system. Costly innovations often are linked to the expansion of medical centers in the health system, and the promotion of new drugs, the penetration of finance capital and instrumentation by medical industries. Cost-effectiveness research and clinical decision analysis remain incomplete unless they consider broader political and economic trends that propel apparent irrationalities in the health system (90).

Interest Group Politics

Marx argued that class position and economic resources usually determine political power. He noted that the dominant economic class is composed of various groups with sometimes different interests. Although these groups unite when they face basic threats from the working class, their varying interests generate contradictions that can provide a focus for political strategy (101-105). In studies of health care, the analysis of interest group politics has focussed mainly on the United States and Great Britain (106-110). This approach demystifies the policy recommendations of many groups advocating health reforms. From this perspective, these groups' viewpoints and proposals reflect largely their own political and economic interests, rather than simple concern for improving the health system.

Alford's (106,107) research delineates three major interest groups vying for power and finances. The professional monopolists include physicians, specialists, and health research workers in medical schools, universities, or private practice. The main consequence of their activity is a "continuous proliferation of programs and projects" that "provide a symbolic screen of legitimacy while maintaining power relationships" in the health system. 'Corporate rationalisers' are persons in top positions within health organisations: hospital administrators, medical school deans, and public health officials. The corporate rationalisers' overall effect, according to Alford, is to complicate and elaborate the bureaucratic structures of the health system. As third interest group is the diverse community population actually needing and affected by health services. Generally, Alford observes, this interest group's efforts are likely to fail. A high probability of cooptation means that leaders may assume symbolic positions on advisory boards or planning agencies, without real change in power structures.

The analysis of interest group politics has proved helpful in understanding local controversies such as attempts at community control of health institutions (111); conflicts among the governing boards, administrators and professional staffs of hospitals (112); failures in comprehensive health planning and regulation (113-116); and the expansion of medical institutions into urban residential areas (117-120). A similar perspective has led to a clearer picture of national health policy decisions, for example, those pertaining to cancer research and occupational health legislation (83-123).

These studies' implications for reform within the present system tend to be pessimistic. Because an "institutional and class structure creates and sustains the power of the professional monopolists and corporate rationalisers", Alford writes, "change is not likely without the presence of a social and political movement which rejects the legitimacy of the economic and social base of pluralist politics." (106).

The State and State Intervention

Because the state encompasses the major institutions of political power, its strategic importance is obvious. The state acts generally to repress

revolutionary social change or political action that threatens the present system in any fundamental way after socialist revolutions, the state apparatus must persist for a long time, but with greatly modified functions. Before focussing on health care, a brief overview and definition of the state are necessary.

Marx and Engels emphasised government's crucial role is protecting the capitalist economic system and the interests of the capitalist class. The famous homily of The Communist Manifesto, was "the state is the executive committee of the bourgeoisie" (2). Lenin (124) concluded that the capitalist class would intervene forcibly to block any electoral victory that seriously threatened the private enterprise system. More recent analysts have studied the structural patterns that preserve the dominance of the capitalist class over state policies (53, 59), the mechanisms by which the state eases the recurrent economic crises of the capitalist system (125-127); and ideologic techniques by which the state reinforces popular acquiescence (128, 129).

In this context the following definition, though limited by the subject's complexity, is appropriate. The state comprises the interconnected public institutions that act to preserve the capitalist economic system and the interests of the capitalist class. This definition includes the executive, legislative, and judicial branches of government, the military; and the criminal justice system all of which hold varying degrees of coercive power. It also encompasses relatively noncoercive institutions within the educational, public welfare, and health-care systems. Through such noncoercive institutions, the state offers services or conveys ideologic messages that legitimate the capitalist system. Especially in periods of economic crisis, the state can use these same institutions to provide public subsidisation of private enterprise.

The Private-Public Contradiction

Within the health system, the "public sector," as part of the state, operates through public expenditures and employs health workers in public institutions. The "private sector" is based in private practice and companies that manufacture medical products or control finance capital. Nations vary greatly in the private-public duality. In the United States, a dominant private sector coexists with an increasingly large public sector. The public sector is even larger in Great Britain and Scandinavia. In Cuba and China, the private sector essentially has been eliminated (64).

A general theme of Marxist analysis is that the private sector drains public resources and health workers' time, on behalf of private profit and to the detriment of patients using the public sector. This framework has helped to explain some of the problems that have arisen in such countries as Great Britain (75) and Chile (130, 131), where private sectors persisted after the enactment of national health services. In these countries, practitioners have faced financial incentives to increase the scope of private, practice, which they often have conducted within public hospitals or clinics. In the United States, the expansion of public payment programs such as Medicare and Medica aid has led to increased public subsidisation of private practice and private hospitals, as well as abuses of these programs by individual practitioners (64).

Similar problems have undermined other public health programs. These programs frequently have obtained finances through regressive taxation, placing low-income taxpayers at a relative disadvantage (79). Likewise, the deficiencies of the Blue Cross and Blue Shield insurance plans have derived largely from the failure of public regulatory agencies to control payments to practitioners and hospitals in the private sector (132). When enacted, national health insurance also would use public funds to reinforce and strengthen the private sector, by assuring payment for hospitals and individual physicians and possibly by permitting a continued role for commercial insurance companies (64, 80).

Throughout the United States the problems of the private-public contradition are becoming more acute. In most large cities, public hospitals are facing cutbacks, closure, or conversion to private ownership and control. This trend heightens low-income patients' difficulties in finding adequate health care (133). It also reinforces private hospitals' tendency to "dump" low-income patients to public institutions (134).

General Functions of the State within the Health System.

The state's functions in the health system have increased in scope and complexity. In the first place, through the health system, the state acts to legitimate the capitalist economic system based in private enterprise (135, 136). The history of public health and welfare programs shows that state expenditures usually increase during periods of social protest and decrease as unrest becomes less widespread (137, 138). Recently a Congressional committee summarised public opinion surveys that uncovered a profound level of dissatisfaction with

government and particularly with the role of business interests in government policies: "... citizens who thought something was 'deeply wrong' with their country had become a national majority ... And, for the first time in the ten years of opinion sampling by the Horris Survey, the growing trend of public opinion towards disenchantment with government swept more than half of all Americans with it" (139). Under such circumstances, the state's predictable response is to expand health and other welfare programs. These incremental reforms, at least in part, reduce the legitimacy crisis of the capitalist system by restoring confidence that the system can meet the people's basic needs. The cycles of political attention devoted to national health insurance in the United States appear to parallel cycles of popular discontent (135). Recent cutbacks in public health services to low-income patients follow the decline of social protest by low-income groups since the 1960s.

The second major function of the state in the health system is to protect and reinforce the private sector more directly. As previously noted, most plans for national health insurance would permit a prominent role and continued profits for the private insurance industry, particularly in the administration of payments, record keeping, and data collection (64,80, 140). Corporate participation in new health initiatives sponsored by the state — including health maintenance organisations, preventive screening programs, computerised components of professional standards review organisations, algorithm and audiovisual aids for patient education programs — is providing major sources of expanded profit (81, 141).

A third (and subtler) function of the state is the reinforcement of dominant frameworks in scientific and clinical medicine that are consistent with the capitalist economic system and the suppression of alternative frameworks that might threaten the system. The United States government has provided generous funding for research on the pathophysiology and treatment of specific disease entities. As critics even within government have recognised, the disease-centered approach has reduced the level of analysis to the individual organism and, often inappropriately, has stimulated the search for unifactorial rather than multifactorial origin (142). More recently, analyses emphasising the importance in individul "life-style" as a cause of disease (14, 143, 144) have received prominent attention from state agencies in the United States and Canada (145, 146). Clearly individual differences in personal habits do affect health in all societies. On the other hand, the lifestyle argument, perhaps even more than the earlier emphasis on specific cause, obscures important sources of illness and disability in the capitalist work process and industrial environment; it also puts the burden of the health squarely on the individual, rather than seeking collective solutions to health problems (147, 148).

The issues that the state has downplayed in its research and development programs are worth noting. For example, based on available data, it is estimated that in Western industrialised societies environmental factors are involved in the etiology of approximately 80% of all cancer (149). In its session on "health and work in America," the American Public Health Association in 1975 produced an exhaustive documentation of common occupational carcinogens (150). A task force for the Department of Health, Education, and Welfare on *Work in America*, published by a nongovernment press in 1973, reported "In an impressive 15-year study of aging, the strongest predictor of longevity was work satisfaction. The second best predictor was overall 'happiness'... Other factors are undoubtedly important — diet, exercise, medical care, and genetic inheritance. But research findings suggest that these factors may account for only about 25 per cent of the risk factors in heart disease, the major cause of death... "(151). Such findings are threatening to the current organisation of capitalist production. They have received little attention or support from state agencies. A framework for clinical investigation that links disease directly to the structure of capitalism is likely to face indifference and active discouragement from the state.

Limits and Mechanisms of State Intervention

State intervention faces certain structural limits. Simply summarised, these limits restrict state intervention to policies and programs that will not conflict in fundamental ways with capitalist economic processes based on private profit, or with the concrete interests of the capitalist class during specific historical periods.

"Negative selection mechanisms" are forms of state intervention that exclude innovations or activities that challange the capitalist system (125, 126). For example, agencies of the state may enact occupational health legislation and enforcement regulations. However, such reforms will never reach a level strict enough to interfere with profitability in specific industries. Nor will state ownership of industries responsible for occupational or

environmental diseases occur to any major degree (135).

Negative selection also applies to the potential-alisation of the health system as a whole. In most capitalist societies, the state generally has opposed structural changes that infringe on private medical practice; private control of most hospitals; and the profitability of the pharmaceutical, medical equipment, insurance, and other industries operating in the health system. While excluding nationalisation through negative selection, the state sponsors incremental reforms that control excesses in each of these spheres, thus maintaining the legitimacy of the whole. As an example of negative selection congressional deliberations in the United States systematically exclude serious consideration of health service (as opposed to national health insurance) that might question the appropriateness of private medical practice or the nationalisation of hospitals (152). Another example is governmental regulation of the drug and insurance industries; aside from its erratic effects, state regulation rules out public ownership of these industries.

The state also can use "positive selection mechanisms" that promote and sponsor policies strengthening the private enterprise system and the interests of capital (125, 126). The positive selection of financial reforms like health insurance, for instance, contrasts sharply with the exclusion of organisational reforms that might change the broader political and economic structures of the present system (135).

Medical Ideology

Ideology is an interlocking set of ideas and doctrines that form the distinctive perspective of a social group. Marx introduced a distinction between two levels of social structures. The "infrastructure", or "economic base," comprises the concrete relations of economic production; social class, as determined by ownership or control of the means of production, or both, is the primary feature of the infrastructure On the other hand, the "superstructure" includes governmental and legal institutions. as well as the dominant ideologies of a specific historical period (39). The events of history, in the Marxist perspective emerge mainly from economic forces; this "economic determinancy" gives causal primacy to the sphere of production and class conflict. Thus, the economic infrastructure generally determines features of the superstructure. Ideology and other parts of the superstructure, however, help sustain and reproduce the social relations of production and, especially, patterns of domination (153, 154). Marxist analysis emphasises the subtle "ideologic hegemony" by which institutions of civil society (schools, church, family, and so forth) promulgate ideas and beliefs, that support the established order (129, 155); the "ideologic apparatuses" that the capitalist class uses to pressurise state power (128); and the ideologic features of modern science that legitimate social policy decisions made by "experts" in the interests of the dominant class (156).

Along with other institutions such as the educational system, family, mass media, and organised religion, medicine promulgates an ideology that helps maintain and reproduce class structure and patterns of domination. Medicine's ideologic feature in no way diminish the efforts of individuals who use currently accepted methods in their clinical work and research. Nevertheless, medical ideology, when analysed as part of the broad social superstructure, has major social ramifications beyond medicine itself (157). Recent studies have identified several components of modern medical ideology.

Disturbances of Biological Homeostasis are Equivalent to Breakdowns of Machines

Modern medical science views the human organism mechanistically. The health professional's advanced training permits the recognition of specific causes and treatments for physical disorders. The mechanistic view of the human body deflects attention from multifactorial origin, especially causes of diseases that derive from the environment, work processes, or social stress. It also reinforces a general ideology that attaches positive evaluation to industrial technology under specialised control (5, 135, 158, 159).

Disease is a Problem of the Individual Human Being

The unifactorial model of disease contains reductionist assumptions, because it focusses on the individual rather than the illness-generating conditions of society. More recently, a similar reductionist approach has discovered sources of illness in lifestyle. In both cases, the responsibility for disease and cure rests at the individual rather than the collective level. In this sense medical science offers no basic critical approach of class structure and relations of production, even in the implications for health and illness (135, 159).

Science Permits the Rational Control of Human Beings

The natural sciences have led to a greater control over nature. Similarly, it is often assumed that

modern medicine, by correcting defects of individuals, can enhance their controllability. The quest for a reliable work force has been one motivation for the support of modern medicine by capitalist economic interests (19, 26). Physicians' certification of illness historically has expanded or contracted to meet industry's need for labor (160, 161). Thus, medicine is seen as contributing to the rational governance of society, and managerial principles increasingly are applied to the organization of the health system (113-115).

Many Spheres of Life are Appropriate for Medical Management

This ideologic assumption has led to an expansion of medicine's social control function. Many behaviours that do not adhere to society's norms have become appropriate for management by health professionals. The "medicalisation of deviance" and health workers' role as agents of social control have received critical attention (14, 64, 162-166). The medical management of behavioral difficulties, such as hyperkinesis and aggression, often coincides with attempts to find specific biologic lesions associated with these behaviours (167-171). Historically, medicine's social control function has expanded in periods of intense social protest or rapid social change (172).

Medical Science is Both Esoteric and Excellent

According to this ideologic principle, medical science involves a body of advanced knowledge and standards of excellence in both research and practice. Because scientific knowledge is esoteric, a group of professionals tend to hold elite positions. Lacking this knowledge, ordinary people are dependent on professionals for interpretation of medical data. The health system therefore reproduces patterns of domination by "expert" decision-makers in the workplace, government, and many other areas of social life (173, 174). The ideology of excellence helps justify these patterns, although the quality of much medical research and practice is far from excellent, this contradiction recently has been characterised as "the excellence deception" in medicine (175). Ironically, a similar ideology of excellence has justified the emergence of new class hierarchies based on expertise in some countries, such as the Soviet Union, that have undergone socialist revolutions. Other conutries, such as the People's Republic of China, have tried to overcome these ideologic assumptions and develop a less esoteric "people's medicine" (176).

Studies of medical ideology have focused on public statements by leaders of the profession (in professional journals or the mass media), as well as state and corporate officials whose organisations regulate or sponsor medical activities (177). However, health professionals also express ideologic messages in their face to face interaction with patients (160, 163). The transmission of ideologic messages within doctor-patient interaction currently is the subject of empirical research (178-180)

Comparative International Health Systems

Marxist studies have focussed on three topics in this area: imperialism, the transition to socialism, and contradictions of capitalist reform.

Health Care and Imperialism

Imperialism may be defined as capital's expansion beyond national boundaries, as well as the social, political and economic effects of this expansion. Imperialism has achieved many advantages for economically dominant nations. Marxist critiques have dealt with imperialists of both advanced capitalist countries and socialist superpowers (especially the "social imperialism" of the USSR). (28, 181, 182). Health care has played an important role in several phases of imperialism.

One basic feature of imperialism is the extraction of raw materials and human capital, which move from third world nations to economically dominant countries. Navarro (183) has analysed how the "underdevelopment of health" in the third world follows inevitably from this depletion of natural and human resources, The extraction of wealth limits underdeveloped countries' ability to construct effective health systems. Many Third World countries face a net loss of health wokers who migrate to economically dominant nations after expensive training at home. Workers abroad who are employed by multinational corporations also face high risks of occupational disease (184).

By imperialism, corporations seek a cheap labor force. Workers' efficiency was one important goal of public health programs sponsored abroad, especially in Latin America and Asia, by philanthropies closely tied to expanding industries in the United States (27,27.). Moreover, population-control programs initiated by the United States and other dominant countries have sought a more reliable participation by women in the labor force (185, 186).

One thrust of imperialism is the creation of new markets for products manufactured in dominant nations and sold in the third world. This process, enhancing the accumulatian of capital by multinational corporations, is nowhere clearer than in the

pharmaceutical and medical equipment industries (88,89). The monopolistic character of these industries as well as the stultifying impact that imported technology has exerted on local research and development, has led to the advocacy of nationalised drug and equipment formularies in several countries (187,188).

Imperialism reinforces international class relations, and medicine contributes to this phenomenon (54, 189). As in the U. S., medical professionals in the third world most often come from higher income families. Even when they do not, they frequently view medicine as a route of upward mobility. As a result, medical professionals tend to ally themeselves with the capitalist class, the "national bourgeoisie", of third world countries. They also frequently support cooperative links between the local caplitalist class and business interests in economically dominant countries. The class position of health professionals has led them to resist social change that would threaten current class structure, either nationally or internationally. Similar patterns have emerged in some post-revolutionary socieities. In the USSR, professionals' new class position, based on expertise, has caused them to act as a relatively conservative group in periods of social change (28). Elitist tendencies in the post-revolutionary Cuban profession also have received criticism from Marxist analysts (190,191). Studies of several countries have analysed the relation among class, imperialism, and professional resistance to change (130,131,190-195).

Frequently imperialism has involved direct military conquest; recently health workers have assumed military or paramilitary roles in Indochina and Northern Africa (196-198). Health institutions also have taken part as bases for counter-insurgency and intelligence operations in Latin America and Asia (199).

Health Care and the Transition to Socialism

The number of nations undergoing socialist revolutions has increased dramatically in recent years, particularly in Asia and Africa but also in parts of Latin America, the Caribbean and Southern Europe. Socialism is no panacea. Numerous problems have arisen in all countries that have experienced socialist revolutions. The contradictions that have emerged in most post-revolutionary countries are deeply troubling to Marxists; these contradictions have been the subject of intensive analysis and debate.

On the other hand, socialism can produce major modifications in health-system organisation, nutrition, sanitation, housing and other services. These changes can lead, through a sometimes complex chain of events, to remarkable improvements in health. The morbidity and mortality trends that followed socialist revolutions in such countries as Cuba and China now are well known (190,191. 200-207). The transition to socialism in every case has resulted in reorganisation of the health system, emphasising better distribution of health care facilities and personnel. Local political groups in the commune, neighbourhood, or workplace have assumed responsibility for health education and preventive medicine programs. Class struggle continues throughout the transition to socialism. During Chile's brief period of socialist government, many professionals resisted democratisation of health institutions and supported the capitalist class that previously and subsequently ruled the country (130,131,192-195). Countries such as China and Cuba eliminated the major source of social class: the private ownership of the means of production. However, as mentioned previously, new class relations began to emerge that were based on differential expertise. Health professionals received larger salaries and maintained higher levels of prestige and authority. One focus of the Chinese Cultural Revolution was the struggle against the new class of experts that had gained power in the health system and elsewhere in society (56,202). Other countries, including Cuba, have not confronted these new class relations as explicitly (191).

Improved health care remains linked to the general level of economic development. In some African nations, for instance, severe poverty hampers organisational and programmatic changes. Countries like Tanzania and Mozambique have undertaken health planning that ties general economic development to innovations in health care (208-211).

Contradictions of Capitalist Reform

Although they retain the essential features of their capitalist economic systems, several nations in Europe and North America have instituted major reforms in their health systems. Some reforms have produced beneficial effects that policy makers view as possible models for the United States. Recent Marxist studies, although, acknowledging many improvements, have revealed troublesome contradictions that seem inherent in reforms attempted within capitalist systems. These studies' conclusions are not optimistic about the success of proposed reforms in the United States.

Great Britain's national health service has attracted great interest. Serious problems have

balanced many of the undeniable benefits that the British health service has achieved. Chief among these problems is the professional and corporate dominance that has persisted since the service's inception. Descision-making bodies contain large proportions of professionals, specialists, bankers and corporate executives, many of whom have direct or indirect links with pharmaceutical and medical equipment industries (75, 110).

The private-public contradiction, discussed earlier, has remained a source of conflict in several countries that have established national health services or universal insurance programs. Use of public facilities for private practice has generated criticism focusing on public subsidisation of the private sector. In Britain, for example, this concern (along with more general organisational problems that impeded comprehensive care) was a primary motivation for the recent reorganisation of the national health service (110). In Chile, the attempt to reduce the use of public facilities for private practice led to crippling opposition from the organised medical profession (130, 131, 194). The private-public contradiction will continue to create conflict and limit progress when countries institute national health services while preserving a strong private sector.

The limits of state intervention also have become clearer from the examples of Quebec and Sweden. Both have tried to establish far-reaching programs of health insurance, while preserving private practice and corporate dealings in pharmaceuticals and medical equipment. Recent studies have shown the inevitable constraints of such reforms. Maldistribution of facilities and personnel have persisted, and costs have remained high. The accomplishments of Quebec's and Sweden's reforms cannot pass beyond the state's responsibility for protecting private enterprise (136, 242). This observation leads to skepticism about health reforms in the United States that rely on private market mechanisms and that do not challenge the broader structure within which the health system is situated. (64, 213).

Historical Materialist Epidemiology

Historical materialist epidemiology is a rapidly growing field in Marxist studies of health care. Its antecedents derive from the classic research of Engels (1), Virchow (3, 4) and the nineteenth-century school of social medicine in Europe. Simply defined, historical materialist epidemiology relates patterns of death and disease to the political, economic, and social structures of society (214-216). The field emphasises changing historical patterns of disease and the specific material circumstances under which people live and work. These studies try to transcend the individual level of analysis to find how historical social forces, at least in part, determine health and disease.

Social Class and Economic Cycles

Considerable evidence indicates that the incidence and prevalence of mental illness closely follows periods of economic growth or recession. The relations are complex and differ by social class (217). Recent studies also have linked economic cycles, particularly those that involve expanding or contracting employment, to general mortality and morbidity trends among various social classes and age groups (218, 219).

Stress and Social Organisation

Previous interest in stress usually has focused on the individual life cycle or family unit Historical materialist epidemiology shifts the level of analysis to stressful forms of social organisation connected to capitalist production and industrialisation (220). Hypertension rates, for example, consistently have increased with the disruption of stable social communities and organization of work that is hierarchically controlled and time pressured. These observations apply to countries that have followed capitalist lines of development and socialist countries that have industrialised rapidly (221, 222). Similar investigations of coronary heart disease (223, 224), cancer (225), suicide (226) and anxiety (227) currently are in progress.

Work and Profit

Marxist studies in occupational health emphasise the contradictions between profitability and improved health conditions in capitalist industries (184,228). Specific research has clarified the illness-generating conditions of the work place and profit system with reference to disease entities such as asbestos and mesothelioma (83), complications of vinyl chloride (123). drug abuse (229, 230), and accidents (231). On the other hand, observation of occupational health practices in socialist countries have shown that rapid improvements are possible when private profit is removed as a disincentive to change (176, 232).

Studies in this area focus on the interplay among sex, class structure, and work processes. The varying experiences of women and men are related to their mortality rates and life expectancy (233, 234). Historically, women's use of health facilities and the attitudes of medical practitioners towards women's health problems have depended largely on women's

class positions (161). This conclusion is especially evident from the history of the birth control movement (235), psychiatric diagnosis (236), and gynecologic surgery (237). The unique health hazards and difficulties that women face as housewives (238) and paid workers (239, 240), currently are attracting greater attention.

One unifying theme in the field is modern medicine's limitations (15). Traditional epidemiology has searched for causes of morbidity and mortality that are amenable to medical intervention. Although it acknowledges the importance of traditional techniques, historical materialist epidemiology has found causes of disease and death that derive from broad social structures beyond the reach of health care alone.

Health Praxis

Marxist research conveys another basic message : that research is not enough. " Praxis," as proposed throughout the history of marxist scholarship, is the disciplined uniting of thought and practice, study and action (129). It is important to consider political strategy, especially as it concerns the health system of the United States.

Contradictions of Patching

Health workers concerned about progressive social change face difficult dilemmas in their day-to-day work. Clients' problems often have roots in the social system. Examples abound : drug addicts and alcoholics who prefer numbness to the pain of unemployment and inadequate housing; persons with occupational diseases that require treatment but will worsen upon return to illness-generating work conditions; people with stress-related cardiovascular disease; elderly or disabled people who need periodic medical certification to obtain welfare benefits that are barely adequate; prisoners who develop illness because of prison conditions (64, 241). Health workers usually feel obliged to respond to the expressed needs of these and many similar clients.

In doing so, however, health workers engage in "patching". On the individual level patching usually permits clients to keep functioning in a social system that is often the source of the problem. At the societal level, the cumulative effect of these interchanges is the patching of a social system whose patterns of oppression frequently cause disease and personal unhappines. The medical model that teaches health workers to serve individual patients deflects attention from this difficult and frightening dilemma (64).

The contradictions of patching have no simple resolution. Clearly health workers cannot deny services to clients, even when these services permit clients' continued participation in illness-generating social structures. On the other hand, it is important to draw this connection between social issues and personal troubles (242). Health praxis should link clinical activities to efforts aimed directly at basic socio-political change. Marxist analysis has clarified some fruitful directions of political strategy.

Reformist Versus Non-reformist Reform

When oppressive social conditions exist, reforms to improve them seem reasonable. However, the history of reform in capitalist countries has shown that reforms most often follow social protest, make incremental improvements that do not change overall patterns of oppression, and face cutbacks when protest recedes. Health praxis includes a careful study of reform proposals and the advocacy of reforms that will have progressive impact.

A distinction developed by Gorz (243) clarifies this problem. "Reformist reforms" provide small material improvements while leaving intact current political and economic structures. These reforms may reduce discontent for periods of time, while helping to preserve the system in its present forms : "A reformist reform is one which subordinates objectives to the criteria of rationality and practicability of a given system and policy... (It) rejects those objectives and demands — however deep the need for them — which are incompatible with the preservation of the system." "Nonreformist reforms" achieve true and lasting changes in the present system's structures of power and finance. Rather than obscuring sources of exploitation by small incremental improvements, nonreformist reforms expose and highlight structural inequities. Such reforms ultimately increase frustration and political tension in a society; they do not seek to reduce these sources of political energy. As Gorz (243) puts it: "... although we should not reject intermediary reforms... it is with strict proviso that they are to be regarded as a means and not an end, as dynamic phases in a progressive struggle, not as stopping places." From this viewpoint, health workers can try to discern which current health reform proposals are reformist and which are nonreformist. They also can take active advocacy roles, supporting the latter and opposing the former. Although the distinction is seldom easy, it has received detailed analysis with reference to specific proposals (64, 83, 107, 213, 244).

Reformist reforms would not change the overall structure of the health system in any basic way. For example, national health insurance chiefly would create changes in financing,rat her than in the organisation of health system. This reform may reduce the organisation of the health system. This reform may reduce the financial crises of some patients; it would help assure payment for health professionals and hospitals. On the other hand, national health insurance will do very little to control profit for medical industries or to correct problems of maldistributed health facilities and personnel. Its incremental approach and reliance on private market processes would protect the same economic and professional interests that currently dominate the health system (64,83,213).

Other examples of reformist reforms are health maintenance organisations, prepaid group practice, medical 'foundations,' and professional standards review organisations (64,213). With rare exceptions that are organised as consumer cooperatives, these innovations preserve professional dominance in health care (245). There have been incentives to improve existing patterns of maldistributed services. Moreover, large private corporations have entered this field rapidly, sponsoring profit-making health maintenance organisations and marketing technologic aids for peer review (81).

Until recently, support for a national 'health service in the United States has been rare. For several years, however, marxist analysts have worked with members of Congress in drafting preliminary proposals for a national health service (152). These proposals, if enacted, would be progressive in several ways. They promise to place stringent limitations on private profit in the health sector. Most large health institutions gradually would come under state ownership. Centralised health planning would combine with policy input from local councils to foster responsiveness and limit professional dominance. Financing by progressive taxation is designed explicitly to benefit low-income patients. Periods of required practice in underserved areas would address the problem of maldistribution. The eventual development of a national drug and medical equipment formularly promises to curtail monopoly capital in the health sector.

Although these proposals face dim political prospects, support is growing. For instance, the Governing Council of the American Public Health Association has passed two resolutions supporting the concept of a national health service that would be community based and financed by progressive taxation (246, 247). This reform contains contradictions that probably would generate frustration and pressure for change. In particular, these proposals would permit the continuation of private practice and, therefore, the inequities of the private-public dichotomy. Yet, because a national health service provides a model for a more responsively organised system, advocacy of this reform seems a key part of health praxis (207).

Health Care and Political Struggle

Fundamental social change, however, comes not from legislation but from direct political action. Currently, coalitions of community residents and health workers are trying to gain control over the governing bodies of health institutions that affect them (111, 117-120). Unionisation activity and minority group organising in health institutions are exerting pressure to modify previous patterns of stratification (248-252).

Gaining control of the state through a revolutionary party remains a central strategic problem for activists struggling for the advent of socalism (124). Party building now is taking place throughout the United States. Advocates of "vanguard party" believe that historically all successful revolutions have resulted from the efforts of a small vanguard who hold consistent ideology and attract mass support during periods of political and economic upheaval. Activists adopting the vanguard approach frequently take jobs as lower-echelon health workers; they recruit members during unionisation efforts and oppose cutbacks in jobs and health services. Supporters of a "mass party" argue that mass organising must precede rather than follow the development of a coherent ideology; therefore, political energies should go toward building alliances that embrace a spectrum of anticapitalist views. Mass party organisers work toward community-worker control over local health programs, occupational health and safety, women's health issues, minority recruitment into medicine, and electoral campaigns for improved health services (254).

Recognising the impact of medical ideology has motivated attempts to demystify current ideologic patterns and develop alternatives. This "counter-hegemonic" work often involves opposition to the social control function of medicine in such areas as drug addiction, genetic screening, contraception and sterilisatian abuse, psychosurgery, and women's health care. A network of alternative health programs has emerged that tries to develop self-care and nonhierarchical, anticapitalist forms of practice; these ventures then would provide models of progressive health work when future political change permits their wider acceptance (255-259).

In anti-imperialist organising, several groups have assisted persecuted health workers and have spoken out against medical complicity in torture (130, 131, 260). Health and science workers also have used historical materialist epidemiology in occupational health projects and unionisation struggles.

A common criticism of the Marxist perspective is that it presents many problems with few solutions. Recent advances in this field, however, have clarified some useful directions of political strategy. This struggle will be a protracted one and will involve action on many fronts. The present holds little room for complaisance or misguided optimism. Our future health system, as well as the social order of which it will be a part, depends largely on the praxis we choose now.

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HEALTH CARE IN A REVOLUTIONARY FRAMEWORK : Possibilities for an Alternative Praxis

binayak sen and ilina sen

Any health care work is by its very nature, political. It is necessary for revolutionaries to get invovled in the non-reformist reforms to achieve the aim of social revolution. Starting from these premises the authors analyse health care in the revolutionary frame work from their own experiences of health care work in the militant workers' and peasants' movement in Rajhara. They have presented their views as a commentary on and a supplement to Howard Waitzkin's article in this issue.

The note that follows is a commentary on and a supplement to Howard Waitzkin's article on a marxist view of Heath Care. The main theme of this note is the relevance and significance of health care work within a left paradigm in India today.

To begin with however, a general point about politics and health needs to be made. It is common in left political circles to regard health care work as apolitical, or at best, as reformistic. We would argue that politics — the process of exercising power to enhance the material interests of a particular class or social group — permeates all aspects of the super-structure, including health care. The dominant ideology at different times has projected feudal or capitalist models of health care work. It is upto the left movement to expose their ideological foundations and concretely shape a future alternative.

Health Care and Health Status

The words "health care work" have been chosen deliberately, because the distinction between "health" and "health care" has not been fully realised even in debates among groups of politically conscious health professionals. It is generally appreciated in such groups that health care is only one among many determinants of the health of the community, (other important determinants being political economy, education, culture and so on). However, the other side of the coin that health care work and health care systems have a social, cultural, economic and political significance that goes beyond their impact on health status has not been given its due importance. Even when some attempts have been made to come to terms with this aspect of the matter, it has largely been on the basis of trivial notions such as "health as an entry point into the community." This is because the participants in these debates have hardly ever taken the political significance of their work as health professionals seriously. While many of them have sincerely and actively taken up political roles, this has almost always been in areas of work outside the field of health care itself. Both theory and practice have suffered in consequence.

> *"That health care work and health care system have a social cultural economic and political significance that goes beyond their impacts on health status, has not been given its due importance."*

Some Lacunae in Current Approaches to a Theory of Health Care

The realisation that health care and health status are only distantly related has created a feeling of deep frustration among many of those health professionals who are seeking a means, within the health care system, to give expression to their own deep commitment to the people's welfare. Lacking a revolutionary scientific perspective about health care work that would give meaning to their professional practice, they have taken up one of two types of roles. On the one hand some have retreated into the practice of health care essentially within the bourgeois "welfare" paradigm, seeking to give their work greater relevance by working among rural or urban poor (often at considerable personal cost). In many cases, they have also tried to give their work scientific and technical validity by incorporating positivist notions of a more rational epidemiology, with the intention of creating more efficient models of health care system for the future.

The other group, claiming for themselves a greater familiarity with the revolutionary theoretical apparatus, have nevertheless confined themselves

> *"The entire question of revolution as process of the elaboration of an alternative praxis based on prevailing material conditions and incorporating currently available elements of revolutionary theory has been by-passed."*

almost exclusively within a vulgarised version of the Leninist framework of Party and State policy. Their attention especially in India has largely been focussed on attempting critiques of existing health service systems. This has largely been from the standpoint only of political economy, the general thrust of the argument being something like 'Health problems cannot be solved within the bounds of the capitalist economy.' Some have attempted to devise alternatives, but these have again been based either on existing text book techniques such as epidemiology or on new techniques rooted in capitalist culture such as operations research — these alternatives wait for their realisation on a dens ex machina, characterised variously as "political will" (D. Banerji) or "dictatorship of the proletariat."

In both these cases, the entire question of revolution as **process** — of the elaboration of an alternative praxis, based on prevailing material conditions and incorporating currently available elements of revolutionary theory — has been by-passed. This is not to negate the importance of capturing State power, but to emphasise that the process of delegitimising the existing ideology in all walks of life has to begin here and now.

Waitzkin's Paper : Critical Comments

The importance of Waitzkin's article is that it serves as an overview — ableit a very brief one — of the area of interaction between the practice of health care and current concepts in Marxist revolutionary theory.

It remains to comment upon some of the points that he has raised in his article.

a) Reformist Versus Non-Reformist Reform

With the execption, perhaps, of academic and technical research, all the kinds of work available for the revolutionary practice of health care require participation in piecemeal reform programmes. The distinction between reformist and non-reformist (or revolutionary) reform, outlined by Gorz and quoted in Waitzkin's article, is therefore deserving of careful study and reflection. However, the **necessity** of such reforms to any revolutionary programme has not been given adequate importance in Waitzkin's article. He contents himself by saying in the opening sentence of this section, that "when oppressive social conditions exist reforms to improve them seem reasonable."

The necessity of social reform programmes was put forward much more strongly by Roza Luxemburg in her attack on Bernsteinian reformism, "Reform or Revolution", she starts at the very outset, "Can the social democracy (i. e. Communists) be against reforms ? Can we counterpose the social revolution, the transformation of the existing social order, our final goal, to social reforms ? Certainly not. The daily struggle for reforms, for the amelioration of the workers within the existing social order, and for democratic social institutions, offers to the social democracy the only means of engaging in the proletarian class war and working in the direction of the final goal — the conquest of political power and the suppression of wage labour. Between social reforms and revolution there exists for the social democracy an indissoluble tie. The struggle for reforms is its means; the social revolution, its aim.".

The distinctions mentioned by Gorz apply mainly at the level of health policy rather than the practice of health care. Moreover, Waitzkin seems to sound as though there are or can possibly be, a set of independent criteria on the basis of which it is possible to decide whether a proposed reform is reformist or non-reformist. The fundamental question of the basic political framework within which the struggle for these reforms is to be carried out, is not emphasised.

How are the differences between reformist and non-reformist health care praxis to be established ?

For the last three years, in Rajhara, the Chhathisgarh Mukti Morcha has been running a health programme based on a militant organised workers' and pesants' movement. Some indications may

> *"Between social reforms and revolution there exists for the social democracy an indissoluble tie. The struggle for reforms is its means, the social revolution, its aim."*

perhaps be obtained from the experiences gained in the course of this work.

The first difference, is that reformism is directed primarily at suppressing emerging class antagonisms and contradictions between state power and peoples' power. Revolutionary reform, on the other hand, by the very fact that it is based on a militant recognition of class antagonisms and of the oppressive nature of state power, is directed towards precisely the opposite goal. Consequently, the most important goal of a revolutionary reform programme is not the achievement of the reform towards which it is putatively directed, but to further the political struggle of which it forms a part.

The second difference is that revolutionary reform does not derive its strength from any exogenous group of "reformers' standing outside the mainstream of the popular consciousness. Instead, its primary reasources are the political consciousness, organised strength and creative power of the working class and peasantry. Consequently, we cannot take a single step in such a programme without considering the direction in which the people want it to proceed. Any attempt to work out new ideas has to be preceded by an effort to explain these to the people, and to establish them in the popular consciousness.

"The Revolutionary reform does not derive its strength from any exogenous group of «reformers» standing outside the mainstream of the popular consciousness."

This also means that at any given moment, the direction of the programme cannot be governed by a "a priori" consideration of the appropriateness of the measures taken. The existing direction is always limited by the existing perception of the people, of the issues around which the programme is formed, based on their collective past experience. Nevertheless, it is necessary for those leading such programmes to have a deep and concrete historical understanding of similar programmes, and of the issues as they exist in the community, (In the case of health care, this would mean that we should possess a knowledge of epidemiology and a knowledge of the health service programmes.) This knowledge is necessary so that it may be posed in a constant dynamic tension to existing perceptions, so that the two may come close to each other in a series of successive approximations.

The third difference is that revolutionary reform is vitally conscious of the inevitability of its own failure. That is, we believe that the ills which owe their existence to an oppressive social order cannot, except marginally, be cured except by a radical restructuring of that order - that is - revolution Consequently, we do not hope nor expect that our praxis will succeed in effecting more than marginal improvements in the health of the people or even in the availability of curative care: However, our attempt is to direct the energies of the people into the establishment of an institution and a programme which reflects their aspirations. This presents to the people a radically new vision of an alternative social order, and a living critique of the existing one.

b) Medical Care and Ideology : Hegmony and Counter Hegemony.

Waitzkin refers in the first paragraph of the section on Medical Ideology to the thought of Gramsci. However, once again the reference is so brief that anyone not already familiar with the Gramscian idea of Hegemony would be unable to make much of the reference. It is worth going into the idea in slightly greater detail, since it forms one of the chief plants on which a revolutionary medical praxis is based.

Gramsci considered that the ruling classes exercised and perpetuated their control over the whole of society not only through the exercise of political force, but also through the power of the ideology elaborated by the ruling class intellectuals. Through this process of legitimisation the ruling class obtained the consent of the whole of society to exercise the power of Government on its behalf.

"In order to establish its own hegemony the working class must do more than struggle for its own narrow sectarian interests, it must be able to present itself as the guarantor of the interests of society as a whole. .". Gramsci had a broader view of the party than Lenin perhaps partly because he had greater experience of a developed bourgeois society. He conceived of it as deeply committed to an ideological and cultural struggle as well as to the seizure of state power. . . Thus he advocated a party that was an educational institution offering a counter-culture whose aim was to gain an ascendancy in most aspects of the superstructure (as opposed to directly political institutions) before the attempt was made on state power. The party organisers trained the workers in the assumption of control over their own

lives and thus anticipated a post-revolutionary situation. (David Melellan : Gramsci, in "Marxism after Marx").

Ideology in Health Care

Through its medical institutions — ranging all the way from state run hospitals through the Jasloks and the mission hospitals to the lovliest private practitioner, the ruling class is constantly engaged in the elaboration and perpetuation of an ideology that serves to oppress and control the workers and the poor.

There are three specific elements of ideology in health care which are not adequately dealt with by Waitzkin and hence need special consideration.

a) The Concept Of Charity :

The first, and in our view, the most important of these, is the concept of charity, or "daya". This is not considered in Waitzkin's article. Perhaps this is because he writes from a Western background, in which there already exists a clear distinction between the humanist and technical aspects of medical practice.

However, in India, we are all familiar with the idea that the medical practitioner, be he ever so crass, attains spiritual merit with each transaction in which he plays the role of healer. The objective caste status and the subjective Brahminical manner of most practitioners of modern medicine further reinforce this tendency. The influence of this tendency is yet again reinforced and consciously generalised by the religions symbolism that pervades the atmosphere and even the architecture in many of the important centres of modern clinical excellence. (Apart from admittedly religious hospitals—Christian, Hindu, Muslim or Jain — good examples are commercial-community based hospitals like Jaslok in Bombay and the Calcutta Hospital in Calcutta).

Of course, the function of the healer neither can nor should be totally divested of transcendent elements of spiritual and psychological authority. Neither can the role of the patient ever be totally divested of its elements of spiritual and psychological dependency.

However, where the healing institution has been built up on the initiative and with the resourcee of a militant organised working class movement, and functions specifically within a revolutionary framework, and with healers who live among the people and aspire to be identified as revolutionaries rather than as do-gooders, this relationship of authority and dependence can have a counter hegemonic influence and thus reinforce working class militancy and self confidence.

(b) Ideology and Technology :

The second area of ideology in health care that needs to be considered is that relating to medical technology. Waitzkin's article does go into this aspect briefly, in the section entitled "Medical Science is both esoteric and excellent." A much more penetrating and thorough going critique of the disabling and iatrogenic nature of modern medical technology is contained in the work of Illich- to which, surprisingly, this section makes no reference. Illich's work also contains the notion of a demystified, locally-controlled, human-scale technology. His notion of a society incorporating these ideas is free of class, free of history and independent of political process. He makes a fetish of Technology.

This is not the place to embark on a critique of Illich. However, irrespective of the viability of the solutions proposed by him, the notion of demystification of technology is important to any alternative praxis in the field of health care. This is because an important part of the ability of the existing health care system to reproduce ruling class ideology is due to its basis in an esoteric, monopolistic technology, seemingly divorced from its roots in ordinary mannual and human skills. It is this technological basis that creates within the field of medical practice a steadily widening gap between mental and manual work.

"An important part of the ability of the existing health care system to reproduce ruling class ideology is due to its basis in an esoteric, monopolistic technology, seemingly divorced from its roots in ordinary manual and human skills."

It is to reverse this trend that the concept of the voluntary health worker is important.

In the health programme at Rajhara, a training programme for voluntary health workers has been put into operation. However, these workers are not seen primarily as agents who, by performing simple

tasks in a decentralised fashion, increase the efficiency of the health programme. Rather, the VHWs are seen as ordinary workers, who, by undertaking to perform certain healing functions on the basis of their skills in and understanding of modern medical technology, render the entire range of medical technology accessable to ordinary human understanding. The training programme also repeatedly emphasises the idea that the primary duty of the VHWs is to spread their understanding of health care technology among their comrades.

C) Internal Organisation

A third ideological function that a health care programme can perform is to create, within the internal organisation of the programme, an image of what the social dynamics of such a programme in a socialist society might be. In particular, the undemocratic and hierarchical functioning of most health care institutions is something that any alternative praxis of health care must try to change.

Conclusion

In conclusion, the limits of this note — all too apparent to the authors must be emphasised strongly. In the first place, it is a comment on Waitzkin's article, and must be read against the background of the article i. e. not independently.

Secondly, throughout this note, in order to achieve the limited aims which the note seeks to fulfil, an attempt has been made to emphasise.

a) health care as against health status.

b) Superstructural elements as against more fundamental aspects related to political economy.

c) the revolutionary possibilities of an alternative praxis of health care as against the humanist values embodied (or at least imminent in) more traditional form of health care work.

It would be disastrous if on the basis of this note, anyone should conclude that we consider the second halves of these contrasts to be unimportant. On the contrary, in each case, it is only possible to emphasise the former where the latter is already taken for granted. This selective emphasis must be kept in mind throughout the reading of this note.

Finally, except where direct quotations have been made, no references are included. The points made in this note have emerged through discussions and practice engaged in with many groups of friends and colleagues over a long period of time.

Orwell's Hints to Writers

George Orwell in his 'Politics and the English language' attacks jargons severely and says: "Modern writing at its worst does not consist in picking out words for the sake of their meaning and inventing images in order to make the meaning clearer. It consists in gumming together long strips of words which have already been set in order by someone else, and making the results presentable by sheer humbug..... They will construct your sentences for you, even think your thoughts for you, to a certain extent and at need they will perfrom important service of partially concealing your meaning even from yourself." He has given some rules for writers to follow: (i) Never use a metaphor, simile or other figure of speech which you are used to seeing in print (ii) Never use a long word where a short one will do (iii) If it is possible to cut a word out, always cut it out (iv) Never use the passive when you can use the active. (v) Never use a foreign phase, a scientific word or a jargon word if you can think of an everyday English equivalent (vi) Break any of these rules sooner than say anything outright babarous..... The most important thing to remember is that good writing is not a collection of beautiful phrases or idioms. Good writing is the result of clear thinking.

(Excerpted from *The Hindu* May 8, 1984)

POLITICAL ECONOMY OF HEALTH CARE IN INDIA

An Outline

amar jesani and padma prakash

Medicine is not a socially independent activity. It is always articulated within a specific mode of production. Therefore, the dominant medical practice in India is bourgeois medicine and health care helps to strengthen and expand the capitalist mode of production. It also reproduces the capitalist relations of production at every level of its operation. The development of health care in India is examined in the context of the dynamics of socio-economic changes which have taken place since independence.

"My inquiry led me to the conclusion that neither legal relations nor political forms could be comprehended whether by themselves or on the basis of so-called general development of the human mind, but that on the contrary they originate in the material conditions of life, the totality of which Hegel, following the example of English and French thinkers of the eighteenth century, embraces within the term 'civil society'; that the anatomy of this civil society, however has to be sought in political economy."

Karl Marx
Preface to
A Contribution to the Critique of Political Economy.

Every human being, in the last analysis, after removing all covers of social existence, is natural and therefore, biological. The flesh, blood and bones comprising the human body are too materialistic for anyone to deny their existence. But this natural living individual is not a lone, isolated entity. Through centuries of social development, the individual has evolved socially, coming into interaction with nature and while transforming it, has himself/herself been transformed. In the course of this social development, human beings have entered into various types of relationships in order to produce the necessary means of subsistence and to reproduce his/her own species and so given rise to the complex organisation of, to use Hegel's term, the 'civil society.'

The 'natural' or the biological forms the fundamental basis on which, historically, the social existence of human beings has developed. In the course of this development completely new forms of objectivity have arisen and although such objectivity have no analogy in nature, they still remain socially transformed natural objectivities.

To illustrate, in primitive societies, the exchange of necessary goods was not the rule but, more the exception. Here the natural use of those goods, to satisfy hunger or other needs was the predominant consideration. But with the evolution of a more complex social organisation leading to the evolution of a social system based on commodity production such goods which were necessary and useful for life also acquired, exchange value of their own. Every commodity in the capitalist economy has therefore, two characters, the use value and the exchange value. But this exchange value cannot be located or identified in the commodity. Exchange value is then, an exclusive social category which has no analogy in nature. "The main tendency of the developmental process that arises in this way is the constant increase both quantitative and qualitative of purely or predominantly social components, the 'retreat of the natural boundary' as Marx puts it. "(Lukacs, 1978).

Health and medicine are such social categories which have reference not simply to the biological existence of the human being, but to the social nature of such existence. That is why the understanding of health has changed according to the needs of different social systems and the needs of the ruling elite of that social system..

Features of the Marxist Approach to the Critique of Political Economy of Health

Four major features of the Marxist approach to the political economy of health may be identified—

The Social Production of Illness : Medical definitions of health and illness are located in the clinical pathology of the individual. In its narrowest and most limited form this definition locates the cause of disease entirely in the human body and disease is seen as a consequence of an unwanted attack of biological entities, bacteria, or virus, on the human body. The control of disease is seen to mean the control or eradication of these bacterial or causative agents. The concept that ill health is

directly related to the socio-economic formation and to the production relations in society has been put forward by several analysts since Engels wrote the *'The Conditions of the working class in England'*. Turshen traces the origins of what is termed the 'clinical paradigm' and discusses its weakness. According to her the discipline that comes closest to explaining the notion of collectivities is medical ecology. "Medical Ecology, thus asserts a relationship between environment, disease and man but selects only biological and socio-cultural factors as relevant." (Turshen 1977). This too ignores the illness generating forces in society. Doyal and Pennell in their book *Political Economy of Health* have elaborated on the evolution of the clinical paradigm in modern medicine. They discuss the direct and intimate relationship between the process of commodity production and destruction of health and between economic underdevelopment and health. (Doyal & Pennel, 1981). This view does not exclude or deny the operation of the biological mechanism which cause illness. The concept that ill health can only be understood as a consequence of the dynamics of class contradictions in society, and that the occurrence of disease is intimately related to the social formation within which the biological, physical and chemical operate is one of the major marxist contributions to the critique of political economy of health.

"Health and medicine are social categories which have reference not simply to the biological existence of the human being, but to the social nature of such existence."

Health as labour power: Under capitalism health is defined as an integral component of an individual's labour power or productive capacity. Labour power being a commodity under capitalism has a specific exchange value — the quantity of social labour necessary to reproduce it.... just as any other commodity does. In other words, the exchange value of labour power is the value of consumer goods and other services necessary to keep the worker and his/her children fit enough to work at a given intensity of effort. But to maintain this level of effort, or the maximum level of productivity, a certain level of physical and mental health is vitally necessary. Below that level of health the capacity to work falls off, and with it, the amount of surplus value that will be generated. The capitalist is simply not interested in the level of health beyond this, even though the worker will be vitally interested from the point of view of the quality of life and not of productive capacity (Schatzkin, 1978).

From this point of view of health as labour power, Schatzkin argues that medical care services are designed for maintaining the requisite level of health, a kind of labour power 'repair and maintenance service'. While educational services help to maintain the knowledge and skill component of work capacity, medical services help to maintain the physical and psychological components. Since the provision of health is part of maintaining labour power, it represents to the capitalist, a part of the wages he must pay out, directly as wages or indirectly as 'social' wages in the form of medical services.

The commodification of health care: A commodity is an external object which through its qualities satisfies human needs of whatever kind and is produced for exchange in the market. Health care is one such commodity. Historically, throughout most of human history, health care was an organic part of a communal society. It has often been indistinguishable from religious or social activities, none of which were exchanged (although gifts were often presented to traditional healers). As communal societies were conquered by feudal and eventually capitalist societies, health care was taken out of the hands of traditional healers, and placed in the domain of doctors and midwives, who engaged in health care for a price i.e. as part of a money exchange. The physician was an independent producer selling the product of his or her own labour. (Roder and Stevenson, p. 19-108).

But "capitalist production is not merely the production of commodities, it is by its very essence, the production of surplus labour" (Marx *Capital*, p. 644). The capitalist can organise the production of surplus value through the provision of health care and can realise high profits in this service industry. It is immaterial whether the surplus value is realised directly through the productive activities in the clinics and hospitals owned by the capitalist or indirectly, through the provision of health care by the state to maintain or increase the productive capacity of labour.

Medicine as a social relation: Vicente Navarro has concretised our understanding of how medicine should be viewed within the perspective of the social system. He argues that medicine or health

services is a social relation and reproduces the dominant relations of production. Medicine, therefore, has been different under different modes of production. He argues that since the mode of production is reproduced not only at the economic but also at the political and ideological levels, medicine contributes to the reproduction of the mode of production at the economic, political and the ideological levels and that medicine is always articulated within a specific mode of production.

These are the features of Marxist approach or methodology which we will use to examine the political economy of health care in India. But any attempt to examine the development of health care in India in the context of socio-economic development brings into focus the subject of the mode of production in Indian agriculture. We are aware that this subject has generated a lot of debate amongst Marxists in the last decade and there are divergent viewpoints. We will not here review the entire debate that has taken place nor put forward our viewpoint on the subject and substantiate it. Our focus is the political economy of health care. We will, therefore, endeavour to show that, the very efforts of the Indian State to penetrate the remotest corners of the agrarian set-up through the provision of health care facilities; is not any isolated and non-social phenomenon. But the efforts in fact strengthen and reproduce the already existing and expanding capitalist relations of production (whether in "pure" forms or intertwined with the pre-capitalist forms).

At the same time, we must admit that this analysis is our first attempt and the vastness of the exercise has made us very aware of the inadequacies in the sphere of information and data. The most evidently thin area of the outline is the lack of analysis and attention to the social roots of ill-health and disease in India. By and large, we have merely assumed that the patterns of illness are reflective of the class, caste and sexual contradictions and are influenced by the level of development, both quantitative and qualitative, of the social system. We have also assumed that changes in the patterns of illness are directly related to changes in socio-economic system, and have proceeded to focus on the changes in health care in light of the change in the mode of production. Our objective is to locate the crisis in health care and medicine within the larger political perspective for class struggle.

Health care under British imperialism

Western medicine came to India in the 17th century. The first medical men to set foot on the sub-continent were the surgeons sailing with the merchant ships of the maritime nations of the time. Throughout the century a number of Europeans found employment as surgeons and physicians in the Courts of the kings and nawabs. By the end of the 18th Century all the factories of the East Indian Company had at least one surgeon in their employ and the Indian Medical Service had been founded (Crawford, 1914).

At that point of time the medicine practised by the company doctor was hardly different from local systems. The doctor of the day had a limited range of therapeutics and curative procedures : . . . herbal medicines, a very few disease-specific chemical preparations, the new 'exotic' drug the Peruvian cortex (cinchona) for intermittent fevers, blood letting, venesection and other such procedures which had been in vogue since the time of Galen. The birth of modern scientific medicine was yet to be. In the following century however, there were enormous developments in the content, theory and practice of medicine in Europe. Not only had the knowledge base of medicine expanded but it was being structured to meet the needs of the dominant class. For instance, the two major disease casuality theories that were competing for acceptance, the coptagion theory and an environment theory were more than medical theories and their incorporation into contemporary medical thought was dependent on how they affected the operations of the dominant class of the time. During the first half of the 19th century the contagion theory which suggested quarantine measurs as a means of controlling disease, was the best accepted. But with the increased movement of goods and of people towards the middle of the 19th

"Since the mode of production is reproduced not only at the economic but also at the political and ideological levels, medicine contributes to the reproduction of the mode of production at the economic political and ideological levels and that medicine is always articulated within a specific mode of production."

century, quarantine measures proved ruinous to the new entrepreneurs and merchants. One important reason for the acceptance of the miasma theory which located the cause of disease in unsanitary conditions was the potentially disastrous effects the acceptance of the contagion hypothesis would have caused (Tesh, 1982).

By the end of the 19th century, the sanitary reform movement in Britain had resulted in limited state intervention in the form of legislations and in the creation of institutions for administering them. But these refoms were actually self-limiting. Although they affected a section of the capitalists whose profits came from housing, water supply and sewerage dealerships, they served the needs of capital by decreasing the cost of disease. At the same time public health work and preventive medicine could never gain the status nor weild the same influence as clinical medicine. Public health work highlighted the shortcoming of capitalism and it would mainly benefit a class which was incapable of conferring status. (Turshen, 1977). On the other hand, clinical medicine with its focus on the individual rather than the social conditions underlying disease states offered a means of diverting public attention from the ills of capitalism.

"One of the aims of the planning was to aid the capital accumulation in the private sector."

The origins of the sanitary reforms in India are rooted in a different set of circumstances. After 1857, and the take over by the Crown, the number of troops on Indian soil increased and the health of the army became a subject of discussion. Moreover, cholera which had been confined to India so far broke out in a devastating epidemic in Europe. The British colonial government was pressurised into initiating sanitary measures in the Presidency areas. But these measures did not give rise to a public health system and the government chose instead, to encourage the setting up of medical research facilities for the assault on tropical diseases, an assault master minded in England. (Ramasubban, 1982).

Outside the government framework, a number of missionary groups and individuals had also begun to set up hospitals and medical institutions. For instance, a number of maternity hospitals and training centres were set up to teach midwives the 'modern' methods of childbirth. The funding for these came from wealthy Indians who wished to set up hospitals as memorials. (Billington, 1973).

Medical Colleges were set up to train assistants and a large number of Indians were taking avantage of the opportunity. The upper castes were specially encouraged to enter these colleges. Right from the beginning allopathic medicine in India acquired an upper caste elite base. (Banerji, 1974). Women too were given special concessions, so that the new maternity homes could be well-staffed.

The development of 'scientific' clinical medicine which embodied bourgeois ideology and relations of production was far more important than the creation of a public health system which might expose the true nature of British imperialism.

The health care network under the British comprised desultorily implemented sanitary measures and a fair number of hospitals and dispensaries with a growing number of medical research facilities undertaking work on tropical diseases under the tutelage of European doctors and researchers.

The path of development consciously adopted by the Indian ruling classes at the time of Independence.

The increasing popularity of modern allopathic medicine amongst the Indian elite strata was not an accidental phenomenon. It was rather a part of the process of emergence of Indian bourgeoisie as an economically powerful and politically shrewd class under British imperialism. As we will show later in this section, the choice of modern allopathic ("scientific") medicine as a basis of development of health-care system in India was deliberate (despite the fact that other choices and concrete proposals existed), and was in consonance with the path of socio-economic development adopted by the Indian ruling classes. To substantiate this statement, we will examine the situation at the time of independence under three headings : a) the strength of Indian bourgeoisie at the time of independence, b) the political and economic strategy adopted by the Indian bourgeoisie for strengthening its class rule, and c) the health care strategy adopted as a part of development perspective.

(a) The strength of the Indian bourgeoisie at the time of independence : On the eve of independence, although, India's total economy was overwhelmingly agricultural, substantial industrialisation had taken place. In fact, India was much

better placed than most other colonial or semi-colonial countries of that time.

India's domestic capital, at the time of independence nearly occupied an equal place with foreign capital in Indian economy (Bettelheim, 1968). According to the same source, foreign capital's sphere of influence was particularly in the principal foreign currency earning industries (tea, jute and cotton) and in those which were the main sources of power in India (petroleum, coal, electricity).

In assessing the political strength of the Indian bourgeoisie at the time of independence, two points should be understood. Firstly, Indian capital had to develop under the tight control of British imperialism. In its confrontation with foreign capital and imperial policies, it was but natural that a tendency developed towards developing stronger economic and political organisations of its own. Moreover, Indian Capital did not develop through "free competition." Due to several intrinsic factors specific to India, and due to the fact that World Capital was already at the monopolistic stage, there was naturally a tendency for Indian industral capital to take monopolistic forms. This situation helped it to organise its various groups with much more ease and also made it more shrewd and alert in extending right political patronage.

Secondly, the Indian bourgeoisie was politically shrewd enough to understand the importance of Gandhi's ideology of harmony between capital and labour. During the 1918 textile workers' strike in Ahmedabad the newly formed Bombay Mill-owners' Association utilised this opportunity to establish contacts with Gandhi. Subsequently in 1921, with the launching of the Swadeshi movements they found in Gandhi a representative leader and in the Congress their representative Party. It is important to note that from this point onwards, the bourgeoisie never lost its political leadership of the nationalist movement. Thus, at the time of independence, the party of the Indian bourgeoisie, the Indian National Congress maintained its leadership of the nationalist movement and very meticulously implemented the strategy of the Indian bourgeoisie for the post independence growth of capitalism in India.

b) The political and economic strategy adopted by the Indian bourgeoisie for strengthening its class rule: The Indian independence was not a social revolution in which, one class through violent means seizes political and socio-economic power from another. In fact, independence was just transfer of political power from British imperialism into the hands of Indian bourgeoisie, keeping the socio-economic structure of the society more-or-less intact. Moreover, under the Mountbatten plan this transfer was affected through negotiation and bargain. Therefore, after taking over the reins of State power, the Indian bourgeoisie did not adopt radical measures attempting to do away with India's pre-capitalist forces. In so far as those forces did not seriously obstruct its plan of gradual transformation of Indian agriculture through state intervention it adopted a policy of compromise and accommodation.

At the same time, in the turbulent 1940s the Indian bourgeoisie feared the militancy of the working masses. It should be noted that from the later half of 1930s, the mass unrest had attained serious proportion. On the industrial front, the number of strikes in 1937 reached 379, the highest since 1921. Between 1942 and 45, the cost of living went up by 200 percent. The year 1940 saw another strike wave, in which workers of cotton textile, jute, oil, coal, iron, and steel and many other industries participated. The number of trade unions went up from

"The Indian bourgeoisie opted for a model of health care service in which health care could be transformed into a commodity."

188 in 1938 to 515 in 1944 with the membership rising from 3,65,450 to 5,09,084 (Dutt, 1983).

At the same time, the All India Kisan Sabha, which took a leading role in fighting against government repression and had helped organise self-help movements for food and funds, quadrupled its membership between 1942 and '45. (Dutt, 1983, p. 279). The end of the war saw two significant peasant movements - the Tebhaga movement between '46 and '47 in what is now Bangladesh and the Telangana struggle in '46 and '51 in Andhra. These were the most outstanding indicators of peasant ferment brewing all over the country.

The political ferment also spread to the armed forces in '46. The RIN mutiny and the support it gained in Bombay from the working class and middle classes shook the Indian bourgeoisie. Thus although, the Indian left, because of many reasons into which we cannot go in in this article, could not destabilise the bourgeoisie nor have a perspective

to take control of the national movement, the latter was forced to recognise the explosive potential for militancy among the labouring masses. The realisation that the mass pressure the bourgeoisie had so far used to their advantage could get out of hand, forced them into granting concessions in the overall plan of development at independence.

In the context of the above, the bourgeois strategy that developed after independence was twofold. Parliamentary democracy was accepted because it would widen the mass base of the regime, to give room to the contending socio-economic forces in the governmental block and to provide a safety valve for mass discontent. This method of bourgeois rule granted universal franchise, formal political democracy, equality before the law and so on all at one stroke. In the Constitution, it gave the State Power a clear bourgeois impress by making the right to private property a fundamental right. The right to work, the right to receive free health care, education and so on were not included in the list of fundamental rights but were relegated to being directive principles. Also, for the future socio-economic development of India, planning with the active intervention of the State in the economy was adopted as the best way for industrial development and for the transformation of backward agriculture.

"The expansion of capitalism is dependent on a politically stable and healthy labour force."

Briefly, the aims of planning with the active State intervention in the economy were the following: (i) To develop an infrastructure of the heavy industry, transport, communication, and energy, so vitally necessary to overcome the most glaring weaknesses of industry or the under-developed capital intensive industries. This development required huge investment and a long gestational period for invested capital, the private sector was not yet ready for this. (ii) To aid the process of capital accumulation in the private sector. This was to be done providing private capital with easy access to the infrastructure, by employing private contractors in the operation of public sector, by enriching individuals or groups of individual bureaucrats and so on, and (iii) To carry out limited agrarian reforms, to provide facilities for agricultural development and strengthen and expand existing bourgeoise forces leading ultimately to the modernisation of agriculture on a capitalistic basis.

c) The health care strategy adopted as a part of the development perspective : At the time of independence, three major reports concerning the health system in the new nation saw the light of the day. In 1939 the national planning committee had set up a subcommittee to prepare a plan for health. In 1940, the Chopra Committee was constituted at the first health minister's conference. And the Bhore committee began work in 1943, and was charged with the task of conducting a survey of the entire field of public health and medical relief on which to base plans for post-war development in the health field. (Bhore, 1946). It advocated a doctor-centered system of health care and urged the creation of a vast health infrastructure. Its main inspiration were the Flexner report (which consolidated the establishment of 'scientific' medicine in the US) and the Goodenough Committee (which had been a more recent report restructuring medical education in U.K.). Briefly, the Bhore committee recommended (i) the main focus of all health measures should be to enable people to enjoy life to the fullest extent and to help the individual reach his maximum level of productive capacity; (ii) the future health care system should be a doctor-based, hospital-centered system with a proliferation of health institutions; (iii) a salaried service should be preferred over private practice although "any apprehension that private practitioner will be seriously affected to their detriment by our proposals for a state health service is unfounded." (Bhore, 1949 p. 16); (iv) occupational and industrial health was an important aspect of health services; (v) maternal and child health was to be given a high priority; and (vi) consequent on the development of a health infrastructure, the pharmaceuticals and the surgical goods industries would have to be encouraged to expand.

The Chopra committee (the committee on Indigenous System of Medicine) report was published in 1948 and made recommendations which, had they been implemented at that time, would have resulted in a drastically different system of medicine. It saw an urgent necessity for evolving one unified system. It pointed out that the Bhore Committee had been rather silent on the question of indigenous systems in their grand plan for the development of health services in India. The Chopra Committee, in fact, had drawn up a plan for health services where the primary levels would mostly use indigenous system and the taluk hospital and beyond would practise 'synthesised' medicine. Almost all the recommendations were rejected. It

was decided that a full course in modern scientific medicine was to be the basis on which other systems were to be engrafted.

The Indian bourgeoisie opted for a model of health care service in which health care could be transformed into a commodity. Even in adopting the recommendations of the Bhore committee, it selectively incorporated those recommendations which contributed to the growth of the health infrastructure and the consolidation of bourgeoisie and its concomitant organisation. The development and consolidation of allopathic 'scientific' medicine was also a deliberate choice which offered several advantages which we will elaborate in a later section. For the moment, it is sufficient to state the supposed resolve of the Indian bourgeoisie to develop indigenous systems did not get translated into any meaningful programmes and India was well set on the way to enlarging the world base for the practice of 'scientific medicine'.

First fifteen years of Planning

(a) Growth of industries hastening captial accumulation : The public expenditure on development in the first three five years plan period was as shown in Appendix 1.

From the second plan, Industry and mining started receiving the attention of the planners and in the third plan it got the first priority. The major investment in this branch was in heavy industry. By 1965, substantial changes took place in the industrial structure. The gross value of output of light industry increased from Rs. 17,100 million in 1951 to 35,900 million in 1965, i. e. it more than doubled in 15 years. In this period, the output value increased by 8.5 times in the heavy industry. The share of heavy industry in the total output of manufacturing industries went up from 22 to 52 percent. The investment in heavy industry went up from 43.4 percent of the total investments in the manufacturing industries in 1951 to 79.8 percent in 1965. (Shirokov, 1980).

Thus, at the end of third plan period, the public sector had set up productive plants mainly in the sphere of heavy industry. It could do this by receiving soft-term loans from the Soviet and other 'Socialist' countries.

Even while developing the industrial infrastructure, in this period a slow but steady transformation of the Indian agrarian sector, was also begun.

(b) The Transformation of Indian agriculture The progress in the agricultural sector in the first fifteen years can at best be termed modest. The production of food grains recorded a much smaller growth than that of cash/industrial crops. The rise in grain production did not outstrip or even equal the rise in population. The sectoral allocations in the first plan gave first priority to agriculture, community development and irrigation which together accounted for 35.8 percent of the outlay. After that, the percentage share of the outlay in these areas consistently decreased.

Throughout this period agrarian legislation strengthened the position of the rural upper classes. The richer peasantry were able to gain greater freedom from their landlords and were able to increase their holdings. The big landlords were being transformed into capitalist farmers. The conditions of the poorer peasantary considerably worsened during these years. On the whole there was a slow development of rural capitalism. (Betteleheim, 1968).

Agrarian reforms were in this period directed not so much at transforming the modes of production in agriculture, as adapting the colonial agrarian structure to fit the pattern of growth envisaged by

"The programmes like malaria control must be seen as death control programmes preceding the birth control programmes of a later period."

the bourgeoisie. They were directed at eliminating the intermediaries and middle men and reducing the effect of feudal and semi-feudal relations. Agricultural policies and programmes favoured those landlords who had undertaken cultivation on their own, rather than rentier landlords (Joshi, 1969). The non-implementation or failure of those portions or land reforms or the 'failure of land reforms' was not surprising, considering as Davey remarks aptly, that the state assemblies were dominated by landlords and kulaks. Likewise, land ceiling legislation was easily circumvented. The Failure to ensure security of tenure has resulted in evictions. In the Punjab alone, the number of tenancies fell from 583,400 in 1955 to 80,520 in 1960 (Davy, 1975).

The Community Development Programme, launched with US aid in the first plan further strengthened the economically and politically dominant classes. Later evaluations showed that 70 percent of the benefits from agricultural extension went to

the elite groups, the more affluent and influential agriculturists'' (Dubey, 1969). The CD projects worked through existing village institutions which were more often than not, dominated by landowning groups. The 'Shramdan' drive which was supposed to encourage people's participation, in terms of free labour on road construction and repair, was usually contributed by the poor who had nothing to gain from roads; while those who benefitted from the roads, the large landholders who needed to transport goods out, got away by merely supervising. The CD programmes not only strengthened the rural elite but also created bureacratic institutions which acted as a link between the rural elite and the government.

After 1960, agrarian policies and programmes became openly favourable to rich peasants. The Ford Foundation sponsored Intensive Areas Development Programmes with its packages of credit, modern inputs, marketing facilities and technical advice was one such. This meant also the increasing use of high yielding varieties and fertilisers. Between 1960 and 1966 the consumption of fertilisers more than doubled (Davey, 1975). The two disastrous droughts in '65 and '67 upset bourgeois plans of strengthening and developing rural captitalism.

"Bourgeois radicalism either in the form of reports or legislations or programmes can best be viewed as concessions gained by working class militancy."

(c) Health Care in a Planned economy: The evaluation of health services and the growth of medicine in India can only be analysed in the background of the development strategies employed by the Indian bourgeoisie. As we have seen the primary aim of Indian capitalism at independence was the consolidation and expansion of capitalist relations and the transformation and integration of pre-capitalist mode of production. Accordingly, the health strategies that were chosen directly or indirectly supported and strengthened the drive for capital accumulation.

There were four factors, one may call them constraints, which limited the bourgeoisie's options in the health sector. Firstly, they functioned in an economy linked to and subservient to World capitalism. Secondly, they were committed to planned development. Thirdly, they had to function within the garb of a 'welfare State' and fourthly, in the beginning at least, they had to counterpoise and diffuse working class demands and tensions. What were the health plans and programmes of the period and how did they advance bourgeois aims and ideology?

In 1951, the population of India was 361 million. Nearly 38% of the working population were wage-earners (Bettelheim, 1968). The economic growth envisaged required a healthy and productive labour. However, the recent series of famines and droughts, increased exploitation of war, further deterioration of the abysmal public health and sanitary services, the post partition exodus had resulted in a labour which obviously could not contribute its best in terms of productivity. The situation also favoured political instability. The expansion of capitalism is dependent on a politically stable and healthy labour force and these called for measures to reduce mortality and morbidity in the Country. Moreover, the unhampered bourgeois hegemony of the national movement had been paid for by making promises to the working class and its leaders as well as the progressive educated elite. In response to the growing mass discontent the bourgeoisie had to make visible gestures which could demonstrate their concern and their intention of fulfilling promises. The creation of large health institutions and building of medical colleges and research establishments was a most appropriate strategy.

At the same time it was recognised that the reinforcing of capitalist ideology and reproduction of bourgeois class relations was necessary to the growth and development of capitalism. 'Scientific' medicine' which had evolved and matured under capitalism was obviously the most appropriate choice. In this sense, the adoption of modern medicine as the dominant system of medicine and the creation of hospital infrastructures where it could be practised was an ideological as well as political necessity.

1) Reduction in Morbidity and Mortality: At the time of independence 50 percent of all deaths were estimated to be from epidemic diseases. The expectation of life at birth was 32.45 years for males and 31.66 for females (Health Statistics, 1982). Cholera, Malaria, tuberculosis and smallpox were major killers. In 1950 malaria killed 75 million and

it was estimated that 156 million work days were lost causing a loss of Rs. 75 million. PAC Report-1983-84). Moreover, "aggregation of labour in irrigation, hydroelectric and industrial projects is attended with severe outbreaks of malaria". (First F. Y. Plan, 1952, p. 500-501). Tuberculsois was the other major killer which claimed fives lakhs lives annually and rendered 25 lakh people ill. It was estimated that 900 to 1000 million mandays were lost because of the disease. (First F. Y. plan 1952).

The Malaria control programme co-ordinated all Malaria control activities and consisted of DDT spraying, treatment with antimalarial drugs and providing malaria engineering services wherever there were developmental irrigation and hydroelectric projects.

The Tuberculosis Control Programme included vaccination with BCG, clinics and domiciliary services, and aftercare. The emphasis was on prevention with BCG. Both these programmes depended on international agencies like the UNICEF and WHO for supplies of necessary chemicals and vaccines.

Both these programmes, especially Malaria Control Programme, achieved spectacular results in the beginning, after which their success levelled off. By 1956 the mortality due to malaria had declined to 19.3 million and in the first year of the programme the number of workdays saved was estimated to be 116 million.

These programmes, especially the malaria programme conducted like a military campaign were conceived in such a manner that they were bound to fail. Cleaver (1976) points out that programmes like malaria control must be seen as death control programmes preceding the birth control programmes of a later period. Together they constitute "the means for obtaining control over populatian growth and thus over the supply of labour". These have been the strategies sought by business whenever they have sought to invest — in US, South, SW Asia or China.

These programmes have also been used to divert attention from the real causes of ill-health by equating disease eradication to 'technical' measures such as DDT spraying in the case of malaria or BCG vaccination in the case of TB. Both eradication and immunisation programmes constitute the 'medicalisation' of socially and economically determined problems of health.' By introducing disease control and later eradication programmes, the Indian bourgeoisie was ensuring control over labour supply. Its early spectacular results also aided the legitimation of the 'welfare state'.

By the '60s increasing urbanisation with a 40 percent increase of urban population, inadequate housing and living conditions, low availability of food and impoverishment and unemployment had pushed up disease incidence rates. The health impact of new industrial processes that were being introduced went unrecorded. In industry, intensification of labour coupled with chronic malnutrition accounted for a rise in industrial injuries which rose by 30 percent between 1961 and 1966 while work force rose only by 16 percent (Ajit Roy, 1973)

2) Institution Building : Both the Bhore committee and the First Plan took serious and anxious note of the lack of medical facilities. Low health status was seen as being primarily because of lack of medical facilities. The major emphasis in the first fifteen years was an increase of hospitals, beds and dispensaries and the numbers of doctors, nurses and other health personnel. (Appendix 2).

"The faithful implementation of recommendations is contradictory to the interests of capital and can be brought about only by continued struggle."

The first plan envisaged an increase of 24 percent in the number of hospitals, a similar increase in the number of urban dispensaries, a 11 percent increase in the number of rural dispensaries and a 10 percent increase in hospital beds. The number of maternity and child health centres both in urban and rural areas was also to be increased. More than fifty percent of the budget for medical schemes was allocated to the establishment of hospitals and dispensaries.

Public health expenditure went into the provision of water supply and health sanitation, the major share going to Madras and Bombay. Since training of personnel of all kinds was so important, institutions and facilities for training were given high priority. The establishment of the All Indian Institute for standardising and co-ordinating post-graduate medical education was also initiated (First

F. Y. Plan). This venture, as well as others, such as the setting up of the Virus Research Centre in Pune, and the expansion of the All Indian Institute of Hygiene and Public Health was assisted by the Rockfeller Foundation. This trend for increasing the medical infrastructure continued throughout the fifties and the early sixties.

The Mudliar committee which published its report in 1961, recommended a strengthening of the district hospitals as against any expansion of primary health centres. In its opinion, the resources in regard to personnel, finance were not available sufficiently for any further expansion of PHCs.

It must be pointed out that most of the expansion in facilities took place in urban areas and a majority of the medical graduates set up practice in cities. Together with this, the pharmaceutical industry which had made small beginnings after the first world war had expanded a little during second world war. By the beginning of the '50s, India was self-sufficient in all the galenical preparations, most of the vaccines and alkaloids. But medicines like Pencillin, Streptomycin and sulphas were largely imported. After 1956, many foreign subsidiaries which had begun as trading operations went into the production of formulations, and public enterprises such as Hindustan Antibiotics and Hindustan Organic Chemicals were started in the late '50s mainly with the help of Soviet aid and technical know-how. But the major expansion of production was of the foreign subsidiaries. By '68-'69 the average profits for pharmaceuticals was 20.3 percent (Rangarao, 1977.)

"The rationale of the Indian bourgeoisie in adopting massive family planning drive was a means of controlling labour."

In short, the health care system being developed was a doctor oriented, hospital centered, curative system largely dependent on modern pharmaceutics with its locus in urban areas. For the Indian bourgeoisie, such a health system created a large base for consumer durables which were manufactured in the private sector. It also motivated the growth of the pharmaceutical and chemical industry. Increase in the number of hospitals and medical institutions also meant many more 'converts' to both 'scientific' medicine and the growing array of drugs and associated products. Also, these institutions were an emphatic and 'visible' assertion of the State's concern in fulfilling its 'Welfare' goals and in keeping with the 'leap frogging' approach to catch up with developed countries that was being advocated.

This is not to deny that the increase in the numbers of health personnel and institutions was not necessary or useful. That would be patently untrue. But arguments which place blame for the current crisis on the non-implementation of 'radical' recommendations of the Bhore committee are inadequate. Given the path of development chosen by the bourgeoisie, the alternative offered in, say the Bhore report or the Community Development Programme could never have been implemented. Bourgeois radicalism either in the form of reports or legislations or programmes can best be viewed as concessions gained by working class militancy. The faithful implementation of recommendations is contradictory to the interests of capital and can be brought about only by continued struggle.

3) Reproduction of bourgeois social relations and social control : The bourgeoisie always adopts policies and strategies which will reproduce and reinforce bourgeois social relations.

(i) The adoption of allopathic medicine as the dominant medical system : From the outset, it was clear that the western allopathic system was to be the medicine of choice. In the period between 1948 and 1960 four committees Chopra, Pandit, Dave and Udupa) were constituted to plan for the development of indigenous systems of medicine in the country. By and large the only recommendations which were implemented were those which helped to suppress or discourage the growth of indigenous systems. We have already noted what happened to the Chopra Committee report. Later reports increasingly emphasised the need to examine indigenous medicine 'scientifically'. Further, it was generally agreed that the only area where indigenous medicine could play a role in the health system was in area of drugs and remedies.

Why was the adoption of allopathic system as the dominant system of medicine so important to the bourgeoisie? Firstly, the class and sex biased, positivist individualist ideology of modern medicine reflected bourgeois ideology. The hospital system reproduces the social structures of bourgeois society and by doing so reinforces and authenticates it. Modern medicine with its dependence on mysterious sounding drugs and its array of task specific

functionaries and unfamiliar language facilitated the monopolisation of knowledge and skills. From this comes the power and influence to those who have access to this knowledge viz; the doctor and to a lesser extent other health professionals. These professionals, mainly doctors, who shared the same class background as the bourgeoisie were necessary for the legitimation, strengthening and maintenance of the capitalist order. In recognising and locating 'scientific' medicine as the dominant system, the bourgeoisie were also acknowledging and encouraging the role of the educated elite.

(ii) The development of maternal and child health services : Concern for the health of women, as mothers, has a long history in India. At the time of independence, the sex ratio (women to 1000 women) had already started declining. But none of the health plans nor policy statements were ever concerned with this. However, investment in the health of the child (and incidentally its mother) were seen as an investment "for building a sound and healthy nation" (First F. Y. Plan). These facilities were seen as facilities through which women could fulfil their socially determined primary role as mothers. In consequence, women's health needs became subordinate to the needs of the family. The deterioration of women's health and women's status through the '60s is to a large extent the result of the policies and programmes that have been adopted by the Indian bourgeoisie.

The provision of MCH service,however relevant, in the absence of primary care accessible to women indirectly perpetuates 'the myth of motherood' and the social location of women under capitalism mainly as 'reproducers of labour.'

(iii) Health Education. One of the most important component of 'preventive' services was and has been health education, which mainly reinforces the victim-blaming ideology of modern medicine. It also helps to mask the social roots of illness and disease. The emphasis on changing life styles rather than on changing the socio-political environment which endanger such lifestyles protects the existing power structures in society and the exploitative mechanisms of capitalism.

Changes in Health Policy after 1965

In the health sector the trends which were discernible in the first decade after independence continued to be prominent until about the '70s. In this section, we will analyse the seemingly drastic change in health policy and programmes in the mid '70s in the context of socio-political and economic developments.

The two consecutive droughts in the mid-sixties had brought impoverishment and ruin to the rural landless and agricultural labourers. The proportion of rural population below poverty line reached a new hight of 57.9 percent (Shah). The nett per capita daily availability of food-grains was around 402 grams the lowest since 1952. It was in this situation that the Green revolution was launched. The concept itself, according to Davey was a part of America's post war strategies and was an extension of the agricultural research of the Rockfeller and Ford Foundations. The Green revolution also coincided with the glut in the world fertilizer market.

In the arease where the green revolution took root the crop yields shot up and also altered the agrarian structure. There was an increase in the numbers of agricultural labourers and despite mechanisation, the demand for labour also went up. In time the landless labour gained in strengh and emerged as a distinct class (Bhalla, 1983). Most of these also belonged to the deprived sections — the scheduled castes and scheduled tribes. At the same time the introduction of new technology and easier credit facilities had strengthened the small and marginal farmers and increased their staying power. Rich farmers were unable to buy them out. However there were no basic contradictions between the large and marginal/small farmers. These holdings constituted two-thirds of the cultivating households. In such a situation agrarian struggle was inevitable. Agitations for better wages were also, in reality struggles against caste oppression.

In areas outside the green revolution area, such as M.P., Rajasthan, Gujarat, parts of Bihar and

> *"Reduction of state inputs in health care and a great involvement of the private sector were the outstanding features of the national health policy and is in keeping with the objectives of the new bourgeois strategy for health care."*

Orissa and West Bengal, it was the small and middle farmers who gained most by the introduction of new technology. They soon began to challenge the economic and political power of the landlords, most of whom were absentee landlords. The interests of these new rich small and marginal farmers were contradictory to both that of the landless as well as that of the politically influential landlord. Having gained economically this section of the peasantry, the middle farmers who were usually from the middle castes, began to develop political clout both on the regional and the national scene. They also began to demand development inputs which would enable them to gain a qualitatively better standard of living... electrification, consumer goods and health services.

By the beginning of the '70s, industrial production had stagnated, the rise in national income being only 4 percent in 1971-72. The population went on rising, hence the labour force had continued to expand. The total work force was 184 million, 8 percent or 15 million were unemployed. While wages had remained stagnant the average product per worker had increased. So, the employing class had benefitted, thus polarising income (Davey- 1975).

The Fourth Plan's emphasis was on rural and agrarian programmes and the enormous emphasis on family planning. This was an attempt to postpone and forestall the crisis and also a recognition of the new and growing political influence of the middle peasantry. In the health sector almost half of the allocation went to family planning.

There have been a number of analyses of why there was an emphasis on family planning. The most obvious explanation is of course, the enormous spurt in numbers in the previous decade, which was mainly because of decrease in death rates. Even-though epidemic diseases had not been eliminated there was a decrease in the number of death in each of these epidemics. Another less obvious reason was that given the high rates of unemployment and impoverishment, the sheer numbers presented a threat to the stability of the system. That there was imperialist pressure, through the use of conditional international loans and such, cannot of course be denied. But the rationale of the Indian bourgeoisie in adopting a massive family planning drive was a means of controlling labour supply to suit the expansion of more capital intensive modern industries.

Throughout the first half of the '70s there was a marked increase in the number of industrial conflicts, strikes, peasant agitations, tribal movements, student and mass movements most of which were directly or indirectly concerned with economic grievances. The Gujrat and the JP movement were against price rise initially but later made political demands. The Naxalite movement and the revolt of the tribals in Srikakulam, were more broad based and directly challenged class oppression. That brutal repressive measure were used to break and suppress them was an indication of the insecurity of the Indian bourgeoisie. The world economic situation had also changed by the mid '70s. Many advanced capitalist countries were on the brink of a third technological revolution. The national bourgeoisie realised that if they were to forge a new relationship with the world capitalist economy they had to re-structure the industrial sector by reducing state intervention and increasing opportunities for foreign investment. This also meant disciplining and controlling labour and stabilising the political climate.

Inputs into rural development therefore served two purposes — firstly, they facilitated the further penetration of capital and secondly, 'visible' efforts such as provision of health care, educational facilities, electricity, low capital intensive 'appropriate' technologies would not only nullify the growing discontent and political influence of the new rich 'middle' peasants and capitalist farmers but also strengthen them as a class who would associate with the industrial bourgeoisie in opposing and suppressing working class struggles. Moreover, these efforts would also mean an expanded market for the new technological consumer products.

The Fifth Plans' Minimum Needs Programme is just one such strategy. In the health sectors it was being realised that a hospital based health system supported by vertical programmes such as Malaria Eradication and Family Planning no longer performed either this ideological role or achieved their socio-politcal objectives. There had not been any large scale improvements in health indicators in the past years. Their role as advertisements for the bourgeoisie's concern for 'welfare' had long outlived its usefulness. Moreover, it was no longer a good economic option. The amount spent for welfare of the working class comes out of the surplus value being created. If this no longer achieves the purpose of either maintaining and reproducing labour or of strengthening class relations by reproducing and legitimating the capitalist order, the loss in surplus value cannot be justified. The only answer was a change in strategy. 'Scientific' medicine gave way to a 'community'

conscious science-based medicine which was accommodating enough to allow the operation of other systems under its hegemony.

Through the '70s a number of voluntary agencies funded by industrial houses, Christian missions or foreign development agencies, and individual professionals frustrated and disgruntled with the existing system began to 'experiment' with alternative health strategies following essentially the 'health-by-the people' approach. The rising cost of health care, of medicines and equipment provided a further impetus to many. Naturally enough this approach had an instant appeal to a mass of socially-conscious urban and rural youth, plagued by the threat of unemployment and sensitive to the increasing deprivation of the masses. Many of these projects achieved initial success in improving health indicators such as infant mortality or maternal deaths, epidemic deaths and achieving high immunisation rates.

In 1975, the Srivastava Committee was the first official document which put forward a proposal for health care which created a new health functionary.. the community health worker. Based on the premises that most of the commonest health problems are of the easily preventable kind and may be easily looked after at the village level, the committee proposed the training of selected villagers as the first contact in the new rural health care structure. It suggested a well organised and graded structure of dispensaries, hospitals and referal services.

The alacrity and the speed with which these proposals were accepted and implemented by the government is a measure of how appropriate and urgent they were to those in power. By then, in 1977 the Janata Party, a configuration albeit temporary, of the commercial bourgeoisie and capitalist farmers had dislodged the Congress, which then represented mostly the industrial bourgeoisie. The Janata Party saw the provision of rural health care as a means of fulfilling election promises. Moreover, they were the representatives of just those sections who would be benefitted most... the rural rich and middle peasantry. Democratic selection processes notwithstanding, the community health workers were certainly not to come from among the poor.

Around this time several countries, met under UN auspices at Alma Ata and signed the Declaration which proposed just such a strategy. The international move conferred on the programme a high status which would play a part in persuading reluctant and antagonistic professional bodies to co-operate.

In 1980, the new strategy for rural health was formalised and integrated into overall bourgeois strategy in the form of a national health plan, proposed by the ICMR-ICSSR committee. This report, a good indicator of the bourgeois radicalism, in the '80s, proposed a pyramid model of health care, based on a diffused primary health care programme relying on limited, cheap, labour-intensive techniques and technology and a smaller, capital-intensive, mainly curative, referral and specialist service using sophisticated, modern, high tech resources, and the hospital system. Both the terminology and the spirit of the report was greatly influenced by Illich. It saw the organising of primary health care on a community basis as an essentially 'political experience' which would enable people to fight other battles and this in turn would set in motion a 'process to strengthen a decentralised, democratic and participatory social order'. (HFA, 1981). The major recommendations of the HFA were incorporated into the Sixth Plan.

In 1982, the government of India published a Statement on National Health Policy. It enunciated an integrated, comprehensive approach toward the future development of medical education, research and health services. Broadly it followed and repeated the recommendations of the HFA. But in doing it re-emphasised certain trends which had been barely discernible in the HFA and the Sixth Plan. For instance, it focussed greater attention on reducing governmental expenditure and utilising untapped resources to encourage the establishment by private practice professionals . . . . and financial and technical support to voluntary agencies (NHP 1982-). More importantly, it focussed on the need to establish a referral system which could provide speciality and super speciality services. Again, to reduce governmental expenditure private investment in such fields was to be encouraged. In providing water supply and sanitation too, appropriate technologies were to be used 'to reduce expenditures'. The 'involvement of community' in the implementation was also seen as a means of reducing costs. Thus, reduction state of inputs in health care and a great involvement of the private sector are the outstanding features of the national health policy and are in keeping with objectives of the new bourgeois strategy for health care.

We will examine briefly how the alternative strategy fits into the overall strategies adopted by the bourgeoisie since last quarter of 1970.

(1) The growing mass of rural poor has little access to any kind of health care. Diseases which could be easily prevented were still claiming lives. Maternal and infant mortality rates were still pretty high. Community health workers, however inefficient orinappropriately selected would ameliorate sickness conditions to some extent. The credit for this in turn, would accrue to the party in power.

(2) More importantly the new alternative is demystifying medicine just sufficiently for people to learn to use and to become dependent on modern drugs. If until now injections had a 'magic' value, soon metronidazole or B-Complex which the CHVs use will become familiar enough for people to ask for and demand them. This expands the base of operation for pharmaceutical companies.

(3) As we have noted earlier, the medicine practised by the community health worker was no different from the medicine practised by a hospital-located health functionary. Its content was the same but its garb was different. Therefore, the dominant/dominated relations that it embodied are strengthened and reproduced. Since the outreach of these rural health alternatives is so much larger, bourgeois ideology is being strengthened.. It is possible that these programmes are hastening the degeneration of indigenous practices and local healers.

As the main disseminators of health education messages, the village health workers are also spreading the ideology of 'victim blaming' shifting attention from socio-political roots of illness and masking class contradictions. In locating the main focus of health care in the family, programmes determine and lend support to the oppressive institutions which are so necessary to the maintenance of capitalist order.

Moreover, the village health workers have generally been from among the rich and middle peasants and middle castes. The acquisition of new techniques and knowledge has led to a different level of monopolisation strengthening the power base of this class. The existing selection process does not cut across existing power relations in society, including that of man and woman, and so reinforces them.

(4) This separation of primary and referrel facilitated the modernisation and development of productive forces of modern medicine on the one hand, while at the same time appearing to cater to the needs of the masses. The new strategy attempted to resolve the growing contradictions between the relations of production and production forces in modern medicine. The introduction of CAT scans, linear accelerators, laproscopy and so on in the last few years must be viewed in this context. The new 'medical leasing' companies which have started to function will facilitate the introduction of new technology and instruments in health institutions.

Conclusion

Medicine is not a socially independent activity. The evolution of medicine and the development of health care can only be understood within the larger perspective of the overall development of the Indian economy and the changes in the relation of production that came about.

The choice of 'scientific' medicine and a hospital-centred structure through which it can be practised was a deliberate choice on the part of the Indian bourgeoisie and was a necessary component in achieving the objective of a capitalistic transformation of India. This also had a profound impact on the traditional practices in India, not simply in terms of making their techniques less effective, but more so by changing the social relationship that such practices of those techinques embodied. Such transformation has further strengthened the domination of bourgeois medicine.

The community health approach so lauded since the late '70s initially gave an illusion that radical changes were being brought about in health care. We have argued here that this approach was never intended to bring about any radical changes but on the contrary, it was very much a part of a strategy to expand the hosptial-centred health care structure at the primary and secondary level in the rural areas. Not only. The strategy also involves inviting private investment and collaboration in the health care system with state gradually reducing its inputs in health. The community health approach also helps the pharmaceutical and surgical goods industry (which is largely in the domain of the private sector) to expand their domestic market.

Lastly India with her vast area and dense population divided into class, caste, sex, cultural, ethnic and a host of other differences is probably the most complex of socio-economic formations rendering attempts to properly comprehend it a most difficult task for the social 'scientists. There is always the danger of making sweeping generalisations and over-simplifications in providing an analytical outline of the development of health care in the context of the dynamics of socio-economic changes in India. We have not taken into consideration in

this analysis the regional differences and the unevenness of socio-economic development. But we have identified the dominant trend of development at the general level and analysed how the development of health care services is integrated with it. We are also aware that we have not included in our analysis the relative strength and political influence of medical organisations like the Medical Council of India nor their relationship with the pharmaceutical and surgical goods industry.

Given the vastness of the subject it was only natural that all aspects could not be covered. But the article, we hope, will generate enough interest in this subject so that the analysis can be deepened and broadened.

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Appendix 1

	First Plan*		Second Plan		Third Plan	
	Rs. in thousand million.	in per cent.	Rs. in thousand million	in per cent	Rs. in thousand million	in per cent
Agriculture and community Development	2.9	14.4	5.7	11.8	10.68	14
Irrigation and Major projects	4.3	21.4	5.3	11.1	6.5	9
Electricity	1.5	7.4	3.8	7.9	10.12	13
Industry and Mining.	—	—	8.9	18.6	17.94	24
Other Industries	1.0	5.0	—	—	—	—
Transport and Communication.	5.3	26.4	13.8	28.9	14.86	20
Social and other services.	5.1	25.4	10.5	21.7	13.0	17
Stocks	—	—	—	—	2.0	3
Total	20.1	100	48.0	100	75.00	100

*Actual result.

(Compiled from, Bettelheim, 1968, p. 157, 161 and 163)

(Appendix 2 contd. on page 48)

REVIEW ARTICLE

A CULTURAL CRITIQUE OF MODERN MEDICINE

anant phadke

The Cultural Crisis of Modern Medicine, John Ehrenreich (Edited), Monthly Review Press, New York and London, 1978, 300 pages, $7.50

It is quite often alleged that marxism is interested only in the economic aspects of society or a part of it. But this view is at best a misunderstanding. Marxism does attach primary importance to the analysis of the process of social production ("economic aspect") of any society but it is also quite concerned with a concrete analysis of the superstructural aspects. In the field of analysis of Health (determinants and dynamics of health status of the people) and Medicine (as science and technology and as system of professionals geared to intervention based on this science and technology) marxists have given due primary importance to the political economy of health. But the ideological/cultural aspects of health and medicine have also been analysed by Marxists. *The Cultural Crisis of Modern Medicine* is one of the most important contributions in this field. What follows is more of an introduction to this book than a critical review.

The book is a collection of a dozen essays abridged, and edited by John Ehrenreich. In his lengthy introduction, John Ehrenreich first traces the historical and political origins of the "cultural critique" of modern medicine. Ehrenreich alleges that the political, economic critique concentrates its fire on the inequitable distribution of health-services, on the problems of organisation of medical-care, and is not much concerned with the nature of medicine itself. Ehrenreich is not entirely correct in his assertion. There are marxist analysts who analyse the political economy of health not primarily from the standpoint of distribution of medical services. For example, *The Political Economy of Health* by Lesly Doyal and Imogeh Pennel is primarily concerned with showing the relationship between phases in the bourgeois economic development in Britain with the development of Medicine and it shows the ideological/political role of medicine at different historical junctures in England. It is however true that traditional marxist analysts have almost exclusively focussed on the lack of proper medical facilities to the poor and on medicine as a money making industry.

Ehrenreich points out that the question of the purpose and nature of medicine was brought forward by the women's movement, and movements of minorities who pointed out that in their experience, medicine was not so much a helpful measure as a tool of ideological, and cultural domination. Along with the radical community movements, the other sources of cultural critique were some critical health analysts (Dubos, Mckeown, Powls, Illich) who showed that modern medicine has not at all been as effective and beneficial as it is made out to be. Most of the infectious diseases in Europe were well on the way out before the era of antibiotics. When antibiotics came, the West had by then acquired the so-called diseases of industrialisation, cardio-vascular diseases, accidents, cancer, psychological and geriatric problems, and so on for which medicine has not much to offer in real terms.

Ehrenreich in his introduction also points out the problems of a cultural critique. For example when one says that the existing system of Medicine is not very effective, or helpful, this gives a ground for conservatives and reactionaries to argue for a reduction in the subsidised, social medical-care-programmes. In backward, developing societies, even a rise in the availability of conventional medicine can help to improve the health status of the population. In such countries a cultural critique is not a priority, though it is still relevant in such situations. In such situations what is needed is more medical care and also a better one, a helpful one and not as a tool of domination. He points out other problems such as dependency, professionalism, problems of technology. Capitalism has given a particular shape to these problems. We should reject their capitalist form but the problems in Ehrenreich's view do not end there and hence concrete socialist alternatives need to be worked out.

Medicine and Social Control : The Book is divided into three parts. The first Section consists of three essays which deal with how modern bourgeois medicine acts as one of the mechanisms of **Social Control**, of perpetuating and consolidating bourgeois social norms and ideology. *Medicine and social control* by Barbara and John Ehrenreich makes a critique of Talcot Parson's (the famous bourgeois sociologist) concept of 'sick-role' which governs the understanding of the relations between the sick-person and

the society in bourgeois society. The medical profession decides as to who is sick and how a sick person should behave. A particular person may be pronounced as below normal, or neurotic even if he/she is just different from or rebelling against what the doctor and the bourgeois ideology regards as normal. A worker may be ill, but the doctor may declare him to be normal and fit for work so that the employer does not have to give any concessions to the worker during his illness. Like law or religion, these medical verdicts cannot be challenged. This power of the medical profession is one of the mechanisms through which people are made to behave in the way in which bourgeois society wants them to behave. The authors show that the medical social control could be either disciplinary or cooptive. Disciplinary control mainly directed against the poor, discourages people from saying that they are sick by making sickness an unpleasant, painful episode--- long waits at the doctor's clinic, unpleasant reception by the medical profession, costly, painful treatment and so on. Cooptive control, on the other hand coopts the recipient of medical care (mostly well-to-do, rich people) into the dominant mainstream of social-cultural life by creating, and reinforcing a certain stereotyped understanding of what constitutes proper social behaviour. There has been a tremendous increase in the jurisdiction of the medical profession (from brith to marriage to old age), in the availability of medical services, and through these two, in the dependency of the people on the medical profession. The authors show how the situation of interaction between the highly trained, higher-middle-class doctor and a patient from a poorer or a minority community or a woman is a fertile situation for conveying ideological messages and cultural values; and how this is done in the U. S. today. This framework is a good starting point for us here in India to explore our own situation here.

Irving Kenneth Zola in *Medicine as an Institution of Social Control* continues with the same theme and further unravels the ramifications of this mechanism. Her analysis however, focuses exclusively on the domination of the medical profession without linking it with the capitalist character of today's medicine and today's society. It reads more like a radical attack on modern medicine as such, and not on its capitalist character. Nowhere does Zola make a distinction between the capitalist limitations of modern medicine and the potentialities created by it which can be used in a socialist society.

Marc Renaud in *Structural constraints to state intervention in Health* first shows how the medical profession, even after the advent of modern medicine, has played a very small role in the improvement in the health of the people. He quotes important authorities to back-up his statements. He then shows how, by their very nature, the incidence and effects of the so-called diseases of industrialisation (for example, cardio-vascular diseases) are not amenable to curative services. So long as the profit-seeking giant corporations continue to decide what we eat, what work we do and how we live and travel, which consumer goods we shall use, ill health is going to continue. The state allows this basic mechanism of production of illness on a social scale unaffected. It also allows the commodification of medical-care. All it does is rationalise the access to medical care and make it less costly. But the drug-industry and the health-industry in general, would continue to live happily. The manufacturers of ill health would then continue to accumulate profits as before. The bourgeois state is not prepared to stop the production of surplus-value even if it threatens the health status of the people; it cannot stop the commodity character of medical care. This is the limit of state intervention in bourgeois society. Renauds analysis is a good concrete case study of the limitations of state intervention in bourgeois society and a solid indictment of the limitations of medical care in this society.

Women, Illness and Medicine : The second section of the book consists of five concrete case-studies which demonstrate how medicine in bourgeois society acts as one of the mechanisms of social control over women. In *Sick women of the upper classes* Barbara Ehrenreich and Deirde English show how medicine in 19th century Britain reinforced stereotyped images of women that they are inherntly prone to illness, and that they ought to be frail, and engaged only in "feminine pursuits" like decoration, courtship, motherhood. If a woman were to engage herself in social, intellectual activity, she would be regarded as being abnormal and inviting illness. By "women" the medical profession meant only upper-class women since it had a vested interest in the cult of female invalidism among its upper-class clients. Medicine gave a "scientific basis" to the male-chauvinistic ideas by proposing "scientific" theories which had no real scientific basis. Scientific knowledge of how sexual, and reproductive organs function did not exist then. This opened a wide door for the male prejudices amongst medical men to be propagated as scientific opinions. medical treatment was more of a punishment. It is quite a shock to read about the barbaric methods of treatment empolyed by doctors

to treat women including the application of leeches, blister-producing counter-irritants to genitalia, removal of the ovaries (for "conditions" like troublesome menses, eating like a ploughman, erotic tendencies; dysmenorrhoea...!) and others. The account of hysteria by the author is also extremely revealing. This short essay is one of the most damning indictment of medicine in the 19th century.

It is quite a surprise to learn that doctors were opposed to the birth-control movement as late as the 1920s. Linda Gordon in her piece on *The politics of birth-control* documents this opposition and the reasons for it. She also shows the connection between the left, the feminist and the birth-control movement, and how later, due to the problems created by World War I, the birth-control movement lost the leftist political edge. Later, the medical profession instead of oppossing birth control, decided to co-opt and monopolise it. With their entry and with the decline of the role of the left, the birth-control movement no more remained a people's movement. Along with the feminist birth-control movement, there was the tendency in the U.S. of new eugenics. The essential argument of this eugenics was that unfit people such as criminals, and paupers, were genetically inferior. They were therefore, interested in the compulsory birth-control for these "enemies of civilisation." Because of the lack of strong anti-racist traditions in the U.S., even the feminist used the eugenics arguments for the propagation of the birth-control movement. This, together with the lack of interest of the leadership in "reformist, peripheral" issues like birth-control, resulted in the decline of the paople's birth-control movement and made it into one dominated by conservatives, reactionaries, racists and the ilk. In the 1930's however, eugenics fell into disrepute because Hitler's Nazi Germany took it over. This zigzag movement of the status of birth control makes very interesting reading.

The next three articles show how the ideology of sexist or of scienticist, commercial professionalism affects clinical practice even today. Doris Haire in her *Cultural warping of child birth* makes a point by point critique of the various technical measures employed by American obstetricians for conducting deliveries from confining the normal woman to bed, to shaving the birth area, to Routine Electronic Foetal Monitoring. She argues that all these interventions are not really indicated and that they are not beneficial to patients but to doctors and to commercial interests. It is because of these unnecessary and potentially hazardous medical interventions that the U. S. is outranked by 14 other nations in the low rate of infant mortality although the U. S. is the most prosperous and advanced nation in the world. The U. S. leads all other developed countries in the rate of infant deaths due to birth injury and respiratory distress such as postnatal asphyxia and atelectasis. The reason ? - monopolisation by doctors of midwifery (unlike in Europe) and their overintervention-list strategy. One cannot disagree with Doris Haire. One may add that even in countries like Britain with a long history of legal, expert, trained midwifery, doctors more or less decide the strategy of intervention and the midwives have to follow it. The midwives are fighting this out and are putting forward a series of arguments, facts, figures, and alternative practices. This disease of monopolisation and overintervention is no longer unique to the U. S.

The other two essays in this section focus on the sexist biases in the medical textbooks. Mary Howell exposes the paediatricians whereas Dianna Scully and Pauline Bart pin down the gynaecologists for their sexist bias and their ignorance about female sexuality. Like other articles in this book, these are also made up of quite concrete stuff.

The third section of this book deals with **Medicine and imperialism**. Frantz Fanon in his *Medicine and Colonialism* depicts the hatred, distrust, and alienation felt by the Algerian people towards their colonial masters and their doctors. Most of the doctors owned land or some business and were directly a part of the exploiting system, even of political oppression and torture. This explains the ill-feeling of the Algerian people about these doctors. As opposed to this, the Algerian people were extremely cooperative, helpful to the health programmes and to the doctors of the National Army of Liberation. It is difficult to fully appreciate the situation in a colonial country for those of us from the younger generation who have never experienced it. But Fanon has made his point clearly.

E. Richard Brown in his *Public Health in Imperialism* shows how the Western interest in tropical diseases and public health in tropical countries was motivated by their imperialist interests. The American imperialists wanted an overall penetration into South America for higher profits. But the productivity of these people was low. The reason for their "laziness" was found to be diseases like hook-wom. Hence the Rockfeller Foundation's first act after its inception in 1913 was to create an International Health Commission to extend worldwide the hook-worm and public health programmes initiated in the U.S. The programme against hookworn in Costa Rica

succeeded and resulted in a 50 percent rise in labour productivity. The Rockfeller Foundation had quite clearly expressed why it put a priority on the hookworm programme. "On account of the direct physical and economic benefits resulting from the eradication of the disease and also on account of the usefulness of this work as a means of creating and promoting influences." This latter element was as important as the first one. Brown convincingly shows how. Brown clearly welcomes the betterment of the health status of the population but shows that the chief aim of these programmes was to prepare better conditions for the accumulation of imperialist capital, and people's health was subservient to this aim. He shows that Health was defined as the capacity to work and other aspects of health were neglected.

James Paul in his short essay *Medicine and Imperialism* puts forth an overall picture of the relationship between the two. He considers five "principal features of medical imperial politics— (1) physicians as covert diplomats; (2) physicians as propagandists and spies among colonial people; (3) medicine as a vehicle for imperialist propaganda in the metropolitan centre; (4) colonies as territories for medical sales and medical experimentation; (5) Medicine as a vehicle for establishing and maintaining the exploitative social relations." His analysis is, however, exclusively based on the colonial experience and it has to be seen as to whether and how many of these five features continue in post-colonial imperialism and whether any new features are added. (For example : the question of brain-drain) The distinctly new phase of imperialism after the World War II must be borne in mind. Many marxists mistake colonial imperialism in general and hence generalise from the colonial experience. James Paul's analysis tilts towards such misinterpretation. He however points out that the contradictions of "imperialist medicine" and hence the possibilities of revolutionary change. It would be worthwhile to study the relationship between imperialism and medicine in India, keeping in mind the five features discussed by James Paul.

The last article in this section traces the relationship between the military and medicine. It shows how medicine has on many occasions not been above nations, and how it has directly, and indirectly helped war-efforts. This much is not surprising. What is more startling is the conscious effort of invaders to use medical work to boost up the image of the conquering nation. Howard Levy has successfully shown with the help of quotations from military men how this occured in the case of the American Army in the fifties and the sixties, especially in the Vietnam War.

On the whole, the book is rich and wide-ranging in the historical material it contains which exposes the ideological role played by medicine in bourgeois society. It does not, however, show the correspondence between the different stages of the development of capitalist economy and the development of health and medicine. This is partly because of its character as a collection of essays. But that in itself cannot explain this weakness. Secondly, the contradictions in medicine in bourgeois society are no where posited clearly, emphatically. The analysis therefore can be misunderstood as an attack on medicine as such and not on its bourgeois form. Morever the possibility and necessity of revolutionary change does not emerge because of this failure to point out the contradictions in today's medicine. Though not a very systematic account in this sense, this collection of incisive and very absorbing pieces of historical analyses is one of the most important and useful additions to the marxist analysis of medicine in bourgeois society. It is essential reading for anybody wanting to understand the nature of medicine in capitalist society.

(Contd. from page 44)

Appendix 2

DEVELOPMENT OF HEALTH INFRASTRUCTURE IN INDIA

Year	Doctors	Hospitals	Beds ('000)	Dispensaries	PHCs	Sub Centres	Pharmaceutical Production Rs. in Crores Formulations	Bulk
1951	59, 338 (1950)	2694	117	6515	725 (1951-56)	—	10	—
1965	99,779	3900	295	9486	4793 (1967)	17,521 (1967)	150	18
1975	1,97,650	4023	404	11295	5293	33,616	560	130
1981	2,68,712	6805	477	28312	59511	51,192	1,430	289

Source : *Health Statistics of India*, 1971-75 and 1982 Central Bureau of Health intelligence, Government of India, 1971-75 and 1982.
Health for All : An alternative Strategy, Indian Institute of Education, Pune. 1980.
OPP Bulletin, July-August, 1983.

Why don't you write for us ?

This periodical is a collective effort of many individuals active or interested in the field of health or interested in health issues. The chief aim of the journal is to provide a forum for exchange of ideas and for generating a debate on practical and theoretical issues in health from a **radical or marxist** perspective. We believe that only through such interaction can a coherent radical and marxist critique of health and health care be evolved.

Each issue of the journal will focus on one theme, but it will also carry (i) Discussions on articles published in earlier issues (ii) Commentaries, reports, shorter contributions outside the main theme.

Our forthcoming issues will focus on : Women and Health, Work and Health, Politics of Population Control, and Health and Imperialism.

If you wish to write on any of these issues do let us know immediately. We have to work three months ahead of the date of publication. which means that the issue on Women and Health is already being worked on. A full length article should not exceed 6,000 words. You will appreciate that we have a broad editorial policy on the basis of which articles will be accepted.

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A Worker's Speech to a Doctor

We know what makes us ill
When we are ill we are told
That it's you who will heal us.

For ten years, we are told
You learned healing in fine schools
Built at the people's expense
And to get your knowledge
Spent a fortune.
So you must be able to heal.

Are you able to heal ?

When we come to you
Our rags are torn off us
And you listen all over our naked body.
One glance at our rags would
Tell you more. It is the same cause that wears
Our bodies and our clothes.

The pain in our shoulder comes
You say, from the damp; and this is also the reason
So tell us :

Where does the damp come from ?

Too much work and too little food
Make us feeble and thin
Your prescription says :
Put on more weight
You might as well tell a bullrush
Not to get wet
How much time can you give us ?
We see : one carpet in your flat costs
The fees you earn from
Five thousand consultations.

You'll no doubt say
You are innocent. The damp patch
On the walls of our flats
Tells the same story.

— Bertolt Brecht