POLITICAL-ECONOMIC-STRUCTURES — APPROACHES TO TRADITIONAL AND MODERN MEDICAL SYSTEMS

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Abstract— The paper is concerned with the WHO-UNICEF suggestion to train indigenous healers to be first-line deliverers of medical care. Rather than evaluate this proposal directly, the paper concentrates instead on the factors currently influencing the relationship between indigenous and Western medicine. A framework, viewing the potential health impact of the use of indigenous healers, is constructed through the comparative method. [6] *Data reviewed consists of monographs, journal articles, dissertations etc., and considers historical, cultural and political theories of the status of native medicine. The paper concludes that the politics of health care is a greater impediment to the provision of "health care for all" in some types of political economic systems than in others. Thus events in the health care system are seen as influenced by the larger socio-political system. This article is reproduced from "Social Science and Medicine" 15A : 101-108, 1981.*

Introduction

Medical need in the developing world

The scarcity of medical service in most of the world is one of the factors affecting the health of the peoples of the earth. Although the outcome of medical care is greatly hampered by poverty, associated problems of malnutrition, poor sanitation, crowding and lack of education, the social and economic gap between the have and the have-not nations extends to the area thought to limit the destructiveness of disease and ill health. Bryant discusses this, perhaps more eloquently than others :

> Large numbers of the world's people, perhaps more than half, have no access to health care at all, and for many of the rest the care they receive does not answer the problems they have. The grim irony is that dazzling advances in biomedical science are scarcely felt in areas where need is greatest. Vast numbers of people are dying of preventable and curable diseases or surviving with physical and intellectual impairment for lack of even the simplest measures of modern medicine. Whatever the desires of nations to reach their people with health care, the actual task of doing so is extraordinarily difficult. It is difficult in Malawi, one of the world's poorest countries, and so is it difficult in the United States, one of the word's richest... [1,pp.X 91].

Country	*Expenditure*	*(%Budget)*	*Population/bed*
Jamaica	$9.60	11.0	240
Senegal	3.47	6.6	700
Thailand	0.60	3.4	1280

Health expenditures vary from between 56 dollars per inhabitant in the United Kingdom to 20 dollars in Indonesia. Eleven precent of Colombia's budget provides 3.50 dollers per inhabitant while 4.7% of the United States government expenditures means 47.40 dollars per inhabitant for health services. The meaning of this is clear in the preceding tabulation of number of hospital beds, whose definition can range from a canvas cot to an electric-powered special. The preceding and following statistics are from Bryant [1] for the period 1961-1964.

The discrepancy between urban and rural areas can exacerbate the problems of providing care. Part of this is due to personal reference:

> The reluctance of doctors to leave the big cities and go out to practice their profession in the rural areas is a long standing basic medical problem which Mexico has in common with all other Latin American countries [2,pp.262]

The result of this reluctance? A difference in the rural-urban physician ratio (1:3000 vs 1:500). This is not just a local phenomena. UNICEF-WHO estimate "that in a number of developing countries less than 15% of the rural population and other underprivileged groups, such as slum dwellers, nomads, and people in remote areas have access to health services". [8]

Another reason for rural shortages of medical services is lack of resources. Many of the underdeveloped countries are predominantly rural and, as our earlier comparisons showed, lacking financial resources even for urban areas.

> At the University in Kampala, Uganda, the press of obstetrical patients is so great that the average hospital stay for delivery is less than 24 hr. At Sierra Hospital in Bangkok, Thailand fully half of all hospital admissions, 17,000 of 34,000 in 1 year, are to the obstetrical service. But despite the overwhelming numbers of obstetrical patients in these two institutions in these countries at large, less than 15% of all babies are delivered by trained personnel [1, pp.41].

Thus, the provision of medical services to all is a problem, particularly so when the lack of resources is coupled with attempts to provide doctor-hospital Western-style services to rural areas.

Indigenous medicine

The previous discussion neglects the presence of medical services in all socio-cultural units, Bryant[1] and Schendel[2] note the influence of local healers and the belief in magical medicine. Bryant notes that accessibility of care and reduced social distance are also factors in their utilization, Lee[4] points out that in Hong Kong it is easier to find a Chinese practitioner (4506) than a modern physician (2317). By deduction we realize, when Bryant tells us that only 15% of a nation's babies are delivered by trained physicians, that the other 85% are assisted into this world by someone (usually, but not always, by someone other than the mother). Stromberg stresses the reliance on local healers in Ghanna for the 70-80% of the population living in rural areas. He states that the absence of modern health facilities, in Ghana as in other countries, does not mean there is a vacuum in the rural areas,

> ...as in many other countries, traditional birth attendants, healers, herbalists, and practitioners of various types exist in most villages and treat many diseases and other health problems....thus there is a health care system throughout the country which is consonant with traditional beliefs and practices [5,pp. 15].

WHO-UNICEF[3] agree and suggest the different types of indigenous healers may be trained and integrated into the general health system.

This solution seems like a panacea. Given the shortage of medical dollars, personnel, and facilities, problems of transportation, the social and cultural acceptability of new ways, *why not* train indigenous healers to care for the medical needs of their communities? The someone delivering 85% of two countries' babies might benefit from training. Furthermore, most of the medical needs of the world are not complex:

> It involves recognizing threats to health that are visible and monotonous: malaria, diarrhea, pneumonia, bilharziasis, hookworm, malnutrition, tuberculosis—or problems that are less a threat and more a personal concern: leg-ulcer, earache, constipation, headache, broken finger, inflamed eye [1,pp. 61].

Given the potential for traditional healers to provide health care that is affordable, accessible, culturally relevant, belongs to the people, and has the possibility for serving as a conduit for new ideas in areas other than medical—what factors influence the relationship between it and modern medicine? There are several theoretical approaches that may be taken. To answer the question, why not utilise indigenous medicine, it is also necessary to investigate the imbeddedness of the current relationship between modern and traditional medicines in the social system. That is, various factors have led to the exclusion of native healing systems from most modern medical systems. What are these factors? How might they relate to the utilisation of native medicine in a modern setting? What happens to the indigenous medical system as a nation Westernises (modernizes, industrializes, develops)? This, then, the factors influencing the utilisation of indigenous medicine, is the focus of this paper. But first, the methodological issues must be discussed.

Toward a framework—the patched-up design

To answer the question, what factors have determined the status of native medicine, requires a comparative approach. Factors thought to be explanatory for one time and place can be shown to be epiphenomenal and hence irrelevant in another. We will find in the next section that the integration of modern and traditional medicines has varied from one country to another. Why? Cross-national comparisons of health systems is one method of looking at health services organisation.[6] This approach is, however, fraught with difficulty:

> Those engaged in the study of comparative health service systems still struggle with problems of theory, method, and standards for cross-national research. In addition, the available data are too often fragmentary, unreliable, non-comparable and subject to political constraints [7,pp. 278].

Elling (see also Elling and Kerr[8]) has introduced a method for cross-national comparison — the method

of contrasting case studies:

> Given the controlling character of the societal context, the concluding point of this brief introduction to the contrasting case studies framework will be that inferences about health services organization may be culled broadly from sharply contrasting systems, but it is likely that cross-system applications can occur only between those with somewhat similar levels of resources and similar political structures [6,pp. 268].

The principle behind this is elegant. The *method of difference*, as expounded by John Stuart Mill is one of his four types of evidence that can be used as evidence for a causal relationship, or in our case, to control for extraneous factors. It states that if various situations have all factors in common but one, that may be regarded as the causal factor.[9] Elling and Kerr[8] found that this principle could be used to identify countries that are over- and under-performers in health, wealth and education levels being similar. The comparative approach will be used here. In other words, possible explanatory factors will be tested by the method of difference for one set of countries; eliminating these, we will then discuss other factors elsewhere. This approach is not without dangers. Campbell and Stanley[10] discuss the dangers inherent in experimental design. They are critical of this type of comparison, stating that it does not control for the selection of the groups to the initial purported causative factor or the loss of groups from this factor. More simply, there is little way of knowing what additional factors are responsible for the initial conditions. They describe a more refined variety of this model as a patched-up design with an inelegant accumulation of precautionary checks. The defense of this approach is twofold: First the world refuses, at least thus far, to be standardised to the interests of science; second, it must be asked if the lack of strictly comparable evidence is to limit the questions we may ask. This is addressed by McGranahan[11], who considers that perhaps cultural and social diversity is too great to permit international measurement. He feels that the need for data in formulating international social policy dictates continued comparative social research. It is the wish of this author that reports of this type, where quantification is deemed unnecessary or impossible, are, if not totally accepted, a stimulus to the further refinement of hypothesis of a broad perspective.

Factors Influencing the Use of Indigenous Medicine

Culture and progress

Galdston[12] differentiates between medicine as the science and art of healing the sick and caring for the well (a body of knowledge), and medicine as the practice of that science and art (the performance of a profession). The relationship or lack of it between traditional medicine and Western medicine is dependent on both parts of this definition. Medicine as a body of knowledge will be discussed in this section; the professions of medicine in the following section. This paper has not differentiated between the various types of native healers or different levels of theoretical complexity of medical systems as suggested by Marchione.[13] In contrast, Sigerist feels that all systems of medicine contain basic underlying similarities:

> There can be no doubt, however, that primitive medicine, as it appears within the various culture patterns, consists of a relatively small number of elements, which are very much the same in all primitive cultures and vary only in their combination [14, pp. 121].

Marchione[13] states that distinctions between three types of indigenous systems may affect the reaction to it by society and other professions. The next part of this section demonstrates the reverse of relationship suggested by Marchione who sees full-time practitioners of great medicine accommodated and given support while part-time practitioners are ignored, and folk healers tolerated or opposed. We discuss three systems on an equal level of complexity. Thus, this factor is controlled for. Yet, any future attempt to integrate a native healing system into a modernising one would be well-advised to consider the characteristics of the native system, for more practical and mundane reasons.

Most studies of health care systems avoid the traditional (e.g. Weinerman[7]) or give it minimal attention, regarding it as a survival from a more primitive, less scientific, time. Attention is focussed on the scientific progress of medicine such as is suggested by Galdston:

> History is a progression of ideas, traced along a circuitous path [12, pp. 3-6].

Garrison[15] is kinder and suggests that folk medicine brings the peace of security against the fear of the unknown. Folk medicine also has its defenders. Dr Bocan Alpha Ba (International

Conference on Health and Health Education) believes that "traditional medicine deserves respect".[16] He states that African doctors turn to traditional arsenals when supplies of Western pharmaceuticals are short. Green [17] comments upon the astonishing technical efficiency of primitive surgery, given the most ancient instruments. Sigerist observes that little medical progress has been shown in some areas:

> This history of the therapy of cancer is very dull. The principles we are following today, namely the elimination of the tumor as radically as possible, were discovered in far remote antiquity. Our operative methods are much more efficient than theirs were, and besides the knife we have X-rays and radium to destroy the tumor cells, but we have not found any new principles yet [18, pp. 62].

One view is that traditional structures are inferior in all ways to modern medicine and are used by only the poor or ignorant: Banerji.[19] notes that the inhabitants of his native land prefer allopathic (Western) medicine irrespective of social, economic, occupational, and regional considerations. Cost and accessibility of services were the two major constraining factors. Local healers were used for minor illnesses or when Western medicine failed, Lee[4], however, points out that in Hong Kong the correlation between utilization of modern medicine and wealth ($r = 0.68$) was in the same direction as between Chinese medicine and the wealth of the area ($r = 0.54$). Futhermore, it seems that people choose rationally between the two on the basis of perceived effectiveness for symptoms. Although the exact statistics were not provided, the younger generation was said to make more extensive use of Western medicine.

An approach that makes the assumed inferiority of traditional medicines more explicit is the historical approach. This approach stresses the evolution of medicine, both empirically and conceptually. Garrison[15] observes that the advancement of medical science is the history of the discovery of a number of important principles leading to new views of disease, to the invention of new instruments, and to the development of a rational scientific concept of disease, not as a demon but as an altered physiology. Kuhn[20] critiques this view, rejecting the accretion approach to progress while retaining the concept of the progress of science. This approach fails to note that most medical systems have performed adequately for the cultural level of the people. Furthermore, some have been medically effective. Bernado Ortiz de Montello found that 16/25 of Aztec drugs produced the desired effects, 4/25 were questionable, and 5/25 were not good enough.[21] Knowlege, then, is not exclusively Western.

It strikes one as strange that the social and psychological functions of medicine are given stress only for the primitive versions. All medical systems seem to function to allay fear of death and infirmity through professionalism (elitism), and in this sphere shamanism differs little from white-coated magic. On the social level, there is evidence that the theoretical perspective of medicine relates to its functions as integrative institution of society. When society is held together by fear, medicine is synonymous with witchcraft and magic; as religion becomes dominant, disease and sin coincide; later, in a rationalist society, science is the new god: from temple to cathedral to medical center.

Another explanation for the apparent decline of traditional medicine is closely related. It suggests that the populace rejects it in favor of more modern medicine, or is it retained due to their ignorance of poverty? Sigerist[14] suggests that the development of magical-religious medicine in Greece was a result of the needs of the indigent sick. Lee[4] points out that economic factors influence the distribution of Chinese medicine. Harwood[22], Logan[23], Martinez and Martin[24], Rubel[25] and Snow[26] provide evidence of the continuing utilisation of native healers by populations of Mexican Americans, Arizona Blacks, Guatemalans, and Puerto Ricans. Schendel[2] traces this cultural lag to superstition, while Foster[27] cites the cultural barriers to change. However, DeWalt [28] is able to show that the use of native curanderos (curanderas) in a Mexican village is the result of a rational process of choice related to the nature of the illness.

How important is the progress of medicine as a factor in determining its role in modernising societies? Is it only the internal characteristics of a medical system that determine its fate? A cross-cultural historical study by Leslie[29] sheds much light on this topic. He shows that traditional medicine in three countries, China, Japan, and India, sharing somewhat similar cultural factors, had a different fate in each. He shows also that the Greek, Ayurvedic, and Chinese medical systems share similar internal characteristics—they are based on humoral theories, have standardised learned practices, long periods of training, codes of ethics, and claims to social status. Yet their incorporation

into modernising medical systems varied. In Japan, the ruling elite adopted modern scientific medicine as the legally sanctioned system. In China, the incorporation of traditional practices into an essentially Western system occurred. In India, a dualistic, though not completely equalistic, system developed. Thus, neither cultural nor internal characteristics of medicine account for this difference.

Another theoretical explanation for the status of traditional medicine is seen to be the organisational struggles of medical professions :

> A characteristic of modernizing societies is the co-existence of modern and traditional professions that claim to perform the same function for the society. As a result of differential support by the dominant classes and their social values and by the academic and political authorities, the modern profession occupies a higher statification ranking than the traditional professional [4, pp.60].

The theory of professionalism, the organization of medicine, as the explanatory factor, for the survival or lack of survival of traditional medicine will be discussed in the next section.

Theories of professional struggles

Much of the work in cross-national comparisons of health systems ignores the political-economic level of organization intermediate between macro-processes (society) and micro-processes (persons). One notable exception to this is the study by Carboni[30] of the formation of a geriatic speciality in the United Kingdom which has not occurred in the United States, to date. Carboni traces this to the division of medical territory by the medical profession in the UK rather than to a more rational, knowledge-based division of labor, an explanation suggested by Stevens[31], for example. This division, then, was based in political processes within the profession to the end of controlling medical resources (wealth, patients, and control over an area of service). This approach has been offered by Berlant[32] as a framework by which to understand the rise of allopathic medicine in the United States. Before examining this approach, it is necessary to mention that the view of individual practitioners may diverge from the organisations perspective Blum[33] found both acceptance of the significance of local healers and rejection of their existence by physicians in his study of a rural Greek town. One famous healer had even hired a physician and X-ray technician to work as his assistants. This occurred despite government and professional opposition to quackery.

Berlant[32] describes the process by which the AMA organized and defeated its medical rivals. He critiques Parson's characterisation of the medical profession as a normative structure, based on idealised beliefs, regulated by a system of social controls, and whose function is to maintain healthy actors to fulfil social roles. Instead, he uses an historical approach, coupled with Max Weber's theory of monopolisation, to show that many of the practices of the medical profession function to increase the power, prestige, and wealth of the profession collectively, regardless of the benefit to society or the individual patients. Weber s theory of monopolisation states that :

> The success of a group is a function of two broad determinants of economic action: the group's tactics of competition (or of conflict) and the conditions of competition. One major but not exclusive condition of competition in modern society is the state, which exercises both authoritative and de facto domination over groups within its territory [32, pp.17].

The tactics of the AMA will be discussed here; the role of the state in the next section. The elimination of external competition is accomplished by two means, according to Berlant.[32] The first, which he sees as the dominant methodology employed by the AMA, is to bring the "force and prestige" of the legal and political community to bear against competitors. This involves licensing and educational restriction. The goal of this strategy is to restrict financial support to one's opponents. The second method is to challenge one's opponents on ethical grounds, thus challenging their symbolic integrity (image).

The second game, that of name calling was practised by both sides:

> The AMA (circa 1924) referred to all nonconformist healers as "sectarian". Its Judicial Council has defined this term to include any practitioner who follows a dogma, tenet, or principle based on the authority of its promulgator to the exclusion of demonstration and practice,
> ... Abraham Flexner, the eminent authority on medical education, contended that homeopaths, eclectics, physiomedicals, and osteopaths might rightly be considered as sectarian rarher than fraudulent practitioners, since they all believe

that anatomy, pathology, bacteriology, and physiology must form the foundation of medical education but regarded chiropractors and mechanotherapists as no more than unconscionable quacks.

... In charging that conventional practitioners laid undue stress on chemical compounds and surgery; these groups, with some justification, considered regular doctors as sectarian [34, pp.2-3].

Despite his moderate stand toward the variety of medical practitioners, Flexner's report on medical education (1920-21) proved to be the coup de grace to most non-regular medical practice. Stevens[31] speaks of the reluctance of the general public (USA) to use the modern (regular) physicians because of their harsh treatments. They were popular as a status symbol among the urban rich, due to the prestige of their European education. Burrow[34] claims that the battles of the AMA to control licensure and restrict entry to and the proliferation of medical schools was against quackery.

Berlant views the demise of the sectarians as casualities of the internal battles of the AMA. He considers the number of irregular practitioners too small to be considered a threat, at most 10% of all practitioners. Estimates of the numbers of homoeopathic practitioners are 2400 between 1835 and 1840. At most, there were some 7000 sectarian practitioners in the 1845—1860s as compared with some 20,000 orthodox medical graduates and another 40,000 non-degreed orthodox matriculants. This was the real threat : the rapid expansion of medical schools and the large number of educated physicians. Six medical schools in the decade 1810—1820 produced 100 graduates out of 650 students; this increased so that by 1860 there were 13 schools comprising 4500 students and graduating 1300 in the 1850—1860 decade. [32]

Berlant describes the tension between academics and practitioners for control of the medical profession and licensure. Medical societies were formed in the 1760s and not until 1783 was a medical school, Harvard, the first serious candidate for establishing the qualifications of a physician.[31] The AMA, established in 1847, soon reached a compromise position with the development of a licensure plan whereby a diploma was not an alternative to licensure but a pre-requisite. It then proceeded to regulate the supply of medical schools and hence physicians [32]

The growth of medical schools had been phenomenal :

> In 1869 according to the Bureau of Education there were 72 medical colleges in the US, 59 regular, 7 homoeopathic, 5 eclectic, and one botanic... (By 1911 every city had their schools) 39 in Illinois, 14 in Chicago, 42 in Missouri, 43 in New York City, 27 in Indiana, 20 in Pennsylvania, 18 in Tennessee, 20 in Cincinnati, 11 in Louisville...one physician for every 691 persons in the United States contrasted with 1:1940 in the German Empire; 1:2120 in Austria, and 1:2834 in France (circa 1913) [15,pp.761-763].

The AMA responded to this by supporting two investigations of medical education. The first, run by a physician, raised an uproar, but created little change. The second, headed by Flexner, led to reform and the securing of a medical monopoly by the AMA. Stevens [31] sees the impact of this report as largely financial; foundation money from the Carnegie Foundation, General Education Board (a Rockefeller Foundation), and other sources enabling the better schools to improve while others declined due to lack of support.

The role of government

As discussed earlier, Weber considers the role of the state as one important condition in the survival of an organization. Leslie s cross national historical account. "The Modernization of Asian Medical Systems",[29] stresses the influence of government policy. He shows the Japanese ruling elite adopting modern scientific medicine as the legally sanctioned system. The Chinese incorporation of traditional medical personnel and practices swings with the pendulum of political change (Wolstenholme and O'Connor[35] : Harbison and Myers [36]; New and New[37] ; and Sidel and Sidel [33]). In India, the ambiguity of government policy has led to dual medical system.[19] Lee[4] details the parameters of environmental support in Hong Kong. The government employs one-quarter of the modern, but no Chinese, physicians. Anyone can practise Chinese medicine without a licence but there is a registration fee of twenty-five dollars. The practices of Chinese physicians are restricted. They are not allowed to issue death certificates, to use medical titles, or to use certain restricted medicines. Schendel[2] describes the incorporation of Spanish and Aztec medicine after the conquest (Cortes) under royal orders, and the diffusion of Aztec pharmacopoeia into Europe. When Germany passed a statute on June 21, 1869, abolishing some of the physician's obligations, the result wes an increase in the number of nature and faith healers.[15]

Berlant considers that the growth of the AMA and its monopolistic advantages were linked to the rise of state power, which was then able to bolster the power of the profession. He then asks what is the advantage to society of allowing monopolization. He feels that an explanation in terms of the public interest is not convincing in light of the differential distribution of the benefits of medical care and he suggests an alternate explanation that is reminiscent of Duff and Hollingshead[33]:

> Particularly in the United States, the development of the medical profession has been closely tied with the development of stratified relationships between social groups, so that quality medical care has tended to be a prized scarcity and an object of class behavior [32, pp.505].

This explanation is good but medical care as an object of class behavior does not tell enough. Elling[40] sees a close relationship between the nature of society and the nature of the health-medical systems.

It can be demonstrated that there is a correspondence between support of the indigenous medical system and the type of political system that exists. Elling (personal communication) has suggested a typology of countries along two continua — the centralised-decentralised power dimension and the concerted-pluralistic action dimension. Thesec oncepts refer to the general nature of the formal (centralised decentralised) power structure as well as to the informal (concerted, pluralistic) dimension of power. It is possible to assign countries to one of four cells as in Table 1.

Table 1. Political structures

	Centralized	Decentralized
Concerted	USSR	China
	India	USA
Pluralistic	Mexico	Canada
	Japan	England
	Hong Kong	

Table 2 shows the varying degrees of support that a medical system may receive along different dimensions. Scores of high, medium, or low reflect action taken relative to that of other countries. Symbolic support is defined as actions taken by the government of a country to preserve indigenous medicine as part of the heritage of a country. Japan is rated medium, not because it has considered its medicine a heritage[39] but as compared to the United States, there has been little persecution of indigenous healers[41] China[33] and India[19] have recognised the cultural roots of their medicines. Japan provides no funds to native medicine but does require licensing of native practitioners[19], thus granting them recognition and legitimacy. China does support traditional medicine financially but not at the level of modern institutions.[39] Licensing of medical practitioners was abolished in China along with the leveling of other professionals, but traditional institutions have received government recognition. India has made some grants available for the study of Ayurvedic medicine and the provision of services[19] A subjective guess would be that it is less than that provided in China. Regulations for licensing of medical practitioners and traditional schools are currently being decided in India (communication from Pandit Shiv Sharma, in visit to UCONN Health Center in 1975). These countries contrast with the United States where non-modern forms of healing receive no support.[43]

Table 2. State support of indigenous medicine

Type of Support	Country			
	Japan	China	India	USA
Symbolic	Medium	High	High	Low
Financial				
Educational	Low	High	Medium	Low
Research	Low	High	Medium	Low
Practice	Low	High	Medium	Low
Legal				
Licensing	High		—	Low
Education	—	Medium	—	Low

How does medical care in a country relate to the form of goverment? We see from Tables 1 and 2 that only the United States, a decentralised, pluralistic country has provided no support to any but the most politically powerful medical organization. This is the result of a system where health is not a national priority, where there is no system, program, or prioity of expenditures for health. It appears that only centralized and/or concerted countries refuse to allow the battles of professionals over the carving up of the medical arena to interfere with the delivery of health. Bryant[1] makes the point that health programs can also be divided among government agencies. A few examples will

suffice. Current philosophy in China dictates that the purpose of the medical and educational system in china is .to serve the people.[44] In fact, it has been noted that one problem of Chinese education is its overly ut litarian nature.[36] This signifies not the absence of professional politics but their subordination to national policy. This has occurred also in Russia where feldschers were employed despite professional opposition[15]; in India where Ayurvedic physicians have not been embraced by the medical establishment[39]; and in North Vietnam were Western and Oriental medicine is being combined.[45]

Conclusions

This paper has discussed some of the factors influencing the status and utilization of native healing practices in the modern world. Though cultural and internal factors may affect the utility of traditional medicine by encouraging bad practices and discouraging new ones, it is equally certain that this medicine of the people contains effective practices and new ideas. Thus, the links between it as a knowledge system and its role in medical system has been tenuous. The role of professional struggles in the medicial arena as the dominant factor has been tempered by the Influence of government where it has been able to direct medical priorities. It has been suggested that in centralized governments or in those where action is concerted, the government is able to set priorities; in other situations, such as the United States, health priorities are the outcome of professional struggles.

From this, it is evident that the outcome of employing traditional medical structures to meet the health needs of the world will depend to a large degree on its interface with professional organizsations and the type of relationship it has with the government, either controlling or controlled.

The question, however, remains unanswered. Why do different kinds of political systems allow their policy or lack of it to benefit medical power groups? Several different models of the articulation between the medical system and the political system exist. Krause discusses the imbeddedness of the health system at several levels: The first is the level of values —

> First there is the issue of occupational ideology inherent in the term profession itself. What citizens believe the medical profession to be determines how they act in accordance with this belief [46, pp. 36].

Friedson[47] agrees with this view and criticizes the medical profession for usurping values when their claim to power is technical expertise. We suggested earlier that the relationship of medical systems to political systems was not due to cultural factors such as the state of knowledge of the profession or acceptance by the local residents, but rather to the nature of the relationship between the health professions as organizations and the form of government. We also noted that symbolic support is one means by which a profession may survive and obtain other types of support.

Krause[46] also suggests that control over the delivery of health services varies according to the ownership and control of health service production. This theme is explored in greater detail by Navarro, who makes the point that physicians no longer control the health system through the power of their knowledge. Primitive, or what Navarro calls competitive capitalism, has given way to monopoly capitalism : Health is the ...

> ... second largest industry in the country... the flow of health insurance money through private insurance companies in 1973 was 29 billion dollars slightly less than half of the total insurance — health and other — sold in this country in that year.. About 515 billion dollars of half of that money flowed through the commercial insurance companies... [where] we find again a high concentration of commercial capital [48, pp. 150].

Navarro continues that the same corporate interests which control the American economy also dominate the health sector. Although physicians qua physicians are losing Influence as the source of power shifits from entrepreneurial to corporate sources, physicians still remain part of the dominant class in terms of economic position and many are now members of the corporate class. The medical system is one way to reinforce the values of and contribute support to capitalism.

Elling (personal communication) suggests that it is this context of the health system that in the end determines if the utilization of traditional medicine is to be of real value or if it is to be a delaying action to perpetuate second-rate medical care. Professionalism, coupled with a stratified society, can serve to thwart the intention of the use of indigenous healers — the provision of better medical care. Thus we find a rural midwife program in Arkansas training women for rural service.[49] But

in fact this program is designed to preserve a two class system of medicine whereby the rural poor mostly black, are receiving minimal care, with little or no access to special services while the wealthy white are treated in medical facilities by doctors reluctant to serve the countryside. Or there is the paradox that is now occurring in India, where the use of indigenous practitioners will mean less available medical care As a by product of their struggle to achieve recognition, Ayurvedic medicine practitioners have agreed to limit the number of practitioners they will certify and train. The price of legitimacy and other support is diminished service to the population. One must question, then, the use of indigenous healers — who is to benefit? — and who is to gain? Their utilization cannot be separated from the influence of the medical system. and its position in the socioeconomic and political systems of a country.

References

1. Bryant J. *Health and the Developing World*, Cornell Univ. Press, Ithaca, 1969.
2. Schendel G. *Medicine in Mexico*, Univ. Texas Press, Austin 1968.
3. UNICEF-WHO Joint Committee on Health Policy, Report of the Twentieth Session. Held at the Head-quarters of the WHO, Geneva, Feb. 4-6, 1975.
4. Lee R.P Health services system in Hong Kong: professional stratification in a modernizing society, *Inquiry* 22, 51, 1975.
5. Stromberg J. Communtity involvement in solving local health problems in Ghana, *Inquiry* 22, 142, 1975.
6. Eilling R. H. Case studies of contrasting approaches to organizing for health : an introduction to a framework, *Soc. Sci Med.* 8, 263, 1974.
7. Weinerman E.R. Research on comparative health service systems *Med. Care* 9, 272, 1971.
8. Elling R. H. and Kerr H. Selection of contrasting national health systems for in-depth study, *Inquiry* 22, 25, 1975.
9. Philips B. S. *Social Research — Strategy and Tactics*, Mac Millan, New York, 1966.
10. Campbell D.T. and Stanley J.C. *Experimental and Quasi-Experimental Designs for Research*. Rand McNally, Chicago, 1963.
11. Mc Granahan D. V. Comparative social research in the United Nations. In *Comparing Nations: The Use of Quantitative Data in Cross-National Research* (Edited by Merritt R. L. and Rokkan S) Yale Univ. Press, New Haven, 1966.
12. Galdston I. *Progress n Medicine*, Books for Libraries Press, New York, 1972.
13. Marchione T. Ph D. Exam. UCONN, Dept of Anthropology. Oct. 22 1975.
14. Sigerist H.E. *A History of Medicine*, Vol. I. Oxford Univ. Press, New York. 1951.
15. Garrison F.H. *History of Medicine* Saunders, Philadelphia, 1929.
16. International Conference on Health Education, *Communication and Behavior Change*, Special Issue of *Int. J Hlth Educ.*, 1969.
17. Green J.R. *Medical History for Students*, Thomas, Springfield, Il 1968.
18. Sigerist H. E. *On the History of medicine* M.D. Publications, New York. 1960.
19. Banerji D. Social and cultural foundations of the health services systems of India, *Inquiry* 22, 70, 1975.
20. Kuhn T *The Structure of Scientific Revolutions*, Univ, Chicago Press, Chicago, 1970.
21. Montello B. O. Imperial Aztec medicine, *Science*, 215, 1975.
22. Harwood A. The hot-cold theory of disease, *J. Am Med Ass.* 216, 1153, 1971.
23. Logan M.H. Humoral medicine in Guatemala and peasant acceptance of modern medicine, *Hum. Org*, 32, 385, 1973.
24. Martinez C. and Martin H.W. Folk diseases among urban Mexican-Amearicans, *J. Am. Med. Ass.* 147, 1966.
25. Rubel A. J. Concepts of disease in Mexican-American culture, *Am. Anthrop*, 62, 795, 1960.
26. Snow L, Folk medical beliefs and their implications for care of patients, *Ann. intern. Med.* 81, 82, 1974.
27. Foster G. M. *Traditional Cultures and the Impact of Technological Change*, Harper & Row, New York, 1962.
28. De Walt K.M. The illnesses no longer understand *Med. Anthrop. Newslett.* 1977.
29. Leslie C. The modernization of Asian medical systems, in *Rethinking Modernization* (Edited by Poggie J. and Lynch R), Greenwood Press, Westpott CT, 1974.
30. Carboni D. Geriatric medicine in the United States and England Doctoral dissertain, Department of Sociology and Communtity Medicine, UCONN, 1976.
31. Stevens R. *American Medicine and the Public Interest*, Yale Univ. Press, New Haven, 1973.
32. Berlant J. L. *Profession and Monopoly: A Study of Medicine in the United States and Great Britain*, California Press, Berkely 1975.
33. Blum R. E. *Health and Healing in Rural Greece*. Standford Univ. Press, 1965.
34. Burrow J. G. *AMA — Voice of American Medicine*, The Johns Hopkins Press, Baltimore, 1963.
35. Wolstenholme G. and O'Connor (M. Eds) *Teamwork for World Health*, Churchill, Ciba Foundation, London, 1971.
36. Harbison F. and Myers C. A. *Manpower and Education*, Mc Graw-Hill. New York 1965.
37. New P. K. and New M.L. The links between health and the political structure in New China *Hum Org*. 34, 237, 1975.
38. Sidel V. W. and Sidel R. The delivery of medical care in China. *Scient. Am*. 230, 19, 1974.
39. Du R. and Hollingshead A. B. *Sickness and Society*, Harper & Row, New York, 1968.
40. Elling R. H. Medical system as changing social systems Paper presented at Theoretical Foundations for the Comparative Study of Medical Systems Conference, Washington D.C., November 21-3, 1976.
41. Ehrenreich B. and English D. *Witches, Midwives, and Nurses— A History of Women Healers*, Feminist Press, 1973.
42. Yamamoto M. and Ohmura J. The health and medical system in Japan. *Inquiry* 22, 42, 1975.
43. Tobe J. H. (Ed.) The Provoker 17, St. Catherine's, Ontario, March—April, 1977.
44. New P.K. and New M.L. Health care in the People's Republic of China : the barefoot doctor. *Inquiry* 22, 103, 1975.
45. Elling R.H. and Martin R.F. Health and health care for the urban poor, Connecticut Health Services Research Series, 5, 1974.
46. Krause E.A. *Power and Illness*. Elsevier, New York, 1977.
47. Friedson E. *Profession of Medicine*, Harper & Row, New York, 1970.
48. Navarro V. *Medicine Under Capitalism*. Prodist, New York, 1976.
49. Arkansas State Board of Health, Division of Maternal and Child Health, Arkansas Midwife Manual, Februay 1, 1957.

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