"HEALTH AND SOCIETY IN INDIA : THE MEDICALIZATION OF HEALTH"

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To

My Mother

For the reasons
no words can express

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DECLARATION

Certified that the dissertation entitled ' HEALTH AND SOCIETY IN INDIA - THE MEDICALIZATION OF HEALTH', *submitted by Ms Roma Banerjee in partial fulfilment of the requirements for the award of the degree of* **Master of Philosophy**, *has not been previously submitted for any other degree of this university or any other university and is her own work.*

We recommend that this dissertation may be placed before the examiners for evaluation.

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CHAPTER - I

Introduction

In all human groups, no matter how small or technologically primitive there exists a body of belief about disease, its nature, its causation, and its cure. The drive for seeking the cause and the cure of a disease has been ubiquitous, because disease and death has always been regarded as disruptive in all kinds of societies and in all periods of time.

It is observed that over a period of time there has been a shift in the understanding of the disease from an ascientific to a scientific one. With the change in the understanding of the disease, the approach to the treatment of the disease has also changed.

In the earliest period the cause of a particular disease was located in the supernatural, something that was outside the social, human and environmental system. So the cure in these times lay in propitiating the Gods and the supernaturals who were believed to have controlled and directed the disease causing forces.

The deviation from this understanding of the disease started with the Hindus and partly with the Egyptians. According to them, the causation of a disease was associated with religion and astronomy, i.e. the natural forces, which

acted as the base for the future theory of natural causes of disease.

It was Hippocrates who propounded the naturalistic theory of disease. The natural forces, such as sun, air, wind, season, and the nature of man are seen as the causes of disease, but these factors were also conceived of as Divine agents.

Thus the seeds for rational system of medicine, based on naturalistic theory of disease, was sown which gradually grew up into modern scientific medicine through developments during the past one thousand years.[1]

The last quarter of the nineteenth century saw the establishment of 'microbe' as the most pervading physical agent in the causation of disease. This set a landmark in the development of modern medicine, that gave the concept of health and disease a new dimension. During this period the respective roles of host, agent and the environment, including the transmission and the spread of infection, were fully identified and elaborated.[2] This cons-lituted an epidimological approach towards health.

With these developments there is a change in man's relationship with nature. Because man's adaptability with nature declined as he became more a manipulator of the nature.[3] Man becomes central to all kinds of development.

Thus the cause of the disease is located in man himself. Disease becomes man's own responsibility. The collective occurance of the disease is then located in each individual. The disease thus becomes something internal to the human system. Its causes are investigated and its cure is being controlled by man himself. Thus based on his understanding of the disease, man, looks for its cure.

But diseases not only threaten the individual but also the integrity of the entire community. Illness and death are considered disruptive events that impose high economic and social costs whenever they occur. It becomes a need for all communities to have 'good' health and restore the health of all those who fall ill.

All societies normally maintain certain specific concepts of health. The World Health Organisation (W.H.O.) definition as "a state of complete physical, mental and social well being and not just the absence of disease and illness,[4]" is widely accepted. But while determining good health it is necessary to examine the relationship of man with his social environment. The disease pattern under a particular social environment, will be different from that of the other. Accordingly a health care system should be built that will be specific to the particular society.

To keep up the challenge of maintaining 'good' health, where 'good' health is specific, all societies

should develop their own medical care system according to their health needs. These systems will be characterised by certain patterns of social institutions and cultural traditions that evolves from deliberate behaviour to enhance health.[5] A few medical care systems are, the traditional chinese medicine, the Ayurveda of ancient India, the muslim system of Unani and of course the most popular system of the contemporary times, the allopathic system of the West.

Each of these systems have a cultural bearing as Hughe's points out about these systems, as having come up in response to those beliefs and practices relating to disease which are products of indigenous cultural development.[6] Thus every society views health problems from the perspective of its own culture, and provides coping responses to them according to the understanding, knowledge values, attitudes and beliefs of the people comprising it.[7]

Medicine as a culture will be reflected in its existence in the form of 'medical knowledge' and its existence in the form of the 'medical care system' will reflect the overall social structure.

The Primary goal of any medical care system is to organise the health services in such a manner as to optimally utilise the available resources, knowledge and technology with a view to prevent and alleviate diseases,

disability and sufferings of the people. There is no single pattern of a health organisation and its structure. To a large extent, it is determined by the structure of other societal institutions, and also by the political, economic and value system of the society, of which it forms a part.[8]

The Indian Medical Care system is characterised by 'Medical Pluralism'. Medical Pularism may be understood to mean one of the two things. It may mean the co-existence of multiple systems of medicine, or it may mean pluralism within a particular system, where different categories such as doctors, Pharmacists, Licentiates, nurses etc. who perform the role of administering health service to people from different social classes and groups. The choice of medicine and personnel within this medical pluralism is often influenced by the relative position held by the sick person in the social hierarchy. Then there are also the factors like availability and accessibility and quality of medical care provided by the diverse systems, and people's past experiences in particular disease episodes.[9]

In India, medical care rests on the assumption that all the needs of the patients are to be met through formal medical care in hospitals. The general hospitals in India are an example of over-utilisation of medical facilities. This is because of the over-crowding in the hospitals and the inconveniences caused by the limited supply of basic

amenities. Adding to these inconveniences are the indifferent attitude of the doctor and the general staff. This diluted quality of medical care has earned the Indian general hospitals, the reputation of being in-human places.[10]

In India, the dominant system of medicine is the allopathic system that we have inherited from our colonial rulers. It is also pupularly believed to be more scientific.

Modern medicine in the past few decades has made great advancement. Medicine has tried to gain precise knowledge, trying to make it more and more scientific in many respects, both technically and informationally, it has become more exact.[11] This has made medicine more specific. For each specific disorder diagnosed is a specific remedy, which is pharmacological in nature.

The swift advance of applied science which has already transformed the industry and military, transport and communication, is now beginning to revolutionise medicine. This development of medicine has been synonymous with the industrial development.

It is under industrialisation that modern medicine progressed the most. 'Medicine during industrialisation developed due to the vested interests of the industrialists. This was the most effective medicine in curbing the

occupational diseases which were the products of industrialization. The industrial diseases that threatened the industrial production, made the industrialists sponsor medical research. With better medical aid the industrial production could be accelerated, by maintaining good health of the workers.[12] Thus medicine became an investment for the industrialists.

Backing up any medical system is an institutional arrangement of that society, as well as the production of knowledge. The production of knowledge is to certain extent influenced by the societies belief system. The institutional arrangement will reflect the overall social structure, which will include the power relations and also the mode of production.[13]

Today, the most prevalent ideology invoked to explain the nature and form of the developed and developing countries is largely grounded in technological determinism. It suggests that the nature of industrial technology defines the general character of society.[14]

Under the industrial ideology, medicine is moulded by technology, which makes it mechanistic and in the process it exaggerates and mystifies the entire health care system. This has led to what may be designated as the creation of 'medicalisation', which over emphasises the curative aspect and delegates to the background the preventive dimension of medicine.

The advancement of medicine is directed towards the invention of new technology, such as radiology, and the use of electronic devices and isotopes which have added new dimensions to their diagnostic power.[15] While absorbing an ever increasing load of technological advances, it becomes difficult for medicine to retain substantivists orientations.

Medical care system in India is dominated by the allopathic system. The popularity of this system has overshadowed the other existing systems of medicine. With the adoption of the western medicine we have also adopted the western medical care system. On the basis of this model we have built a huge infra-structure of hospitals, Primary Health Centres (P.H.C.) and their sub-centre's and dispensaries. This system is overweighed in favour of curative programme and is thus more curative oriented.[16]

There is not enough emphasis on the development of Public health. As a result of this neglect those diseases continue to persist which should have been eradicated. We concentrate more on finding new technology to treat these diseases. For eg. doctors are called upon to treat the cases of gastro-enteritis, or hook-work, or typhoid, which are caused due to contaminated water and milk. We can prevent the happening of these diseases by making use of simple technology, but we wait for the disease to take place and then take to curative medicines.

It has been observed that the practitioners of modern medicine in India do not want to go to the rural areas. This is due to the lack of even basic facilities and durgs, much less the sophisticated equipment they are accustomed to. But a similar tendency, to avoid the rural areas, is observed even among the learned practitioners of the indegeneous system. They too prefer to set up their practices in the urban areas.[17]

These private medical practitioners are influenced by forces of the market situation in selecting human settlements for setting up medical practice. They see the urban settlements as more profitable. On the other hand, doctors in the government service have other considerations for not going to the rural areas.

Under these circumstances the rural areas are deprived of both private and government services in medical care. Nevertheless, this dichotomous development in the medical care system does not affect the kind of fauith that people have in it. It continues and the dependence on the system increases gradually and steadily over time.

There is thus the creation of a dependency relation ship between man and medicine or the medical care system. This dependency has strengthened medicalisation basically through three factors. First, the patients behaviour as a

consumer. He aims at consuming medical services, by utilising new technologies that mystifies him. His preference

Thus,there are certain non-medical aspects which are of importance and need more emphasis under our health conditions. But we over-emphasise the medical (curative) aspects of health. This implies that there is a seperation of health from the disease. This will redefine health in a more rigid manner and give desease a more abnormal form.

People too have shown a preference for curative medicine and have readily accepted modern medicine in their desire for an effe ctive cure. It is the people who want good curative services and see preventive and promotional a spects of medicine as secondary. The benefits of modern medicine are not being 'thrust' down the throats of unwilling villagers. If most medical interventions in India are in the sphere of curative medicine, the fact that the people want it that way, is one of the reasons, for the perpetuation of the curative system of health care.

Backing this health care system in India is the industrial structure. It has been noted before that the medical care system will be synonymous with the overall social structure.

Industrialization has directed all development towards the urban areas as a result of which the urban areas have 'developed' fast.

for selecting any kind of medical treatment, is solely his decision. It is after all the patient (consumer) who is ill, and the choice of treatment however narrow it may be, is his. Second, the professionalisation of the medical personnel, especially the doctor who is the team leader in any medical service. This has been due to the specialisation, in fact, over-specialization, of the doctors, as a result of which doctors often tend to over-treat an ordinary case.

The third factor encouraging medicalisation is the industrialisation of the medical care system. Under this, the Pharmaceutical industries produce, all kinds of 'new' medicines including banned medicines by just changing their brand name. The pharmaceuticals often spread the use of various medicines by using medical men as its sales-men. The pharmaceuticals also use the media to publicise its latest inventions. The production pattern of the pharmaceuticals is more profit oriented than helath based.

Apart from these three factors that work together to medicalise health, there is yet another factor that promotes medicalisation. This is the state. The role of the state in medicalizing health can be viewed through the health policies. Our health policy, which is curative in orientation and urban based is to be blamed for the increasing medicalisation. Despite its concern over the badly maintained

public health, it has not been able to strongly implement the health committee recommendations for promoting public health. Though for curative health it has set up an elaborate and bureaucratic infra-structure. It has also emphasised on the production of highly professionalised staff for maintaining these structures. In doing so it has successfully perpetuated medicalisation of health in India.

It is from these view points that we shall study medicalisation of health in India.

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CHAPTER - II

Health Services in India

In the developing countries especially India, it is very important to take genuine interest in health care system, to raise the level of health of its people. A lot of economic development and growth depends on the health of the mass. The concern for such problems has emerged recently in all countries. The health problems faced by developed countries are different from those faced by the developing countries.[1] It is thus necessary for each country to tackle their health problem in the light of their social engironment.

The medical care system that we have today is the consequence of the British intervention. This has influenced its planning and objectives.

Since independence our approach to health problems have been rather simplistic. We have adopted the western model of health services thinking that it was ideally suited for our country.[2] The basic emphasis, of this model, was on the adoption of the latest medical technology developed and to make it available to the people of this country. This has been sought through the expansion of the bureacratic machinery of the medical and public health departments. This is complimented with the expansion of the institutions of medical education to train the agents, required for the

delivery of health care (eg. doctors).[3] It is not realised in the process that how far is this system appropriate or relevant in tackling our health problems.

This kind of a development has led to the creation of an infrastructure needed for the purpose, from the big hospitals in metropolitan cities to the primary health centres and dispensaries in the rural areas.

If we go by the above targets set by the leaders, in this field, as an indicator of good health then we can say that we have achieved a good deal.[4] We have managed to set up a huge ministry of health and family planning, large departments of public health and medical services all over the country.

These developments can be seen as a consequence of industrialisation, where the key to success lay in technological development. The Allopathic medicine itself has been co-terminus with industrial development.

India owes all these developments to the imperial state. It is therefore necessary to study the decline of the indigenous systems of medicine under the colonial rule, to understand the present state of health services in India. It was only with the decline of the indigenous systems of medicine that directly or indirectly influenced

the practice and acceptance of the Western system of medicine in India.[5]

MEDICINE IN ANCIENT INDIA

Ayurvedic medicine, was one of the first to gather the science of health and utilise some rational methods of diagnosing illness.[6] This system perceived the diseased person as a whole, taking into account his cultural and social set up. In this system the constituents of the persons were connected with his limits and extensions in time and the nature of his connections, with the natural environment, with the psyche, and with the polis and eosmos. These determined their health and illness, which may not always have been at the conscious level. These were also the ideas that constituted the cultural prism through which men and women throughout India had traditionally viewed the person and his state of well being.[7]

With the onset of the Muslim rule, the physicians from the Middle East had come to India. They were trained in the Unani system, which was largely galenic in influence and curative in their approach. They began to compile and translate the Ayurvedic texts.[8]

This brought about a synthesis of the two systems, which was knwon as the Tibb.[9] With such an understanding,

many Hindus practiced the Unani and many Muslims the Ayurveda. Practitioners of both were patronised by the persons of the other religion. The two sets of physicians showed a lot of co-operation in advancing the knowledge of human body and its working

The medical care offered by these indigenous practitioners could not keep pace with the actual health problems of the community which were mainly due to poverty and ill environment.[10]

It is important to realise that most of our health problems arise out of certain social factors, eg. poverty, and other factors within the social environment. It has been established that health and disease are influenced by certain life situations that transcend the direct impact on physio-chemical forces. Thus it was important to look these situations while treating a diseased persons.

The practice of medicine in ancient India, was also associated with magic and religion; and astrology. These magico-religious practices are found till today among certain tribal groups, and even in the urban areas, though not as popularly practiced as it was in the ancient times. The scientific relevance of these practices are still under question. Here the treatment of a disease was closely

related to the culture, in the sense that the disease was seen to come out of certain kind of a social behaviour of a deviant nature. The diseases here carried a social meaning. The treatment of the diseased person was regarded as a art and the knowledge constituted a science.

In contrast to this, the basis of modern medicine is provided by biological sciences and in the recent years the scientific content of medicine has increased enormously. With these advancements the treatment of a disease is based more on diagnostic observations. With this, medicine as a science has emerged well but its practice as an art has diminished.

MODERN MEDICINE IN INDIA

Modern medicine was introduced in India by the colonial rulers in the latter half of the 18th century. It was mainly intended to serve the colonial settlers in India and their armed forces. Even after the introduction of this medicine, the Indian population of this medicine, the Indian population preferred and followed the indigenous medical practices.

The British interest in extending and establishing their system of medicine was mainly to back up the colonial rule. But this system its beliefs and values that supported

it constitutes an important legacy left to independent India.[11]

The emergence of an organised public health system in India is traced back to the special Royal Commission appointed in 1859 to inquire into the causes of the poor conditions of the British Indian Army.

It was recommended to set up special commissions of public health to study the health problems and initiate appropriate measures for improvement. But these commissions worked in a typical bureaucratic manner by operating through their head quarters. Thus they were in no position to judge or assess the actual conditions of the rural people or work for their disease control.[12]

It was not easy, for the western medicine, to establish itself in India. They had to put up with a lot of resistance from the Indians, who doubted the 'ritual purity' of the western medicine.[13] Thus, although the East India Company had employed British Surgeons from the early seventeenth century, the companies Indian servants used the indigenous practitioners even when the western medical help was available.[14]

The colonial rulers then realised that they had to collaborate with the indigenous system to establish their medicine in India.

Thus , when they started with the Western medical education, which began in Calcutta in 1822, they combined the classes with the classes in Ayurvedic and Unani systems of medicine. Once the Western medicine made a formal entry into the Indian system, the colonial rulers saw no reason as to why the indigenous systemsshould be promoted any further. Their sole aim was to propagate their own system. From here began the discouragement for the indigenous system, which was followed by its gradual decline.

The first step towards this decline began with the breaking up of the policy of integrated medicine in 1835, when the Calcutta school was converted into a college for modern medicine.[15] By this time the indiginous courses were abolished.[16] The Western courses lengethened and the courses were conducted in English. Another medical college was established in Madras, and after another ten years, the Bombay Grants Medical College was established, and later there followed the opening of a row of medical colleges all over India.

There were also the establishment of medical schools to train licentiates, mainly to serve in the rural areas. By 1938 there were 27 medical schools training licentiates.[17]

Thus the Western system was fast expanding through these medical colleges and schools. The indigenous systems were being pushed backwards with no scope for further advancement

A major blow came to the indigenous practitioners of medicine when an act was passed, according to which compulsory registrations of the practitioners of Western medicine was made. In one of its clauses it was made clear that these registered practitioners were in no way to associate with the indigenous system of medicine or its practitioners.[18]

After the passing of this act the practitioners of the indigenous medical systems were reduced to the position of unrecognised, unqualified laymen, whose professional opinion was at a discount at the courts of law and in the eyes of the Government.[19]

This incident was demoralising and came as a great insult to the practitioners of the indigenous system of medicine. The discouragement that they received from the colonial rulers further continued.

Thus the Western system of medicine had finally established itself in India. And over a period of time the support for this increased. This system was looked upon as the more scientific system which symbolised development.

The students joining the Western medical colleges were, initially, the Europeans, Eurasians, and the native Christians. There were, later, plenty of Brahmins willing to undertake medical education, inspite of the emphasis on anatomy and

surgery which could be expected to offend their caste prejudices. But they were less significant to them in medical education.[20]

By the beginning of the 20th century the market for Western medical science had expanded and some Indian doctors had established very successful practices. Some were even in a position to take patients away from the European doctors of the Indian Medical Service (IMS).

By 1939, the idea was that only one type of medical education was relevant to Indian conditions, namely as a close approximation as possible to medical education in Britain. This, thus, confirmed the place of the Allopathic system in the Indian Society as the crucial one.

India could have adopted a wide variety of standards of training designed to match the varying local needs, she could have also sorted out a single 'national' medical system with the indigenous system integrated to it. But instead she went for the Western model.

The early leaders of the Indian Medical Association argued that the indigenous practitioners be allowed to join the Indian Medical Association (I.M.A.) and that they also be included in the Medical Council of India (MCI). They had argued that there were some valued indigenous drugs and methods which should be taught more widely.

But the inclusion of the indigenous systems and their practitioners in the IMA, and MCI could call for a de-recognition of the Indian medical education by the General Medical Council in Great Britain. Thus, the support for the indigenous medicine weakened when the focus of medical politics became the desire to make the Indian Medical Education internationally acceptable.[21] Thus the indigenous practitioners were permanently pushed into a sub-ordinate role.

Similar was the fate of the licentiates, who were already bitter about the "casteism" in medicine. The prospects for their advancement was very restricted unless they went back to medical colleges for a degree. Later the General Medical Council (Britain) refused to recognise any Indian doctors if licentiates were included in the MCI. After a row of arguments the licentiates further lost their status by their exclusion from the MCI. With this the already existing pressure for ending the licentiate education got redoubled.

This did not have a good impact on the rural areas if seen in the long term. Because the medical graduates would naturally be reluctant to take up posts in the rural areas for which a licentiate qualification was needed. The argument given by the government for the abolition of the licentiate training was that the absence of a 'cheap doctor' prepared to work in the villages would accelerate

the uses and advantages of Western medicine considerably in these areas.[22] But this did not happen in reality.

Very few Indians had denied the British model that was followed and very few were concerned about the effects these decisions had over the medical care service in the rural areas. By the time India gained independence the Western system of medicine was made to integrate itself into the Indian society, with one kind of the 'basic doctor', as the team leader of the health care system.

HEALTH SERVICES AFTER INDEPENDENCE

After independence it were those Indian doctors who collaborated with the colonial rule who stepped into positions of power. These doctors were socialised into the system of modern/Western medicine. They failed to produce a coherent medical policy that would look into the actual needs of the people of India. They especially failed to provide a public medical and health policies that would benefit or rather attend to the problems of the rural people/mass.

At the dawn of independence there could have been two options regarding the choice of a medical care system. One, either outlaw all except the Western system of medicine, as followed by Great Britain or two, to integrate all medical teaching into a 'national' system, as done in

China. But India followed neither, instead she went for the multitude of systems in medicine, and the continued bickering between the existing systems helped only to further frustrate attempts to deal systematically with Indian health problems.[23] Despite the existence of these multitude of practitioners it was the Allopathic system that formed the basis for all our health policies. Thus the government made clear what our choice, for the system of medicine, would be for the future.

Thus the mode of operation after independence had been that of the Imperialist state. Here the decision for the only appropriate system was the Western system. The co-existence of the indigenous systems only contributed to the persistence of the existing medical pluralism. The failure to integrate these systems into 'national' system, and their individual existence has made the medical care system chaotic. Thus along with the production of the modern allopathic drugs, there is also the production of the indigenous drugs and chemicals.

Under industrialization these systems have come up to compete with each other, which may also be viewed as their way of survival under the present social and political conditions. This attitude of competition within the systems of medicine has given the entire medical care system a commercial orientation.

Under these conditions our medical care system has taken an impersonal and formal attitude towards health. The health care system has an infrastructure that is based on hospitals and dispansaries. There has been various primary health centres and sub-centres provided for the rural areas. The pharmaceuticals have been developed from a scratch. It now produces a number of life-saving drugs and its output is on the increase. There has been a progress in the control of communicable diseases. We can undoubtedly boast over all these developments but at the same time we cannot overlook our failures which are even more glaring. This is an indicator of the lopsided development of our health services.

The Present medical system provides health care services mostly to the urban and well to do, and is not made accessible to the backward and especially to the rural people. This infrastructure that has been built in the medical care system is more urban oriented. Only a few pilot experiments have been done whose values and capability for generalisation are still in question.[24]

It has been pointed out rightly by Imrana Qadeer that despite its professed commitment to save all, especially the poor the present medical system is riddled with uneveness and inequalities.

Though a major part of our population belong to the rural areas it is served by only 20% of the doctor's population, and that the major institutions of medical care are urban based. On the other hand majority of our population depends on the primary health centres and its non-functional referral system for its health problems.

Out of the 6901 hospitals in the country 5045 (70%) are in the urban areas. The distribution of beds is far more distorted with 90% beds out of the 486.805 beds being placed in the urban hosiptals.[25]

A similar picture emerges in the context of the availability of drugs. The commitment to provide drugs remains only at the oficial level. In reality even the public sector has been relying more on the sales of non-essential items like tonics, vitamins and nutritional supplements.[26] Thus, the production pattern of our pharamaceutical industry has actually not been in response to the needs of the people but more market-oriented and utterly commercialised.

It has been in our nature to equate modernization with westernisation. Thus we feel contented when we imitate the Western model in our country. Our policies are mainly directed towards borrowing of some Western models. These advancements have only helped on the well-being of the well-to-do classes. This is reflected

in the adoption pattern in the kind technology. Most of these have been curative and diagnostic equipment which is too costly and installed only in major hospitals which are located in the urban areas and accessible only to the well to do classes. On the other hand the rural areas do not even get the benefit of the elementary facilities like laboratory or x-ray machines.

Our several schemes of production were not to produce the essential basic consumer goods required by the masses of people but only to produce the luxury and semi-luxury goods for the well-to-do classes. In a stratified and hierarchical society like India, where resources are limited, those at the bottom of the hierarchical scale will have the least access to all resources. The poor are poor not only by wealth but also by health.[27]

The disease pattern in India today still consists of certain communicable diseases like T.B., Pneumonia, malaria, meningitis etc. These diseases occur among a particular socio-economic group mostly belonging to the lower strate.[28] This points not only towards a mismanaged health care system but, it also contests the claims of overcoming some communicable diseases. Even if the claim is conceded, it is applicable only for a certain class, which is naturally the well-to-do class.

What has been overlooked by the government while framing the health schemes is the preventive aspect of health and disease. A preventive approach is more suitable and will prove more fruitful in the present conditions. Although we need to maintain a curative approach, we must emphasise the other side of health development.

Even as we recognize the problem we have still tried to introduce the most developed technology the world has discovered. We have done this with the assumption that our people should get the best that is available. But this technology choice has been limited for curative purposes only. We definitely need to improve our technology, but if this technological development is aimed for preventive measures, it will prove more beneficial and fruitful for our health conditions.

Whatever the decision be, on this issue, one significant factor remains, that is, the type of health care system we develop will depend upon the choice of technology to be adopted.[29]

Our growth of the health services has been poorly planned and controlled. As a result of this the programes that have been developed in the last twenty years has only resulted in rural-urban and inter-class imbalance, both in the availability and quality of services.

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CHAPTER - III

The Health Industry and The Medicalization of Health

The lopsided development of the Indian health services has been dealt with in the previous chapter. We have also pointed, that our health infra-structure has been overloaded with a diagnostic and curative medicine. These developments of the health care system has reflected a western model, which has been consciously incorporated in our system .

It is emphasised by social scientists that services based on hospitals and dispensaries, are western ideas. There is evidence that hospitals were built even at the time of Ashoka the great. But these did not form a part of the health care system these were there for medical social service. Hospitals were places where the sick went for treatment and poor were given assistance at the time of discharge, and the old people went to these hospitals to die.[1]

This nature of hospital changes under the impact of industrialization. Modern hospitals form a social universe with a multiplicity of goals, profusion of personnel and an extremely fine division of labour. This has given the hospital the ability to deploy power through its elaborate and bureaucratic structure.

The hospitals today are well equipped with the latest medical technologies beginning from day to day, ordinary drugs to huge and elaborate machines for diagnosis. These become more an achievement in the field of science and technology rather than in actual health purposes. This is because most of these technologies, elaborate in nature actually is not needed, at least in our country. And they do not even serve the greater population and its basic health need.

Yet, we do boast over our achievements, of opening up various hospitals and dispensaries for the people. For us it is as if the existence of too many hospitals and dispensaries and other primary health centres (P.H.C.'s), for the rural areas, are attributes determining better health. But, actually it is institutionalising a dependency on the medical care system, and disregarding the preventive medicine. It is around this feature that our health care system revolves.

It is necessary to distinguish between clinical and non-clinical services in health. This is usually not done. The health services distribution of separate services has actually not been done in an organised way. It has only showed an anxiety to maintain certain international standards within our medical care system. In doing so it has forgotten the national needs and in the

process it has made the entire health care system chaotic. It has forcibly tried to raise our national needs to an international level to match the pattern of medical care development, which is, of course, an illusion.

This attitude, for international recognition of our medical system, emerges due to competition. This competition arises under industrialization. Industrialisation is characterised by technological determinism, as has been mentioned before. This began in the western societies and the oriental countries followed suit without acknowledging its contextual relevance. In India, it was because of the British intervention that industrialisation occured. Though the process of industrialisation may not not be complete, to a certain extent it has succeeded. Along with industrialisation, there exists the technological determinism, which is reflected in the medical care system.

From the day to day use of the medical technology, to the most sophisticated diagnostic technology, has given the health care system the nature of an health industry, which has medicalised health. Here the human body is looked upon as a machine, whose parts needs to function systematically for the maintainance of the whole. The hospitals and dispensaries take the form of a garage which become the medium between the human machine and the medical technology, to promote medicalisation.

This synonymity of the health care with medicine, drugs, doctors and hospitals has been observed by Ravi Narayan. According to him the established conspiracy between the medical profession, the Pharmaceutical and the growing medical technology has fostered medicalisation. All these have geared up to convert health into a commodity and promotes, advertises and sells it in the pursuit of a profit motive.[2]

Medicalisation may be described as the mutual reinforcement of three forces - first, the unrealistic expectations on the part of the patient, second, the medical management of a technical system having primarily symbolic functions, third, the advertising of Pseudo-inventions that constitutes an even larger share of activities performed by the pharmaceutical industry. These three factors converge as a back up for industrialising the health sector.[3]

It is from this point of view on medicalization, we shall proceed with our work. Here medicalisation takes place, and revolves around the three factors mentioned above. First at the level of the consumer, where the patient gets medicalised because of his behaviour as a consumer of medical aid. Second, at the level of the professionals, where the doctor as the captain of the health team plays his role as a mediator of medicalization. Third, the Pharmaceutical level, where the production

patterns of the drug industry medicalises health.

We shall try and see how each of these have made their contribution towards medicalising health. All the three above factors are inter-related and each influences the other in their role performance within the health care system.

CONSUMERS LEVEL

The patients have often acted as consumers in 'the choice of medical treatment'.

It is often asked by social scientists : what are the needs of the people? Under the Indian Medical Pluralism, it is often misleading to say people prefer indigenous medicine to the modern allopathic medicine. Thus the needs of the people are identified with tradition without actually knowing what the people want.

It has been observed by a number of social scientists that the preference for allopathic medicine was more than the indigenous system. The Narangwal study indicated that people accepted allopathic medicine readily in their desire for an effective cure. It was also observed that 87% of the patients of this area were treated with one or more modern medications, either alone or combined with the traditional remedies.[4]

Another study of Indian traditional healers by H.V. Wyatt, revealed that 87% of these traditional healers possessed syringe and needles. He observes that when medical staff try to reduce the number of injections by giving tablets, the parents or the patients ask for the tablets to be given by injection and if refused they go to a pharmacist, or a health worker or the local healer. Interestingly drugs such as Chloroquine, pencillin and streptomycin, as well as vitamins for injections can be bought from traders who will also administer the injections.[5]

Despite the dichotomous development of our health services, where the rural and the urban health services are differentiated we come across interesting behaviour of rural patients.

It cannot be denied that the Indian village is increasingly becoming a part of the larger society through the inroads of media, mass communication, education and urban employment. This gives the people in the rural areas a chance to see themselves in comparison to their counterparts in the urban areas. They become aware of most curative services in the urban areas. Therefore today,they are not satisfied with the village health guide, or a medical trainee on a village posting. They prefer to travel to the urban areas to consult specialists at considerable social and economic costs.[6]

A similar observation is also made by Dipankar Gupta. He denies the existing distance between the allopathic medicine and the poor as an outcome of a preference for traditional medicine by the village masses. He supports his argument by drawing attention towards the number of people who line up and crowd the hospitals and P.H.C.'s.[7]

These are a few instances when people from the rural areas have prefered the curative medicine and better medical technology. It is true, that to them the symbol of western medicine is a syringe and a stethescope. Their frequent trips to the urban areas to satisfy their unsatisfied health needs by the health worker at the P.H.C. is a clear indication for their preference for better medical services of a higher quality. They have the freedom and the knowledge to choose the kind of medicine that will satisfy their needs.

Bhore committee observes that we have tacitly, and rather uncritically adopted the model of health services from the industrially advanced and consumption oriented societies.[8] Under these conditions health gets wrongly defined in terms of consumption of specific goods and services.

Role of the media has been very important in educating people, through health programmes sponsored

by the government and advertisements on various medicines and other medicated items. This has lead to self-medication and also influenced the choice of medicine to some extent.

The concept of self-medication is not a new concept of recent times, it has existed for a long time, since the days we had folk medicine. Even today in our villages people take to home remedies based on folk medicine, which is also self-medication. But under industrialization, the self-medication reflects consumer behaviour. The patient knows what medicine will relieve him of his pain and he pays for the medicine and buys it from the market.

Today the role of the patient is either that of a client, or a consumer. As a client he gives himself totally into the hands of the professional and depends on the kind of services delivered to him. To him the professional is the decision-maker. But as a consumer, the patient will decide upon the kind of service he wants. He is actually a purchaser of services.[9]

Advani has observed that this behaviour of the patient, as a consumer, is found among the middle class and especially those educated. They are not only critical of the services, but will also assess the kind of service

before taking it. They rather tend to "shop around for medical services".[10]

It has also been observed that there is a growing tendency among patients to go on their own to a specialist and get certain investigations done without heing advised by a general medical practitioner. There are also other instances of patients going to a doctor with an amopoule and asking him to give an injection. They are so injection minded that they would not be satisfied unless an injection is given. If some specialists did not do as directed by the patient, some other specialist would gladly do it and earn a fee. That the public is responsible for this undesirable state of affairs is undeniable.[11]

These are a few examples which show clearly the manifest preference for modern medicine. People want good curative service, and they see the preventive and promotional health services as secondary.[13]

Health is essentially an individual responsibility, that, if the individual cannot be trained to take care of his health no community or state programme of health services can keep him healthy. It is therefore, important to study the attitude of the individuals towards health.

The behaviour of the patient as a consumer may also be influenced by the growing professionalism in medicine. It will be emphasised here that the market situation created under industrialisation has turned medical care system into a market, where the professionals sell health and the patients buy health. This, then, leads to the commodification of health, and this is inescapable under industrialisation.

This attitude towards health will also have an impact on the professionals, the doctors, too.

PROFESSIONAL LEVEL

That the professionals have an important place in 'the society in the context of science and technology, is widely recognised in industrially developed societies.[13] A developing society like India may also be seen as a professionalizing society.

Professionals may be looked upon as a gorup of individuals engaged in a particular occupation who enjoy a considerable amount of autonomy in their working condition. They are granted monopoly in a particular area of social life, which is backed by state sanctions, in the managements of which the professionals play a major role. They are expected to follow certain code of ethics which stresses the welfare of the client rather

Than that of the practitioners. They undergo a long period of specialised training on systematised theoritical knowledge, which they apply in real life. Then finally there is certain prestige attached to this occupational group. This level of prestige of course differs from society to society.[14] Professions in developing societies have not developed as much as its counterparts in the developed countries. A lot of interception on their autonomy and monopoly is felt at the level of the state and partly at the level of their clientele.

Health services are organised around the professional authority. This basic structure constitutes the dominance of a single professional (the basic doctor) over his other sub-ordinates. This forms an hierarchy of authority which is institutionalised and is directly analogous to the hierarchy found in the rational legal bureaucracy. This results in a division of labour strictly governed by the hierarchical authority.[15]

This will give the physician the authority to control Clinical decisions and influence the other workers in the hospitals. This leads to the physicians influence in the choice of medical technology in hospital, which is usually considered to be technological expansion.[16] This is because the physicians demand hospital acquisition of the latest and most comprehensive technologies, to meet the needs of his patients.

This attitude towards the technology expansion in the health care is attributed to the physicians training at the university level. This training emphasises esoteric and technological form of medical care.

Thus the technical training received by the doctors at the time when they are in medical colleges play an important role in moulding the doctor. It is therefore necessary to look into the kind of medical education received by these doctors.

Medical Education, too, like the other structures of the health care system is borrowed from the western countries. We have shown great anxiety over the maintenance of international standards in the course outline of medical education. We have thus produced highly trained physicians but have not provided them the right set up to use their specialised training. For example the inadequate health infrastructure in our rural areas. Understandably, the doctors prefer to settle in the urban areas where they have some opportunity to use their acquired sophisticated diagnostic knowledge. Oommen has rightly pointed out the dilemma of an urban trained physician who spends several long years in training to be a doctor with the hope that the future would be rewarding - both professionally and financially. To ask him to either expect or receive much less would be unrealistic and unfair.[17]

The medical education is more curative and urban based. Further the government does not give any incentives for rural service. The P.H.C.'s and the dispensaries opened in the rural areas, over which the government feels proud as an achievement for providing health services to the rural, are so inadequately equipped and situated in remote areas, the doctors posted in those areas look upon their posting more as a punishment rather than a career gain.[18] Moreover the medical education is such that without the elaborate hospital set up the doctors find it difficult to work and feel dissatisfied with their work.

Our medical graduates going abroad for further studies is not an uncommon feature. Doctors argue that more jobs and funds should be provided so that the scientific training and experience gained abroad can be used in India. They feel that with better facilities in India, the desire to go abroad by our doctors will be reduced.[19] Doctors, thus, associate themselves with the symbols of modern science and sophisticated equipment.

Another interesting feature in the context of medical education is the pattern of specialization. It will be observed that most specialisations are in the field of Cardiology, Opthalmology, Neurology, Gynaecology, Paediatrics and the like. But specialisations in more

common diseases especially in the context of Public health, like epidemiology is not popular.[20] The reason being that these specialisations fetches a better market for the practicing physician in the urban areas which is dominated by industrial diseases, other than the already existing diseases which are the consequence of mal-nutrition and bad sanitation conditions. Other than these reasons, the clinical specialists are rated higher than the public health specialists. The clinical specialists are successful in acquiring a better social status. Then finally the clinical specialists can better utilise the sophisticated medical technology and satisfy their professional thirst.

This professional craving and the patient's expectation as a consumer, project a new doctor-patient relationship, in the form of a professional-client relationship.

The doctors relationship with the patient will be different in the general hospital and in the private hospital. In the general hospital the doctor is paid by the government for his services to the patient. And the patient here does not directly pay the doctor, although a certain amount is deducted from his income. So the patient does not face the direct situation of the commodification of health, and at times is not even aware

of it. Under this situation the patient behaves as a client, where he leaves his decisions to the professional.[21] Hence it is the decision of the professional on the kind of services according to his judgement of the clients' health condition.

This situation will be different in the private sector where there is a direct exchange between the doctor and the patient. Here the doctor sells health for which the patient pays him. Here the patient will behave more like a consumer where he will himself decide on what kinf of a medical service he wants.[22] Consumerism will emerge more distinctly in the private sector, where health gets commercialised.

In the health sector today private practice is more easily accessible and acceptable form of medical care that people have come to recognize and utilise. This is because of the discredit that the public sector has received due to the poor services. These have been due to inadequate drugs and equipments, the inefficient health delivery care system, and their bureaucratic structure. These factors over the years have given way to private practice in becoming deeply entrenched in society, and acquiring more credibility.[23]

Thus the private practice has flourished due to the inefficiency of the government sectors. But that

does not mean that the general hospitals and dispensaries have failed. They are equally utilized or over-utilized, but by a certain social group, which mainly consists of the lower class.

Other than the preference of the people for private practice, doctors with necessary economic backing also tend to set up private practice. Because here they can exercise their professional monopoly without being questioned by the authorities.[24] Though in a private hospital the junior doctor will have to follow certain code of rules. Nevertheless doctors find it more rewarding, financially, to work in the private hospitals rather than in the government hospitals.

The profession of the doctor is labelled as a noble profession. "The commitment to the image of a selfless service obviously leads to inhibitions to the presenting and forwarding the demands for improved conditions for doctors, and it is liable to be used against doctors who are in conflict with their employers".[25]

The view that professional with whom the health of the patients should be the first consideration and the personal inconveniences should not weigh at all, is appropriate for the Indian ontext. Doctors have often pointed out that the authorities do not seem to realise that a doctor is over worked and worried about his

livelihood. Under these conditons where his personal safety and that of his family is at risk, he cannot be expected to carry on his duties in a detached manner and be insensible to all pains and pricks.[26]

With this understanding of the medical profession, the Indian authorities have rather taken this profession for granted. It has therefore not allotted it appropriate rewards for its services, specially those working in the rural areas. Which is a reason for the distance between the doctor and the rural mass and the urban poor.

It is not unexpected, that the practitioners of private practice will be influenced by the forces of the market situation in selecting communities for setting up medical practice. They see urban areas as more profitable,[27] and thus private practice will be spread all over in these areas.

Not only the private health services but the government health services also are spread out more in the urban areas. Doctors in these hospitals, under the Government, prefer postings in the urban areas rather than the rural areas. This is because, the professional looks for higher returns after his long period of training, both financially and career wise. A professional trained to look at more specialised diseases will hardly find satisfaction in treating people suffering from diseases

due to malnutrition and unhygenic conditons. He cannot exhibit his technical skills in the rural areas. He prefers to treat patients with complicated diseases.[28] His success over treating complicated cases is not only a morale booster for him but takes him higher in his career record. This also gives him recognition by the people and finally the society, which, adds to his social status. And of course professionally he becomes a more satisfied individual.

This professionalisation in medicine applies both to the private and the government sector. This professionalisation has promoted curative and diagnostic medicine, for which the doctor has to depend on the medical technology. This in turn leads the patient, who comes to the doctor for treatment, to depend on the medical technology. Thus professionals have played an important role in medicalising health.

The physicians mode of treatment will also to a large extent determine the kind of medical technology used in health services.

INDUSTRIAL LEVEL

Our health system is dominated by drugs and medical technology. These drugs and medical equipments are produced at the industrial sector and their production

has been gradually increasing. In this context the pharmaceuticals play a very important role. as medicines have become the key to modern medical treatment.

Our drug production pattern has also followed the western societies. This is due to the multinationals dominance over our drug industry. The drug produced are more tuned to the needs of western societies.[29] These drugs satisfy the needs of the urban areas and the well-to-do classes. This drug production pattern has been highly commercialised and consumer oriented.

The pharamaceutical product marketed in India do not cater to the needs of the majority of her population. The majority of our population suffers from diseases like leprosy, tuberculosis, and malaria. The medicines for these infections are always in short supply, and the ones that are marketed are the more expensive ones, and beyond the reach of the ordinary mass.[30]

Our multinationals dominated drug industry have produced drugs for the rich who form a small section of the Indian population. Its sole aim of the drug industries is to expand business and maximise profits.[31] These companies have come up with new kinds of medicine by often changing their brand names. By doing so they have been successful in attracting the attention of the consumers, of these medicines, through advertisements.

There are 15000 drugs marketed in our country. Most of these drugs consist of a combination of anti-biotics with antibiotics, anti-biotics with vitamins, vitamins and vitamins, various tonics and digestive ensymes.[32] These vitamins and tonics account for the 16% of the total drug market in India.[33] These drugs have been produced to compensate the inadequate food intake that cause deficiency disease missed out cannot reach these medicines, either they are not made available to them, or because of the inaccessibility to these because of the high costs.

There has been an increasing dependence on drugs and medical technology. With the proliferation of health personnel, chemists and druggists, the pill culture has infilterated different areas and communities through commercial channels. This dependence on drugs has marginalised and systematically eroded the previously existing alternatives.[34] Many of which were holistic, low-cost, locally available, indigenous and encouraged self reliance. But the increasing drug consumption has been mostly for self limiting and trivial health problems.[35]

The drug producing companies have often used the doctors as their salesman. This has affected the prescribing habits of the professionals. To keep up with the rapid advances in 'medicine' the medical practi-tioner, either shows no interest in the standard journals

(which are usually expensive) or they are not accessible to them. So the practitioner often depends on certain literatures provided by the representatives of the pharamaceutical companies for updating their knowledge in therapy and medical technology. These literatures provided by the pharmaceutical companies often make false and exaggerated claims for a drug, by quoting journals and text books out of context. They also withheld essential information regarding the side effects of the drugs.[36] The propaganda material of the drug company is so good that it successfully confuses even the best doctor.

Commercial claims through press, radio and television also influence the prescribing patterns. These have resulted in inappropriate prescription and over-prescription. This misuse and over use of a certain medicines as 'cure-all', for common cold, as substitutes for minor, infections due to bad sanitations and over the counter remedies, are speeding up the appearance of resistance staains. Consequently hundreds and thousands of people who succumb to infections do not respond to medicines.[37]

The drug industry in India has an open market. Where drugs are often sold over the counter without any prescription by the physician, they are openly sold by the

chemists and pharmacists.[38] In the process drugs without established therapeautic utility are too often sold over the counter, than those with proven effectiveness. Often toxic drugs are advised for minor conditions, which can be managed with simpler and safer medicines.

The situation is such taht so long as the pharmaceutical products bearing the name drugs are available in the market, they continue to be sold. It is the consumers of these drugs who have helped these companies to keep up their market. They too cannot be blamed for their unrealistic expections of these medicines. They get carried away by the convincing propoganda of the pharmaceutical companies on the superiority of their respective products.

Medicines can be looked upon as double edged sword, when used properly it gives good results and when used in a wrong manner it can be dangerous and may also prove fatal. It is therefore necessary to check the drug production pattern by nationalising the drug industry. This will enable the marketing of drugs with proven effectiveness which will cater to health needs of the people.

The use of medicine can thus be seen at three levels. First, at the consumers level where the consumer is seen as the one who shares a direct relationship with

medicine by actually taking it. Second, at the professional level, where the professional acts as a medium for communicating it to the consumer. And the third level is the industrial level, where the pharmaceuticals as industries act as providers of the medicines. They of course use various channels through which they can propogate their products.

Each of these three levels in the use of medicines has affected the health care system. They have each shared in common the knowledge of the scientific development and each of them have applied it their own way. This application of medicine is owed to the scientific development that takes place under industrialisation.

Industrialisation, as mentioned before, is characterised by technological determinism. As this technological determinism enters the health field it industrialises health. The health care system then begins to function as an industry, where its major emphasis is on the utility of the medical technology. Thus this dependency on the technology medicalises health. The medicalization of health then revolves around three factors, the consumers, the professionals and the pharmaceuticals. Each of these work together as a team to further medicalization.

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CHAPTER - IV

State, Medicalization and Health Policies

In the last chapter we have tried to see that how under industrialism, technological determinism influences the health care system. The technological culture within the health care system leads to a technological dependency while delivering medical care. This technological dependency has been seen at three levels. How the three team up to medicalise health has also been observed.

We also have certain political factors which are responsible for medicalizing health. These factors are located in the lack of co-ordination between the health policies and their implementation by the state.

Our attitude towards development has always been that of aping the west. This has existed for a long time and has persisted with the purpose of maintaining international levels. We have always put forward a political will of maintaining international standards to perpetuate a political standing among the more progressive societies. We have thus forced ourselves to interact at the level of their health needs and have very consciously overlooked our national needs. In doing so, we have failed to give our national needs the first priority. As a result we have not been able to develop a health care system in

response to our actual health needs. This is viewed through the inconsistent health policies and their uncoordinated implementations.

MAINTAINING INTERNATIONAL STANDARDS

The direction that our health care system would take after independence was decided in British India by the Bhore Committee set up by the government. This was an extensive report based on the actual Indian health situation. It had made enough efforts to put forward a clear picture of the existing health scene in India.

It was pointed out in this report that in British India, there prevailed a low level of health as compared to New Zealand and Australia. Thus we started a comparison of the Indian health situation with the affluent countries. The causes of this low level of health was traced in the badly maintained public health. There was the necessity for the fulfilment of certain fundamental conditions, that included in the need for an environment conducive to healthy living adequate nutrition, the availability of health services to all members of the community, and the nature of co-operation of the people in the maintenance of their own health.[2] It, thus, realised that a large amount of preventible suffering and mortality in the country has been due to the inadequacy of provision in the respect of the above mentioned factors.

These were pointed out to be the 'major' drawbacks within the existing health care system in British India, and was the major cause of the low level of health. Next the committee goes on the analyse the "Modern trends in the organisation of a national health service". Here it makes studies of the tendencies apparent in some of the more progressive societies of the world. In its observations it found that, the modern trend was towards the provision by the state, of a complete health service as possible. There was an emphasis on the distribution of "medical" benefits to all, irrespective of their ability to pay for it.[3] The same was to be enforced in the Indian context, knowing well that the health problems that India faced were far different from those faced by these progressive countries of the world.

Nevertheless, medical services were to be made freely available to the people, and the contribution from those who can afford to pay was to be made through the channel of general and local taxation.[4] This idea for the free availability of medical services was taken from Soviet Russia.

For the provision of these medical services there was the need to build a health infra-structure. For this the committee gave some long term and short term programes.

These programes dealth mainly with the building of hospitals and dispensaries and also the primary health centres for the rural areas. It also laid out a chart for a bureaucratic health administration. In this health infra-structure it was suggested to set up a 'ministry' of health at the centre, 'ministries' of health at the provinces and also the setting up of the local area health administration.[5] Thus it was all set to launch an elaborate and bureaucratic healthcare structure for an Independent India, with its 'existing' kind of health problems. We did follow the committee recommendation in this respect, and have bureaucratised our health care system through the centralization of the entire system.

Thus the foundation for a quest for maintaining international standards were laid. The health committees that followed the Bhore Committee also followed suit.

The Bhore Committee with its recommendations for building an infrastructure to a certain extent was justified. This is because, at the time Bhore Committee gave its report India did neither develop its clinical (medical) aspect of the health care system nor the public health. It was therefore necessary to build a health infrastructure, which would include in its structure hospitals and dispensaries for medical aid.

But the later committee reports had laid emphasis on the further expansion of the hospital and dispensaries based health infrastructure. Though it felt that, the preventive and the promotive aspects of health needed more attention, not much attention was given at the level of implementation. Besides its emphasis on the expansion of the existing infrastructure in health care system, the committee's also lay emphasis on the production of the highly trained personnel for running the health care system. This was mainly to maintain international standards in medical education.

PROFESSIONALIZATION FOR INTERNATIONAL STANDARDS

It was felt by the Bhore Committee that the basic doctor was necessary to tackle our health problems. The doing away with the licentiates and the prevalence of only one kind of doctor, i.e. the basic doctor, was to bridge the gap between the urban and the rural medical care systems. So, the basic doctor was to be produced and accordingly the number of medical colleges were increased, but, only to serve the urban population. The rural areas suffered more. This was because the inadequately equipped primary health centres did not take into account the professional interest of the highly trained basic doctor.

It seems in retrospect that the aim to have only one kind of the basic doctor was not to bridge the gap between the rural and urban medical care systems. But it was to do away with the licentiates as their existence could hamper the international recognition of the Indian doctors.[6] Had it been otherwise, then enough attention would have been laid on the development of the P.H.C.'s, according to the standards of the 'basic doctor', so that he had an incentive to go and serve in the rural areas. Thus, here again was an example of the lack of co-ordination between the health committee recommendations and their implementations by the government. This lack of co-ordination has lead to a quantitative growth of the medical care system and qualitatively it has not done much.

The Bhore Committee report had also stressed on the professionalisation of the medical personnel, at all levels, and specifically the doctor. It has dealt with the kind of medical education to be offered to the medical students, in detail. It talks of a five years and six months training for the 'basic doctor'. It also emphasised on making the doctor a social physician. So out of his long period of five years and six months, three months were to be devoted to educating him on preventive medicine.[7] The rest composed of teaching all technical knoweldge in curative medicine based mainly on

diagnosis and pharmacology. This hardly gave the doctor a social orientation. Instead, medical education became more curative and diagnostic in nature. Thus backed with such medical education the doctors skill could not be made use of outside a certain conditioned set up, like in the rural areas.

Yet the production of the basic doctor was necessary, to maintain international standards. This is obvious from the Mudaliar Committee report. In this report, the committee strongly felt that India was no longer isolated in participating in all health problems of international health. The W.H.O. had laid down certain minimum standards of qualifications and since India was an active member of the W.H.O., it was necessary to maintain these standards, the revival of the licentiates, serving the rural areas, was not acceptable,[8] as they did not acquire these minimum qualifications.

The Mudaliar Committee had not only emphasised on the production of the highly skilled doctors for maintaining international standards, but it also made certain suggestions that would widen the already existing gap between the rural and urban medical care systems. It suggested that the work carried out by the less qualified doctors could be carried out by the para-medical personnel, by training different categories of paramedical

personnel. The committee did not realise that these 'categories' of paramedical professionals could only make the rural health services more chaotic. First, the different categories of the para-medical personnel were not clearly distinguished. This could only lead to a bureaucratic confusion, in terms of its functioning. Secondly with their kind of training, it is not advisible, for the para-medical personnel, to administer curative medicine to the rural mass.[9] This example of the recruiting of para-medical personnel for the rural areas is, to point at the deteriorating health services in these areas.

The basic doctor, conditioned better for serving in the urban areas, prefer to settle down finally in these areas. The urban orientation of the medical education was realised in the Srivastava Committee report published in 1975. Here it realised that along with the urban orientation of the medical education, it prepared the doctor to rely more on curative methods and sophisticated diagnostic aides.[10] In the process the role of preventive and promotive medicine in the health care system has been largely overlooked.

Thus the committee felt that the existing system of medical education did not prepare the right type of medical personnel for a national programme of health care. It thus set out to restructure the entire programe of

medical education[11], which we will deal with, later in this chapter.

The Srivastav Committee felt that the role of a doctor should be that of a social physician. Where the work of the physician is not merely with the treatment of sickness and prevention of disease, but also with those social and cultural problems that contribute to the fabric of health.[12]

It was initially suggested, in the Bhore Committee report, to set up separate departments of public and curative health. This was basically for maintaining an efficient functioning of the two aspects of health and a balanced growth of the health care system. It realised that if the two departments were to function separately it would lead to an unnecessary duplication of institutions, personnel and equipment, if reasonable standards for their functioning were to be maintained. It was later left as an option, whether the two departments should continue to work separately or should merge into a single organisation. We opted for the setting up of two different departments of health, but we have not distinguished between the functioning of the two department by maintaining different sets of personnel. Thus the duplication of the personnel was avoided.

A point that we would like to mention here is that the avoiding of simple duplication of personnel was not enough. There was also no attempt made towards the production of public health post graduates, for an efficient and appropriate understanding of the public health situation. Only after this distinction in medical and non medical aspects of health is properly understood, can the health problems be tackled in an organised manner. Our pattern of medical specialization hardly include any public health specialization. What we promote are a whole lot of clinical specialisations as mentioned in the Bhore Committee report.[13]

The fresh medical graduates, too, hardly show much enthusiasm towards specializing in public health. One, basically because of their clinical background at the graduation level, and second, there is not much incentives for them to join these specialisations as they are doubtful about a future in this field. This is because of our poorly developed public health system, which does not receive much attention at the implementation level.

Thus the concern over the inadequate public health in these reports, remain only a concern, a concern that is mentioned because one cannot overlook it completely.

In the Srivastava committee, the departments of preventive and social medicine were regarded as important

for the community orientation of medical education. The teaching of community medicine to them, was to be a joint endeavour and not merely the responsibility of the department of preventive and social medicine.[14] Thus the separate existence of the two departments are regarded only at the structural level and the two are merged together while functioning. There was thus no attempt made towards the systematic functioning of the two departments independently, for the maintenance of the health care system. And the overall effect comes to be inadequate promotion of the public health.

After emphasising on the community orientation of medical education, this committee suggests the continuing education of the doctor. By continuing education this committee means the trainig of the physician, with a view to assist him in maintaining and extending his professional competence throughout his life.[15] This over and again emphasises curative medicine by further strengthening the existing professionalism in medicine. This has overshadowed the role of preventive medicine in health care system. It is not that this professionalism has developed in response to our health needs. They have been developed for the vested interests of the government, to maintain international standards.

PUBLIC HEALTH - A RECENT TREND

In the last health committee report under the chairmanship of Dr. Ramalingaswami it is felt that we need to break away from the existing health care system which is western oriented. But its emphasis on the preventive and promotive medicine is also borrowed from the west, as it is the latest trend in the contemporary western societies.

It has been rightly observed by M. Chatterjee, that in the 1950's, we had a concern for the establishment of an infrastructure and technological development. This consisted mainly of building hospitals, and establishing medical scientific capacity and training doctors. In the 1960's we had an added emphasis on the development of the rural health care. Here we also had certain mass camaigns against certain specific diseases and campaign for family planning programmes. In 1970's our approach was towards certain basic needs which included in it the increasing of the number of trained para-professionals, orientation of doctors towards rural health etc. And currently an emphasis is laid on terms like ' community based ', 'village level','appropriate technology', 'self reliance' and 'integrated development.[16]

Thus, after all these years of emphasis on the curative oriented medical system has turned the health care

system, into a medical care system. The health policies' emphasis on this kind of a system has medicalised health to a large extent. The preventable diseases that were to be taken care of according to the Bhore Committee report, are still prevalent in our country. A fresh example of this is that of the epidemic pattern of Cholera in 'Delhi', in 1988. We have still not been able to do away with the constant existence of malaria, despite the Chadha committee which was set up to plan out a malaria eradication programme. It did give its recommendations and a malaria eradication - programme. But the programme failed at the implementation level.

But, we have come a long way, in our curative aspects of health. We have done well in clinical medicine. We can tackle a lot of sophisticated and complicated diseases without foreign assistance. But we cannot do away with the day to day common diseases that are responsible for the low level of health that we have, compared to the other progressive countries of the world. Why did we not compete with them at that level ?

The concept of community participation had its roots in our ancient history and philosophy, but its current widespread use in the health sector in largely due to the declaration of the World Health Assembly held at Alma Ata U.S.S.R. in 1978. It was defined as the care

which is "universally accessible to individuals and families in the community throughout, their full participation, and at the cost that the community and the country can afford to maintain at every stage of their development in the spirit of self reliance and self determination".[17]

Our latest health committee under the chairmanship of Ramalingaswami has emphasised on this approach of the community orientation of health services. Now what needs to be seen is that with this approach towards our health care system how far can we 'demedicalise' the already medicalised health care system?

Here then we must ask the question, can the expectations that we have, of the people, be met within the existing social, economic and political conditions.[18] It is thus necessary to understand the potential and the nature of the community's participation in the context of a specific society (rural or urban).

The mere mentioning of the community participation in health is not enough. The nature of the community participation can be of various kinds. It could be an effort on the part of the people of a community to avail of the medical services provided to them. The community participation can also involve certain representatives from among the people to formulate

a health programme, which is usually done by outsiders.[19] What is actually needed is that people are made to realise their health problems, needs and priorities, so that the health programe be made relevant. Instead of these arising out of the predilections of the health planners, if the programmes are based on local felt needs as realised by the people themselves, then these health programme can be used more effectively and will be more satisfying for the people.[20]

Thus the community participation in health care can progress from receiving to contributing, advising, decision making, initiating, implementing, controlling and supporting health programmes.

This way of increasing the responsibility of the people, towards health care for the people can, to a certain extent, help in bringing down the degree of medicalisation of health. This can only happen when the people's understanding of good health services move away from the concept of 'making medical services available to all irrespective of their ability to pay for it'. The existing attitude towards health has only lead to an over-consumption of the medical services by medicalising it. There is therefore a need to break away from this orientation towards individual health and more emphasis be laid on the maintenance of public health. To understand

and feel the actual health problems that affect the people it is of urgent need to educate the people in public health through health education.

DRUG INDUSTRY

There is yet another side to our health policies that medicalises health. It is the drug industries which have received a lot of encouragement from our health policy makers. Manufacture of drugs in our country has over-stepped certain limits, and there is an urgent need to revise our drug policies to bring down medicalisation at this level.

The ICMR and the ICSSR joint report noted an outstanding feature of the modern health services all over the world. Drugs which were earlier a small appendage to the health services have now become almost central to their existence. This is partly due to the tremendous energy and propoganda capacity of a profit motivated drug industry.[21] In India we have a steong pharmaceutical manufacturing industry capable of manufacturing nearly all the drugs needs in the country. We also have adequate number of well trained scientists, doctors and engineers to ensure the proper production and distribution and the use of these drugs.[22] Despite this fact we are faced with too many problems relating to the drugs and pharmaceuticals scene in India.

The first striking fact is that we have too many drugs on the Indian market today. Among these, many are substandard or spurious drugs which are sold openly in the market, sometimes even without prescriptions. Then we are also faced with the doctors tendency to over prescribe drugs. This leads to not only the wide spread use of drugs but also the use of unnecessary drugs that are not needed.[23]

We are faced with a drug chaos. Viewing the way of entire system has grown over the years it is un-realistic to expect that the recommendations put forward by the Hathi Committee can bring order in this chaotic drug system.

Due to the vested interests of the pharmaceuticals the drug production pattern is more profit oriented than national needs based. Where the majority of the population suffers from diseases like leprosy, tuberculosis and malaria, the drugs for these diseases are in short supply. Moreover, those extensively marketed for this purpose are more expensive ones.[24] One drug market is flooded with items such as tonics and vitamins of high quality which only the affluent class, that forms a very small minority, can afford.

It is necessary to identify a limited number of drugs with proven effectiveness and quality, and their

availability at reasonable as well as affordable costs. This would be a significant step in promoting basic health in developing countries. This is the direct approach for limiting the spread of unnecessary drugs. The W.H.O. list for essential drugs was based on this concept.[25]

The W.H.O. action programme for essential drugs had drawn up guidelines for rational drug policies, which are therapeutically and medically sound and economically, most appropriate. A whole hearted support was extended to the other W.H.O. programmes but a similar support was not extended in this case. This was mainly because of the fact that most of these drugs were manufactured by the multinational companies or their collaborators. And the government could not afford to displease them for political reasons.

This attitude of the government towards the multi-nationals is most evident from its response towards the Hathi Committee recommendations on the nationalization of the drug industry and the taking over of the multi-national drug industries. The Hathi Committee's recommendation was mainly to blunt the potentiality of the foreign companies to exploit their names and smother the development of the Indian sector.[26]

The government was most reluctant to accept the Hathi Committee recommendations. Because of the Indian

governments dependence of foreign aid and investment. It could not act against the multinationals because the government had to depend on them for the supply of a major part of the fourth plan investment, which was around Rs.240 crores. The public health sector could provide only upto Rs.4.3 crores.[27] This suggests that the government did not plan a pre-eminant role for the public sector. The multinationals were willing to make a major share of investment of bulk drugs. They could foresee a possibility for enlarging control in formulations by investing in bulk drugs. The government too did not have to pay any compensation because there was no nationalization of drug industry. Otherwise the compensation could have been between Rs.140 to Rs.400 crores, officially and non-officially. In the ultimate analysis these factors weighed in favour of retaining the multinationals.[28] Thus the monopoly of multinationals still continues.

Drug policy which is an important component of the health policy, has always favoured the multinatioonals. They control a large share of the drug market. It has been inhibitory to small scale entrepreneurship and the public sector.[29]

The Hathi committee noted, that the multinationals had built up large reserves inspite of their insignificant

initial investment. They had mainly done so through the business of formulations.[30] These companies produced nearly 80% of the formulations as against 12% of the bulk production. They preferred formulations because every rupee worth of bulk drugs was Rs. three in formulations, so the company could recover the entire invested capital in three to four years.[29] The Indian drug industry could not compete against these products in quality. Thus the multinationals found market for their formulations and products in India. Their interest was mainly in profits and not satisfying the needs of the Indian people at large. With the encouragement from the government it continues its monopoly in the Indian drug market, thus blocking the scope for self reliance of the Indian drug industry.

STATE MEDICALISES HEALTH

The Indian state intervenes into matters of health because it is a welfare state. Normally a welfare state is linked with planning. The state planning and welfare is done through its policies for the people.

Health too, in this case is responsibility of the state. The aim of the state is to control. Thus the policies framed cannot be detached from a political ideology.

We have observed that the health committees in India have found the roots of major health problems in public health, but implementations have taken place more along the curative health. The development of the elaborate bureaucratic health structure has been done mainly with the political will of maintaining standards among the industrialised countries.

The State has promoted medicalisation of health by strengthening the medical care system, by making medical services available to the people irrespective of their ability to pay for it. This has lead to an over consumption of the medical aid, which becomes the first priorith of the people, since it is also the major emphasis of the government. People are unaware of their basic health problems that actually lay in inadequate public health.

The widely available curative services in the public and the private sectors are made use of largely by the people. With the government's present policy of including the private sectors in achieving certain health targets only shows the inadequacy of the public sector. IN the process it ends us strengthening the further spread of the curative medicine. This has left the people, as mere consumers of the medical aid which is increasingly made available to them through different channels.

The state has also professionalised health through its over-emphasis on the production of the highly trained doctors. The fact that it makes available to this small group certain technical skills in medicine, this knowledge to a large extent becomes esoteric. This knoweldge is used by the doctors to their advantage for academic and economic gains. The, autonomy and monopoly, the state, offers to these doctors while delevering health care put them in a better position to control the health of the people. It is became of the medical education, that the physician acquire, which they use deploy control.

Similarly in the case of the pharmaceuticals, the governments hesitation towards nationalising the drug industry had made lots of unnecessary drugs available in the market. These drugs are 'often harmful to health and access to these are not difficult as they are sold openly, over the counter and without prescription from a registered doctor. This is encouraged by the government by housing the multinationals who produce numerous formulations for unwanted drugs. This is again done with the vested political interests of the government.

Thus the role of the state can be seen in promoting medicalisation through the three factors, mentioned in the previous chapter. One by increasing consumerism

through the spread of curative medicines, two, through the increasing professionalization in medicine, by promoting higher medical education to maintain international standard which cannot be applied fully to satisfy its national needs. Three, through the promotion of the pharmaceutical's profit oriented production that hardly match the national needs.

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CHAPTER - V

Conclusion

Medicine in India has changed over a very long period of time. This change has been from folk medicine, which forms a part of our social culture to a scientific one, which is more universal in nature.

Modern medicine is scientific medicine. The progress and the development of this medicine in India is due to our colonial rulers, who had introduced it in India.

The modern medicine developed under industrial society. The effectiveness of this medicine worked to the advantage of the industrialists, for benefits in industrial production. With the spread and development of this medicine, its effectiveness mystifies the ordinary people. This effectiveness of modern medicine, leads to its acceptance by various people in the different areas and belonging to different social classes.

The introduction of the modern medicine in India took place under British imperialism. It was introduced by the Britishers, mainly to look after the health of the military forces, who were suffering under the Indian climate. Thus to maintain the good health of the army it was necessary to take to the allopathic system.

India at that time was suffering from epidemics and other communicable diseases which could not be controlled by the indigenous systems of medicine. The Allopathic system had the capability to curb these diseases through its medical formulations, which were based on more scientific principles. Although the effectiveness of this system could not be denied, people preferred the indigenous systems, on which they had more faith as it was closer to their culture.

With the establishment of modern medicine in India the indigenous systems were pushed down, due to colonial politics. However, there was not much resistance put up, against the establishment of modern medicine, by the people. Though a group of indigenous partitioners resisted the imposition of the western system of medicine, they did not achieve much success. Even the efforts made by, a few, to integrate the indigenous and the western systems did not succeed. The Indian government clearly supported the western model. So the status of the indigenous system of medicine and their practitioners could not be retained. It was partly because of the policy of the state that the indigenous systems were branded as unscientific and its practitioners as quacks. Modern medicine had its victory and today even after independence it still continues to rule India's health services systems.

Modern medicine is characterised as scientific because it came up at the time of the reformation movement in Europe. The scientific thinking in medicine begins from here. The impact, that the social conditions, had on this trend in medicine, has to be accepted. However, the nature of medicine will always be determined by the social factors that exist in a particular society. It will be conditioned by the over all social culture of the society.

Contemporary societies are characterised by industrialism which fosters a technological culture. Industrialisation has brought about a technological revolution in contemporary societies where the role of technology is associated with development and progress of science.

Modern medicine too is characterised by technological determinism. Medicine has made great advancement in accumulating medical knowledge. Most of these advancements relate to new technologies in diagnostic and curative medicine. This has changed medical practice which depends on technology use. Medical practice without the aid of certain basic technologies is regarded as impossible. This direction medical development has overloaded the medical system with an infra-structure with the latest medical technology.

Undoubtedly we have progressed, when it comes to

scientific achievements, through the acquisitions of the various medical technologies beginning from the common day -to-day drugs to the installing of the latest technologies. But these do not meet our health needs. We seem to have blindly aped the west by taking to the western model. We have gone for higher technologies in our anxiety for maintaining international standards. But, we have not shown a similar anxiety for maintaining the health standards, at the level of mortality and nutrition. This has lead to a disproportionate growth of the health care services.

We cannot deny the technological determinism in the modern medical care system. The dependence of the entire health care system on this medical care system also cannot be denied. These are inescapable and 'inevitable' under industrialism. They signify development and progress.

Now the question is who are the people who utilize these technological developments. The answer to this will depend a lot on the accessibility and availability factors.

It is observed that the use of medical technologies are more popular in the urban areas. This is evident from the distribution of the medical benefits which are better and more easily accessible in these areas. This is largely because industrial urbanization parallels

modernization and these features will be more synonymous with the modern culture.

A different picture of the 'availability' and 'access - ability' patters will emerge in the rural areas, which parallels the traditional culture. It is in these areas that a major proportion of our population resides and it is in these areas that health care is most need and should be delivered with utmost care. But we lack of good health care system here, both in curative medicine and preventive medicine. More than peoples resistance to modern medicine, it is the bad condition and the inadequately equipped health centres that make it impossible for the highly professional doctors to work here.

This is largely because of the government's attitude towards rural development. Inspite of knowing well, that the public health in these areas need more attention, because the disease pattern consists of diseases due to the badly maintained public health, the government still emphasises on setting up primary health centres and dispensaries for curative purposes. Moreover these small units of health services can hardly look after such a large population, specially when they are inadequately equipped.

The curative and urban oriented medical care has over-emphasised the health of a small group belonging to the

urban areas. So the impact of the expenditure on health by the government is more visible in the urban areas. Here we will find a health care system which is flooded with various hospitals and dispensaries, in both the public and the private sector.

Public sector hospitals and dispensaries are over-crowded with people, mostly belonging to the, middle lower socio-economic group. These people are treated free of cost in these hospitals. Therefore, seeking medical aid is not expensive in terms of money. These people often tend to misuse this free availability of medical services by indulging in unnecessary physical check ups and laboratory tests.

On the other hand, the private hospitals and clinics are visited by comparatively affluent people, who can afford to pay for their treatment. Here the patient often behaves as a customer and demands a particular kind of treatment, that will satisfy him. At times the doctor may have no choice but give in to these demands made by his patients; who after all pay him for the services rendered by him.

Irrespective of the fact whether it is the 'public' or the 'private' sector it is sure that people do avail of the services made available to them. This continued

dependence on the clinical medicine has lead to the medicalisation of health in the urban areas, which is gradually reaching the rural areas through various channels.

A lot of medicalisation takes place because of the patients role as a consumer. The patient is often aware of what he wants from the doctor. The patients have shown a tendence of gulping pills or taking to injections, or going in for unnecessary laboratory tests and x-rays out of their own will and decision. The individual is the decision maker, in choosing the kind of treatment he wants and aslo tends to "shop around for doctors" to satisfy himself.

Here the role of the pharmaceuticals is of great importance. The pharmaceutical companies often use the media to popularise their products. Through its advertisements, it gives certain tips as to when to use a particular product. These advertisements help the patients to identify their symptoms in times of bad health and take to these medicines or demand them of their doctors when these are not available without prescriptions. This has lead to the encapsulation of medicine, which clearly defines the disease.

The doctors prescription habits are to a certain extent dictated by his patients If one doctor does not

satisfy their demands, there is always an-other doctor available who will satisfy them. So with the fear of losing clients most doctors will prescribe to satisfy the patient because this will be to his advantage at least in terms of monetary gains. Thus the doctors will indulge in commercialised services.

Doctors prescriptions are also conditioned by the representatives of pharmaceutical companies. These representatives furnish the doctor with booklets that inform the doctor of the latest medical technology and its use. These aslo include the products of the pharmaceutical companies. This physician pharmaceutical nexus around which the medical care system revolves is very popular and play an important role in medicallising life.

The professionals role is important to understand the medicalisation process because the professionals form the medium between the two groups, one, of the producers of the items of medicalization and two, the consumers of these items of medicalization. One is the medicalising group i.e. the pharmaceuticals and the second is the medicalised group i.e. the consumer. The role of the physician is most important in medicalization because it is the medium which acts either as a buffer or as a catalyst. Most of the time, because of the doctors over-professionalization, he has acts as a catalyst and rarely as buffer.

A system that rewards technology use with both profits and prestige, the physicians have every reason to use technology. Development of specialists has also affected technology use greatly. Specialisations have developed in response to professional, technological and economic interests in the past and is most likely to be responsive to such forces in the future.

There are a lot of malpractices that encourages the unnecessary use of technologies as skull x-rays, electronics featal monitoring, cesaran sections and clinical laboratory testing. An over emphasis on technology and a corresponding decrease in human concern on the part of the physician can dehumanise medical practice.

Thus the nature and style of medical practice by the physician is of great importance. It is the authority, monopoly, and autonomy the physician enjoys while taking decisions in medical practice that is of importance. The legitimacy to this kind of practice is channelised through the medical associations. The prestige and the social status that the physician enjoys is also thus decided by them. The medical associations are hostile towards state intervention in matters of clinical decisions. Their autonomy feels threatened when such an intervention takes place. It is the responsibility of the state to maintain

certain checks regarding the malpractices in medical

certain checks regarding the malpractices in medical care. But state often cannot pay much attention on making these checks, because of the medical associations who contorl medical practice.

The role of the state is central in making decisions for any national programmes, accroding to the needs of the people. The state takes the responsibility of its people for their welfare, even in health care. But our health policies has not favoured the fulfilment of certain major national needs. It has first sought to maintain certain international standards for political purpose and maintaining good relations with the other western countries. In the process, it has played the major role in medicalising health by legitimising the dependence on the medical care system and the medical technology. This overemphasis on the development of the medical technology and its utilization has swayed the health care system more towards the medical care system.

The medicalization is an 'inevitable' and 'inescapable' feature in industrialised countries has been mentioned before. Technological development is assumed to be associated with progress, the more technological developments that a society can exhibit, the more developed it is thought to be.

Greater the acquisition in this field, the stronger becomes ones position in the developed world. Thus there will be an increase in the dependence on the medical technology for better medical aid and the over all health care system. This will 'medicalise' health.

Technology till now has only emphasised more on curative health. It is widely felt that this emphasis should be reduced and attention should be diverted towards Public health. How will the public health be tackled under the given social and political conditions?

For public health too, we will need some technology. We need to use technologies of various kinds to solve the problems in public health. For eg. malaria is a common disease in India, which occurrs due to the mosquitos that surround unhygenic areas, mostly dirty pools of water. To prevent the occurance of malaria, either the individual is asked to take 'quinine' available under various names, or the place is sprayed with chemicals of the 'D.D.T.' group or both. This is just an example of preventive health, where we make use of technology at two levels, at the individual level, where the individual gulps pills to prevent the occurance of the disease and at the environmental level, where we make the use of D.D.T. compounds to prevent the occurance of the disease. Under industrialization and the

present technological determinism the dependence on technology for good public health is thus exhibited and may increase increase in the future. Reverting back to a dependence on nature, for health, will then mean going backwards in development.

The practice of the indigenous practitioners under industrialization has also got commercialised. Therefore, taking to these indigenous medical practices can not automatically 'demedicalise' the already 'medicalised' health care system.

It is not that medicine by itself medicalises life, it is the practice of medicine that is important. The practice of medicine will vary from society to society depending on what aspect of health is given more importance. This decision of the important to be given to the health care system will lay in the hands of the state. The choice of medicine and the personnel's administering these services will also be decided by the state.

Our state's stand for the choice of a particular type of health care system reflects a political will of maintaining the international standards. But if our state follows a particular path showed to it, then it should make sure that the other conditions necessary for its successful implementation should also be there. It is the nations responsibility to improve the quality of life and raise the

standard of its people. This is possible through political will, socio-economic development, use of suitable technology and formulation of a national strategy to achieve the national targets and priorities. But in our case it is not so.

With this dependence on technology, the approach towards health is like a social pathology and it has to be ascertained where the commitment lies. The maladies of Poverty, lack of basic amenities like housing, environmental sanitation safe drinking water etc. have all continued to add to the widening gaps between the health needs of the people and the available resources and facilities.

Our medicalization has not raised the health of our society, because we still suffer from the same old preventible diseases. If medicalisation took place in the western countries it was out of felt needs because of their kind of disease pattern, but we have got 'medicalised' by imitation.

It is difficult to say whether a demedicalisation is possible under these circumstances, given the social and political conditions. With the emphasis on public health, in recent times, there is a possibility to 'medicalise' public health, it may help raise the health level of a large number of our population in the rural areas.

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