State in Medical Care

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The nature of state intervention in medicare has been determined by two factors the demand of the people on the one hand, and the ruling classes' urge to acquire legitimacy and credibility on the other. Often enough policies which have been a consequence of the pressures brought to bear by the working class, have subsequently adapted to benefit the interest of the dominant class effective medical care to the poor, can never, the article contends, be provide by a state geared to the interests of capital accumulation.

MODERN societies, without exception, view certain basic health care services as commodities to which every member of the society should be gauranteed access, regardless of their ability to pay. This general proposition seems widely shared among nations, whatever their cultural and political complexions; vastly different approaches, however, have been adopted for acting on that precept" (Reinhardt, 1982).

Reinhardt's statement reflects a somewhat universal value; but, besides approaches, the understanding and interpretations of the general proposition he mentions also differ widely. Though it has long been established that 'basic health care' includes food-cloth-shelter-safe water-sanitation, etc, as popularly understood in India it actually means medical care, i e, medical intervention to prevent and treat diseases. That is why the Indian state maintains a large number of institutions where a citizen, dying from some disease, may claim free life-saving medical aid. There is no state agency which provides free food to a citizen dying from hunger or for that matter clothing, shelter, etc, to the similarly deprived. Neither is there any demand on the state from any quartor to arrange for such provisions. In fact, conceptually it is yet to be accepted that the basic elements of health care should be provided free to the pauperised people; to each according to his ability—is the motto; one should earn his living—is the precept. Emergency situations, e g, disasters like floods, earthquakes, accidents, etc, of course, make exceptions. In contrast, universal-free medical care by the state is not only welcome but such provision is actually there and more is being demanded.

The endeavour to provide medical care for its members by human society is as old as any other social activity. state, religious institutions, voluntary collective efforts—all have played their part. Modern societies, enriched by modern scientific knowledge, have turned their attention to basic health care with, as Reinhardt says, vastly different approaches. In the socialist countries, state intervention is almost comprehensive in all aspects though the citizens contribute in varying proportions to its financing. In the developed capitalist countries state intervention in the matter of safe water supply, education and sanitation is quite significant and, though food-clothing-shelter remains as yet an individual responsibility, various social security schemes help the pauperised citizens and guard against death from deprivation. As regards medical care, approaches are different. In the US there is no direct state intervention and the semblance of a free market is sought to be preserved, but with the introduction of medicare (for aged) and medicaid (for poor) programmes and financial support to other agencies, the financial contribution of the state has, steadily in the last two decades, come to bear the largest share in the national health care expenditure. United Kingdom's National Health Service is somewhat unique and rather incomparable among the capitalist countries as it is run entirely with state revenue. Other countries heavily depend on different kinds of insurance systems with heavy state and employer contributions. In Canada medical care is almost totally state care.

Among the developing and under-developed countries, the trend is similar. Pressure on the state to provide for more and more health care is put from all corners—deprived classes, liberal section, political forces and international community—albeit from different motives. Accordingly state health care is expanding more rapidly than private sector health care. The Indian scene may be reviewed in two categories—non-medical health care and medical care.

The debate in the wake of WHO's call 'Health For All' has brought about a change in the concept of non-medical health care. It not only includes food-clothing-shelter-safe water-sanitation-pollution-free environment, etc, but is also held to be dependent on education, economic security or effective employment, women's equality, social justice, political control over economy, etc. For all these factors, the supreme role of the economy is indisputable. The market economy does not care for the achievement of all these health determinants for the broad masses. Clearly, the private sector of the economy cannot be induced to work for equitable distribution of non-medical health care, nor can such health care be achieved through individual efforts. Its realisation depends entirely on the political direction of state policy and its effective implementation. In other words, non-medical health care for the masses depends entirely on state intervention for the development of new economic relations conducive to equitable distribution.

Why State Medical Care?

State intervention in medical care depends not so much on the economic structure of the social formation; all societies appear to agree on the state's increasing role in providing universal medical care. The extent and magnitude of state intervention depend primarily on political commitment and then on the level of development of the state as an institution and on the degree of its dominance over social activities. In India,

the operation of preventive medical intervention, e g, national disease control and eradication programme, routine immunisation, etc, is almost exclusively in the hands of the state. Free curative services operated by the state effectively reach only a few selected target groups, e g, government employees, including the armed forces, organised labour force (ESI), and the socially powerful minority in both urban and rural areas. The rest of the population depends upon various kinds of private and corporate services. All concerned people agree that the services are inadequate and effective curative services do not reach the largest section of the people in need. A variety of prescriptions have been offered as remedial measures and these should be considered in their political and economic dimensions.

It is often argued that liberal philanthropic welfare has given way to capitalist welfare measures, e g, medical care which is intended to contribute towards maintaining reproduction of labour; state medical care, like education, is actually a part of the social wage of the labouring class. This argument appears to be relevant in the context of an advanced capitalist economy where the role of skilled and highly skilled labour is significant and capital's stake in developing that kind of labour is high enough to justify large state allocations to medical care in order to maintain the health of the labour force. In the drive for accelerated industrialisation in USSR and China, state policy accorded priority to maintaining the health of the labouring force by organising medical clinics in each factory complex (Deacon, 1984; Wilenski, 1979). But this argument is not sufficient to explain the Indian situation. Labour in Indian industry and agriculture is mostly low-skilled and unskilled and the reserve force is so abundant that its continuing health and quality cause the least worry to the capitalists. There is as yet no evidence to suggest a linear co-relation between productivity and improvement of the health status of the people. Even in the case of the ESI, the apathy and neglect of the state as well as of the employers indicate that they are more interested in something other than the protection of the workers' health. On the other hand, the argument that the entire state medical care service is entended to earn legitimacy for the ruling classes and the existing social order and to secure credibility for the state as the benevolent friend of the poor appears to be more plausible. It will be evident if the real state of affairs prevailing in the operation of the state health service is reviewed.

State authorities never tire of proclaiming that the state service is free and is meant for the poor. Actually, both the principle and practice are otherwise. In principle—legal, constitutional and otherwise—state medicare is not meant for the poor alone. By policy the access is universal. Both the millionaire and pauper have equal rights to claim free state service. Not only that, the population groups who enjoy exclusive access to reserved medicare schemes, e g, CGHS, ESI, railway, armed forces, public undertakings, big industries, etc, also receive free treatment from state hospitals without restriction. Even foreigners are freely entertained as a routine. What happens really is that the larger portion of effective state medicare is cornered by the socially-economically-politically powerful sections who, in addition, are exclusive recipients of other medicare projects not accessible to the poor. That the real objectives of state policy are compatible with this situation is evident from the fact that state medicare infrastructure is concentrated in the urban areas; that provision of high cost medical technology, e g, C T Scanner, Echodiagnostics, cancer-therapy, intensive care, surgical super-specialities, etc, which have little relevance to the major medical needs of the poor (TB, leprosy, enteric disease, bacterial and parasitic infections, etc), is rapidly increasing; and that the state frequently spends large amounts for high cost treatment of dubious outcome for the VIPs. An example: state medicare in West Bengal is fairly well developed compared to other provinces. But even after the devastating experience of the enteric disease epidemic in 1984, the government is unable to provide for cheap oral rehydration salt packages to the chronically afflicted population on account of stringency of funds which does not impose any constraint, however, on the expansion of high cost technology proceeding as per schedule in the metropolitan hospitals frequented by affluent clientele. Secondly, state service is far from free for the poor. Supply of the needed essential drugs is grossly inadequate and people have to purchase these as a routine. In the urban and semi-urban hospitals it is now customary to engage at the patient's own cost an additional care-taker in order to obtain minimum necessary caring services. The practice of some form of payment as premium to the doctor or hospital worker for the privilege of admission in a free bed is still rampant in most of the provinces. Quite frequently such premiums ae obligatory for investigative, surgical and similar services. It should however be kept in mind that even with the premium, state service, on the whole, is much cheaper than the market product both for the poor and the affluent.

Medical Care vs Non-Medical Care

Official versions of state policy, expert commentators and the WHO strategy for Health For All—all in quest of better health for the people—emphasise non-medical health care and preventive intervention and underplay medical care. As a long-term strategic approach this cannot be disputed. But a good deal of ambivalence and many contradictions appear in the field of practice. The strategic approach takes into consideration only the conventional measurable indices of health, e g, mortality, morbidity, disability, water supply, sanitation, etc, on the one hand and the proportion of doctors, paramedics, beds, drug consumption, etc, per unit of population on the other, in determining the efficacy of health care service. But medical care serves a prime need which cannot be quantified or statistically measured.

Healers have been venerated and honoured since the infancy of human society for the vital function they perform both at the individual and social levels; they respond to human distress. Most of minor illnesses treat themselves; people learn to tackle a good number of everyday physical ailments themselves; when people seek a healer it is a response to more than the mere physical illness but includes added factors of apprehension, fear and helplessness which compound the distress. The healer propounds an explanation of the causation of ailment (however weird), prognosticates, takes charge of the battle, relieves the patients of their helplessness, applies his technology (however primitive and absurdly ritualistic) of diagnosis and treatment and emerges triumphant when the self-healing ailment heals itself. The entire episode restores confidence and balance to the sufferer and his kinfolk, enabling them to again face the adverse world with renewed courage—the unknown enemy is now known and conquered and the healer, the weapon to tackle the enemy, is there. Even when the healer fails, he allays distress, offers comfort and finally legitimises death, the most fearful enemy, by performing rituals intended to ensure a comfortable after-life for the dead. This is one of the most vital psycho-social functions for mankind to adjust to environmental adversity in the struggle for survival and progress. Biologically potent therapy came much later, only recently. In fact, as late as in 1980, Oliver Wendell Holmes wrote that, except for opium and wine, "if the whole *materia medica*, as now used, could be sunk to the bottom of the sea, it would be all the better for mankind—and all the worse for the fishes". Modern doctors also perform the same psycho-social function, only they are immensely more successful owing to the remarkable development of potent preventive, life-saving, curing and relief-producing technology of medical science. But distortions of this very achievement have developed, influenced by economic and socio-cultural transformations. Modern medical care generated tremendous mass demand and was rapidly transformed into a commodity attaining its characteristic features. Doctors rely more and more on the infallibility of technology and are at the same time getting enamoured more and more of its commercial return. Time for consultation is now priced and cannot be wasted for demystifying, caring and personal attention. Drug industry, flooding the market with useless drugs, makes skyhigh profit so that access to essential drugs becomes dear for the poor. The very expansion of medicare services gave birth to bureaucratisation and de-personalisation. In short, while the demand for more and better medical care is increasing, escalating prices are pushing it out of the reach of most people.

Medical care continues to be one of the most pressing felt-needs of all societies. Medical care renders credibility to any health care service and ensure people's acceptance of it. China's post-revolutionary health policy is a case in point. Policy makers understood that in order to ensure mass participation in the public health programmes, the people's felt-need of medical care must somehow be met and they rapidly set up a comprehensive organisation to serve even the people in remote, inaccessible areas. To improvise, they requisitioned the services of the indigenous system of medicine. The point is to provide for some form of medical care to all regardless of standard and quality which could come later. The Chinese health system is now so organised that a citizen of a remote village is assured of the most sophisticated treatment, if needed, in an urban centre.

In our own society, preaching and practice differ. While almost everyone harps on the priority need for non-medical health care, in practice expansion of medicare service goes on unabated. Government health centres, established to provide comprehensive health care, have over the years turned into centres of curative service. People, who persistently deprecate the growing trend of setting up sophisticated diagnostic and curative centres, never fail to rush there for their own needs. The reason for this is not far to seek. Medicare needs of Indian people are so urgent and enormous that they overshadow all other needs. And their priority cannot be over-emphasised. Though it is well-known that availability of safe water is the final answer to the massive problem of diarrhoeal diseases, the instant need of the diarrhoea-stricken dying child is curative intervention and not safe water. To save the life of their dear ones, the poor risk further pauperisation, the extremely poor risk destitution. Medical care is a commodity which never fails to find consumers who cannot afford it.

To sum up, medical care is the most important felt health need of the people; medical care is the pivot of health care service; medical care adds credibility to health care programmes and ensures people's interest; medical care meets needs of the people which, though not quantifiable, are indispensable in acquiring strength to fight against adversities. And whatever role is assigned, on paper, to medical care, it will continue to play the dominant one in health care service. People's demand for more and better medical care will never diminish.

Medical Care Delivery

How then to ensure a certain standard of effective medical care to the people? At present the delivery of medical care is operated through three channels with some overlapping. Firstly, free care—through government and non-government hospitals and clinics. Secondly, indirectly paid care—through various medicare schemes for employed people, e g, ESI, government employees' medicare, corporate employees' medicare and insurance schemes. Thirdly, directly paid care—through open market which includes a few voluntary institutions. The system, as underlined earlier, has failed to provide medical care to the poor. That is why pressure on the state to provide for the deprived is mounting. The state, on the one hand, is not in a position to disclaim such responsibility for obvious political compulsions; on the other, it cannot really provide for a minimum standard of effective

medicare for the deprived population without jeopardising the existing exploitative economic order. To find the way out, several prescriptions have been offered as remedies. The ICSSR – ICMR report recommends a 6-tier organisation from the smallest unit at the lower level covering 1,000 persons operated by two part-time voluntary health workers. The required cost has been worked out to be very low, e g, Rs 30 per capita per annum. The entire scheme appears to be not only simplistic but idealistic as well. It also offers universal access for affluent and poor alike; allows private market to thrive; does not provide for guaranteed emergency care and rests on the premise that both the higher echelons of administration and the providers are imbibed with the spirit of selfless public service. Several other prescriptions include (a) people should be taught and trained in demystified principles of medical care so that they can take health in their own hands, (b) indigenous and non-allopathic systems should be adopted to develop an alternative cheaper culturally acceptable medicare for the poor. None of the alternative schemes suggests dismantling of the sophisticated modern medicare merrily operating in the market. Parallel existence of inaccessible and costly high grade and free low grade services devalues the latter and breeds demand for the high grade one. The poor are already aware of the virtue of modern medicine. True, owing to poverty, they have to go for the cheaper alternatives most of the time, but that is no indication that they love these alternatives or have reconciled themselves to using them for ever. Government experiment in West Bengal illustrates the point clearly. Government appointed homeopath and ayurved practitioners are in a few health centres. It is a common scene in those centres that they spend their days without patients while people throng to the allopathic counter even when the latter is attended by only a pharmacist. The most repugnant feature of the alternative prescriptions is the common objective that each is aimed at lightening the burden of the state. People should be made to realise that they are responsible for their own ill health and therefore must learn to take care of health hazards by themselves. Hence the slogan "people's health in people's hands". Or they ought to remain satisfied with traditionally superior, culturally compatible indigenous medicine with a few doses of cheaper but holistic homeopathy here and there. In any case, they should not bother the state for more costly modern medicare. The modern medicare system will be there but only for the privileged and affluent as usual. The alternative schemes have a common virtue. They spare the state large expenditure and at the same time see to it that its image is not tarnished.

For this purpose, a number of issues, e g, cultural compatibility, self-sufficiency, demystification, etc, have been broached in order to confuse the problem which is essentially economic. In fact, the chief contribution of modern science is to demystify the secrets of the universe—natural and biological. At the present level of knowledge, the ancient medicines stand almost totally mystified, while modern medical science has been able to demystify the phenomenon of ill health and health care to such an extent that even illiterate people now can acquire an insight into the socio-economic and biological dynamics of physical disease and its management. Self-help is another utopia. It has long been abandoned by humankind since the introduction of division of labour in social production. By no stretch of imagination does it seem advisable to consider creation of self-sufficient human beings producing their own material, biological and cultural necessities by themselves or immediate communities.

The development of state intervention in medicare has two driving forces behind it. Demand of the people on the one hand and the ruling classes' urge to acquire legitimacy and credibility on the other. V Navarro describes the relationship precisely. 'Social demands of labour' include increase of social wages, the comprehensiveness and levels of which depend on the strength of working class pressure; 'social demands of capital' include measures to smooth down and cushion the dislocation, uncertainty and dis-welfare created by the process of capital accumulation, e g, social security and health care. Navarro explains, "there is no single-factor explanation of social policy... there is no clear-cut dichotomy between the social needs of capital and the social demands of labour. Any given policy can serve both. Indeed, the social policies that serve the interests of the working class can be subsequently adapted to benefit the interests of the dominant class... the 'bias of the system' has always insured that these policies can be deflected to suit the capitalist class. Indeed, history shows that concessions won by labour in the class struggle become, *in the absence of further struggle*, modified to serve the interests of the capitalist class" (Navarro, 1976). Several spanners have been thrown into this convenient process of concession and legitimacy—fast rising cost of modern medicare, increased demands from all sections of population, increased awareness of the discriminatory distribution of state services, effect of the international slogan of Health For All, increased trade unionism among the employees of the state health services, etc, to name a few. Mere slogans and superficial measures now fail to contain dissatisfaction. It is now realised that provision for a minimum standard of medicare for all entails a magnitude of expenditure sure to undermine other state priorities determined by the ruling classes. Hence the urge and campaign for cheaper alternatives. Noteworthy is the fact that the alternatives are prescribed for only the poor. The state cannot afford to alienate the privileged classes.

What the Poor Must Demand

Underplaying of the role of medical care should stop. Such underplaying ignores the felt-need of the people. Rakku's story revealingly demonstrates that Rakku risked further pauperisation for the elusive life-saving medicare for her child; seeing the government auxiliary-nurse-midwife on her way to the city hospital, "she suddenly felt resentment towards this woman. She wondered why as a health worker she did not have

medicines for helping sick children. Why did she only have injections [vaccines] for healthy children and advice to mothers to stop having more children! Here was her child dying and this woman could not help her" (Zurbrigg, 1984). Valuable scientific advice about safe water, personal hygiene, immunisation, balanced diet, etc, do not cut much ice with the Rakkus.

Effective medical care to the poor will never be and cannot be provided for by a state geared to the interest of capital accumulation; nor can it be provided by collective humanitarian urge. India has a long tradition of philanthropic, charitable, humanitarian effort to provide medicare to the poor and such efforts have increased through the recent spurt in voluntary agencies' activities in the health field, but this has hardly made any ripple on the health scene. The deprived people will have to earn medical care; it must be demanded from the state.

A. State medicare should be exclusively reserved for the large indigent population, i e, people living below a predetermined income level. Other existing schemes of medicare be similarly reserved for the existing beneficiaries. Affluent people be left to fend for themselves. Semi-affluent people be assisted to develop their own medicare facilities through insurance system, as is prevalent in the developed countries.

B. To operate this scheme, the population will necessarily be divided into economic categories as has been for the rural rationing system. In marginal situations and in the case of exigencies persons from unauthorised categories may be entertained in the state institutions but in exchange of a price, not free.

C. Eventually other related functions will have to be modified and rationalised. For example, state expenditure on medical education will be steadily reduced to that optimum level necessary to train personnel destined for state service.

A host of objections and problems will come up in the course of implementation of this scheme. It has been argued that such a scheme is discriminatory, is not fesible and works against humanitarian principles. Surely it is discriminatory but it is a reverse discrimination in favour of the poor aiming to abolish the present discrimination and introduce equitable distribution. The feasibility of such compartmentalised service has already been established. Several such medicare services, e g, ESI, armed forces, railway, etc, have long been functioning. In Andhra Pradesh such compartmentalised public distribution service for foodgrains is being operated for the entire state. About humanitarian principles, the less said the better.

Is this scheme another alternative to meet the medicare needs of the poor? Will the state concede this demand if only its rationality and feasibility are established? The prudent answer is NO. This scheme is founded on the premise that no scheme of equitable distribution and social justice is implemented by the state in an exploitative, class divided society. A few sporadic benefits may be realised from time to time through class struggle to produce only some palliative effect. The demand under this scheme is entirely different. It does not call for some concession for a particular group. It is not only a demand exclusively for the deprived classes so that they have a concrete slogan to struggle for and organise, but also calls for restructuring of the entire medical care system of the society. Moreover, the prospect of earning an exclusive right will provide the necessary urge to struggle for it and, once achieved, the poor will be equally zealous in guarding it. Likewise, the danger of exclusive control of a state apparatus by the poor is apt to invite strong opposition and resistance. The present beneficiaries of state service will oppose it as they stand to loose an existing privilege. The controllers of the state exchequer will oppose it as it only entails increased allocation for the poor but opens up a possibility of establishing a system of accountability of the providers to the recipients. When this inevitable opposition comes, it instantly identifies the real beneficiaries, exposes the nature and utter inadequacy of the present system; it shatters the humanitaring camouflage of the state; it makes a dent in the legitimacy of the present order. In other words, this scheme envisages conflict and polarisation of the contending forces. It may act as a nexus for class struggle.

Then again, what happens in the unlikely event of the state conceding this demand? An exclusive state medicare service will necessarily render the situation conducive for the deprived classes to exercise control over it. The essence is control. Without control there is no participation. They only participate meaningfully who weild power and authority. The very exclusiveness will generate demands for guaranteed service, accountability of the providers, uniform and better standards, more state allocation for medicare—in other words, struggle for control. Struggle for control will soon make it apparent that without eventual control over the state itself, nothing could be achieved or sustained. It will soon be apparent that the fundamental problematic is political and economic. Without political control no change in the economic order is possible. Without economic change, provision of non-medical health care will remain elusive. This situation is not peculiar to health care. The same situation prevails in the other sectors of state policy, e g, education, housing, agriculture, etc. The same discriminatory practice operates under cover of universal eligibility. It cannot be reversed without political control. The way to achieve political control is struggle. It may also begin in medical care.

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