TOWARDS A CRITICAL MEDICAL PRACTICE: SOME THOUGHTS REGARDING UNIVERSAL ACCESS TO HEALTH CARE

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What does it mean to look at health and health care from the perspective of contemporary political theory?[1] In this paper, I would like to explore this question for the MFC community.

When the CMC Anveshi Collective began we were strongly aware that there were several impasses in medicine and health care in India, but were unclear about precisely what they were. It was that sense of vague urgency that drove us to focus on the range of essays in *Towards a Critical Medical Practice* (Eds., Anand Zachariah, R. Srivatsan and Susie Tharu. Hyderabad: Orient Blackswan, 2010, henceforth TCMP). As we wrote the introduction, we settled on two paradigm cases to illustrate the crisis – one, Hina Begum, who lived in Hyderabad old city, and was chronically ill, overworked, underfed, weighed down by a welter of family problems, working as a house servant for a living. It dawned on us that there was no disease category her symptoms pointed to, and therefore no legitimate medical cure for her malaise except the 'quackery' of a 'glucose chadhao' (intravenous glucose) when her energy levels fell. She represented the condition of a large number of women in different parts of the country whose lives were trammeled by chronic, medically invisible morbidity. That was one limit of medicine, as we knew it in India. The other case, Mr. B a retired schoolteacher, went all the way to CMC Vellore from Bihar with a complaint of worsening cough and weakness. Clinical examination and a history of smoking indicated the possibility of cancer, but the doctors put him through a battery of tests none of which conclusively pointed to a specific cause. Meanwhile he deteriorated, was put on the ventilator and, a short while and 40,000 rupees later, died alone in the intensive care unit. Post-mortem examination revealed extensive spread of a rare form of lung cancer, bronchoalveolar carcinoma. Why did Mr. B travel have to travel to Vellore from West Bengal? What is the meaning of this kind of

[1] This paper draws on many of the insights gained in collaborating on the Introduction to *Towards a Critical Medical Practice*, in writing the paper on "Development and the administration of public health", and in thinking about the different essays as part of the collaborative effort to edit the papers in the volume.

health seeking behavior and what dissatisfaction does it indicate? The doctors put him through various evidence-based protocols of investigations and treatment, which were ultimately futile. The cost would have depleted his family savings. Does this indicate a decreased confidence of medical professionals in their clinical skills? Had his local GP counseled him regarding the possibility of incurable cancer, would he have chosen to die at home in the presence of family and friends? What is the culture of medicine that produced this forlorn end? This was the other the limit of modern medicine that was visible to us. Both these cases are described in the first part of the introduction to the volume, as *symptoms* of the crisis of medicine in India.

With Hina Begum the question is why this cluster of morbid symptoms is not visible as a widespread problem that needs systematic solution. Behind this is the question: why is there no research initiative that can determine and work on a health problem that is specific to India?

Mr. B illustrates that even with the best clinical traditions and medical ethics in a premier hospital, there is a lack of confidence in clinical competence. There is in addition a curious weakness of ongoing effort to assess the most effective and economic course of action in the circumstances of the patient. Both the patient and doctor are steeped in the culture of tertiary care determined by biomedical science.

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When we began working as a collective to write TCMP, we were struck by the difference in perspective between the social scientists and the doctors. Doctors are generally trained to diagnose and cure diseases, i.e., solve health problems, while social scientists and cultural theorists tend to think about structure and dynamics, without necessarily proposing solutions or cures. Medical activists are also in a different way, directed thinkers who engage with specific problems in medicine and 'medical politics'. In medical practice and in activism, the manner of thinking is convergent, arriving at a task to be performed. The stress in this paper is not on doing something or finding a solution to a problem of health and health care, but on understanding the scope, shape and size of that problem, indicated for us by Hina Begum and Mr. B. The purpose is to

provide medical and activist practice a long-range view of the changing medical terrain using theoretical and historical insights and perspectives that come from contemporary cultural studies and recent trends in the social sciences. It is to understand this terrain in our current moment—i.e., the configuration of neoliberal economics and the promise of universal health care.

The questions I will address are:

1. What is the political and economic terrain health care is situated on and what are the constraints this terrain poses for a politics of health?

2. What is the historical context of 'our' approach, as doctors and medical practitioners to health care when seen against this terrain?

3. How do these affect the status and condition of patients and others who require health care? Indeed it is from the vantage point of a patient's need for a cure to ailments that put them out of a day's work that this paper is organized. The importance of this daily basis arises from the dominance of daily wages in this era of informal work. At the same time, the problem of the patient in the current terrain of medicine, as I will argue, is goes beyond cost, to risk and survival.

The terrain of neoliberal health care in contemporary India

If we look at health care policy today (and we have a good opportunity to, given the involvement of some of us in discussions of the 12th Plan) we see that it is determined by the Planning Commission and medical experts, and is influenced by the medical and pharmaceutical industry, corporate hospitals and the insurance business. Some such combination of expertise, business, policy and finance is at the root of most of the enterprises that we encounter and live with in our world today. The first specific difference in health care is that the effective point of application of health care policy, business and science is a person's body, touching on her suffering, ability to live, work, earn and support a family. I will explore some of the implications of this in the last section of this paper.

The second difference is that, while most enterprises justify their ventures in terms of profitability (predicated on their usefulness to society), medicine does so in the name of the latest science. Whatever the level of medical care on offer, either to cure an individual patient or to immunize or protect a population against a disease to which they are susceptible, it is justified as the most advanced knowledge in the field. E.g., in immunization, whether it is oral polio vaccine, human papilloma virus vaccine, or HiB vaccine, scientific knowledge determines what needs to be prevented, technology determines the method, and statistical/epidemiological studies, the target population. In advanced therapeutic care under insurance like the Arogyasri programme of Andhra Pradesh, health care is determined by specialists in corporate hospitals and the insurance business in collaboration with policy makers, such that the most advanced biomedical procedures are offered to the poorest patients. So to stress the two points:

1. The decision on what is necessary for health care is beyond the ken of the ordinary user; such a decision is taken today by government, industry and expert.

2. The therapeutic or prophylactic solution to any health problem is decided according to the norms of the best biomedical science.

One criticism of the current configuration of medical care in neoliberal India proposes that we must go back to a state run health care system. The reasoning is that private industry's profit motive corrupts medicine's duty to the patient. This is seen as the cause of catastrophic expenditure and lack of access in India. In contrast to this, critics argue, the state run health care system will be more equitable, effective and economical. Thus more government hospitals must be built, the system tightened, doctors must be made to work anywhere they are asked to, so that good health care is provided everywhere in the country. However, when we look at state run medical care after 1950 what do we see? We see a primary health care system that runs powerfully funded, centrally coordinated immunization and family planning programmes. The Centre gradually relegates to the state governments curative care for illnesses experienced by people on a day-to-day basis. Beleaguered by economic, organizational and motivational problems, the state administration relinquishes curative care to the

private practitioners and nursing home businesses that begin to appear. Except for immunization and eradication programmes to tackle intractable diseases like tuberculosis and leprosy, the need for everyday medical care remains unaddressed in most places except in metropolitan centres. Thus from the 1960s the government focuses on public health measures that improve national health statistics in the eyes of the international health fraternity and leaves clinical services to private industry.

Veena Shatrugna's paper on nutrition in TCMP emphasizes another problem with governmental policy thinking. Food policy systematically seeks out the most economical solution to the problem of food, cutting scientific corners with respect to health and resistance to infectious and chronic diseases. There is a remarkable blindness with which upper-caste administrators find economic solutions that override the diverse cultural and nutritional wisdom of many different communities. Similarly, the system of vertically implemented immunization and eradication programmes in India reflects an economistic, reductionist, utilitarian and caste-culturally distanced mode of thinking about public health.

One of the key arguments in our book is that the history of governmental health care in India has left us without a viable, effective system of curing people of diseases that immediately cut into their daily wage.

Given the changed economic scenario after the 1990s, and the increased money available for state expenditure, would a better-funded health care programme result in a more equitable and effective system than in the 1950s-80s? The proposals for Universal Access to Health Care (UAHC) being discussed in the approach to the Twelfth Plan answer in the affirmative. To come round a full circle, these proposals are driven by governmental policy, public private partnerships, market investment in health, expert opinion and scientific knowledge. Thus the orientation, logic and thrust in the first three decades of state run medical care are historical predecessors to the proposals for today. As I will argue in some detail, there seems to be little reason to expect that a combination of vertical preventive programmes and advanced tertiary clinical services will solve problems of the kind represented by either Hina Begum or Mr. B. In what follows, I will address the best-case scenario of free universal access to health care. To put it more

clearly, UAHC as envisaged will not result in initiatives to focus on diseases and syndromes specific to our condition and it will certainly not put a brake on excessive medical technology and laboratory testing. The fundamental problem of medicine's orientation is not addressed by universal access.

Why cannot more scientific medicine and better governmental policy, even if offered free of cost to India's population, provide an answer to a patient's health care problems?

Government and health care in the West – implications for India

Recent historical studies have shown that medical science has, from its inception in Modern Europe through the eighteenth and nineteenth centuries, arisen in close relationship to the science and techniques of government. In our Introduction to *TCMP*, we refer to the studies pioneered by Michel Foucault, which argue a rather startling proposition: the modern science of government developed through the growth of early modern medical technology. Society defended itself and its health from the risk of annihilation by diseases like the Black Death and leprosy, through the refinement of the techniques of early modern medicine. The administration of care to a 'sub-normal' population (the unemployed, the poor, the mad, those afflicted with leprosy, those suffering from a plague epidemic, etc.) provided a series of experimental sites in general administration. Society learned to discipline and govern its population to a considerable extent through its experience in administering medical care to control morbidity, epidemics and mortality, (and idle malingering). The technology of public health and the science of clinical medicine both grow in this symbiotic relationship with administrative practice in the nineteenth and early twentieth centuries.

If we move 'fast forward' to the middle of the twentieth century, when this interrelated configuration of government and medicine has to cope with the aftermath of World War Two, another mutation takes place in that relationship, first in Great Britain, followed by other European countries. There was a unanimous political concern across the spectrum of the ruling elite to boost the sagging morale of the people through the introduction of social security. This crystallized in the Beveridge proposals that formed

the basis of the welfare state, and within it, the first system of universal access to health care, i.e., the National Health Service (NHS). Thus, a broad network of governmental health care with its specific emphasis on medical practice, education and research replaced the private practitioner. In hindsight, if we remember the Keynesian mood of intervention to lift the economy out of the Great Depression, it seems clear that the other implicit aim of these policy directions was to drive the health care industry as a macroeconomic stimulus to the weak post-war economy. The NHS succeeds brilliantly. However, Foucault observes that by the 1970s, despite the NHS being conceived as the administration of 'a right to health', a curious stagnation takes place: instead of people becoming healthier as a result of good quality care, they become passive consumers of health in a medical industry that thrives on their problems.

What does this historical relationship between medicine and government imply for us?

One, it implies that modern medicine is governmental in its structure and its perspectives and priorities are determined by statist concerns. This is built into the structure of medical knowledge (statistical reasoning, epidemiology, determination of effectiveness based on population studies as in EBM), through its historical relationship with the sciences of the state. The problems it chooses to address and the methods it adopts to address them have evolved in response to the needs of government.

Two, whatever personal concern doctors have for patients (and we may rest assured that even this personal concern has a political history in the freedom movement), they are trained in a state controlled academic discipline of medical care, governed by institutions (e.g., the MCI) which jealously guard the scientific standards of medicine through out the modern and modernizing world. The concern of the doctor for the individual patient is always expressed through the scientific perspective of the risks and consequences of disease to the governed population and to society as a whole. Biomedical curative strategies are given overwhelming legitimacy in doctors' minds by institutionalized research criteria. Doctors administer medicine in a governmental mode. This is a systematic effect of scientific medical knowledge and disciplinary training. The implication of this is that there seems to be very little hope for a fresh perspective within

medical science on what is necessary for health care in our context as presented by patients on a day-to-day basis.

Three, medicine, unlike theoretical physics or mathematics, is not pure, unsullied by practical concerns – it is from its modern inception, a science that is deeply embedded in politics, economics and administration. Therefore, the claim that biomedical science provides the most scientifically advanced cures of disease is partly an ideological cover to push solutions to research problems that are determined within a framework specified by policy and investment. Governmental science policy (of typically a Western country) on the one hand and corporate medical industry on the other, find different historical routes to sponsor a problem for research (e.g., unhealthy lipid profiles). Business invests in a medical strategy (Statins, to continue the previous example) to solve this problem for society. The norms of medical strategy (lipid level norms), especially those established by tertiary level care and specialty medicine today, are thus fully infused with the logic of policy and multi-billion dollar business interests. Under these conditions, the jealous guarding of the scientific norms and legitimacy of biomedical science becomes a cover for the monopolistic implementation of a specific business driven solution to a problem configured by governmental needs. Given this, there is no reason why biomedical solutions found with these specific constraints should be the best ones in all the contexts in which it will be applied. One of the impasses of medicine in India today is that we do not have strong criteria for medical research strategies for common illnesses in our country and for treatment approaches that are sensitive to cost and the individual context of the patient, while we have imported specialties that have limited utility and high cost.

Four, the birth of specialty medicine (cardiology, neurology, endocrinology, pulmonology, etc.) occurs in this historical context after 1950. We argue in the introduction to *TCMP* that when medical care and research begin to answer to the state's needs and has macroeconomic implications that touch 9-14 percent of the nation-state's budget, the scale, scope and cost of the solutions for medical problems go beyond the reach of the individual patient. There also occurs post 1950, the tertiary care formatting of medical knowledge. Clinical care and treatments guidelines are defined in the mode of technology intensive tertiary care medicine in the context of universal health care. When

these solutions to medical problems find their way to the Third World they are beyond governmental budgets too. This (as the technological horizon within which the privatized corporate hospital comes into being) is the fundamental reason why we have 'catastrophic out of pocket expenditure' in India. Any treatment that is defined for primary or secondary care for the Indian setting would be regarded as inferior to the gold standard of tertiary care.

Thus, we argue in the Introduction to *TCMP* that medical science and governmental policy as we know them are not promising candidates to find solutions to our medical problems. The difficulty is that medicine as it is structured today is responsible more to the state and its indicators of health, business needs, and the guidelines of scientific practice. It is not geared to address responsibly, effectively and economically the need and interest of a patient who approaches it with a problem.

However, if and when we begin to implement UAHC, and if by good fortune and excellent government the individual patient would not have to pay anything, why worry? And after all, given the abysmal level of health care, shouldn't anything more only be good?

The location of the patient under the horizon of Universal Access to Health Care in India

I have argued in the previous section that medicine does not respond to the patient's needs – it answers another call. How does this appear from the patient's perspective?

A critical insight that emerges in *TCMP* is that a majority of patients who come for treatment of their diseases are 'intractable'; i.e. they are disinclined to follow the regimen required for the cure of an illness. This intractability, Lakshmi Kutty argues in her essay is because medical science does not address the context which constitutes the lived background of disease in the patient. As Hina Begum's case shows, this intractability is often due to a lack of congruence or commensurability between what the patient needs and what is offered her.

Anand Zachariah argues in his discussion of organophosphate poisoning and on ischaemic heart disease that an alienness of context arises because a solution designed for a typical western patient with specific cultural concerns, is transplanted to an Indian patient with entirely different constraints, concerns and indeed a different culture of illness and healing. There is thus a mismatch between how medical care imagines the model patient, and what the patient needs and can handle. This is a mismatch between medical knowledge and the illness context. Zachariah goes on to argue that the disease category has to be developed appropriately for the local context, e.g., suicide or IHD in India are different from the same disease in the Western setting. How does one develop a contextual or local knowledge of medicine appropriate to the local setting?

Another critical insight is that this intractability is not simply due to the difference between medicine's idealized model of the patient and the context most of the users of medical care come from in India. This mismatch is also to a large measure due to modern medicine's biomedical structure and scientific orientation. This leads to, what Vasanta Duggirala suggests in her collaborative essay in *TCMP* is, a 'medical text' of a disease that has no place for a patient's experience of illness. Medical knowledge has no register in which to integrate the patient's perspective of the illness, which is always to be read as a surface phenomenon. The medical practitioner has to cope with this surface phenomenon as part of the mundane task of medical care, while performing the real task, i.e., the scientific treatment of the disease.

From another vantage point, Susie Tharu, in her paper also harks to the anxiety, the lack of confidence and the hazard of taking a trip to the hospital in the twenty first century where the patient is never sure that her doctor has her interests in view. She proposes that this helplessness, which marks the patient's location (rich or poor), is rooted in a confrontation with modern medicine's fundamental governmental structure, business alignment, scientific orientation and a common unilateral, top-down approach to both the public health and clinical care.

The last symptom of the difficulty I will point to here is what the World Bank (and liberal economics in general) recognizes as the lack of knowledge/ information access and the consequent imperfection in the market within which the patient seeks a

cure. Chinu Srinivasan in his paper on the pharmaceutical industry describes how one expert, the doctor, prescribes a medical solution from another expert, i.e. the pharmaceutical or medical industry, without the patient having any knowledge or control over the medical transaction. The World Bank in its *Investing in Health* (1993) report proposes that this information inequality should be redressed by government hospitals putting up prices of specific packages to control costs of privatized clinical services. However, there are deeper implications to this market imperfection with several long-range consequences.

Firstly, there is the risk of the medical encounter: the patient is exposing her body, livelihood and life an action that she has no knowledge or control of. This lack of control is exacerbated by a complete absence of a family doctor who would help the patient mediate, assess the efficacy of, decide on, prepare for, and control the consequent risks of the intervention.

Secondly, the governmental baseline pricing of packages will not address the major part of the problem. As I have argued, in the neoliberal environment, with the emphasis on public private partnership frameworks, goals and targets of success, there is little assurance that the implementation mechanism will keep the patient's interests primary. The danger is that the Indian government is looking at ways to force-feed economic growth through opening the medical industry and hospital to large scale investment – the implications of this will become evident when we see that a policy of universal access to health care could over the next ten or twenty years, lead to a medical sector that will be any where up to 15% of the national income. Indeed, the government and its advisers are on record saying that if the first boost to economic growth came from the services sector and the IT industry, the second great spurt of growth would come from medical care.

What are the implications of a patient location in this terrain?

Undefined Medicalization/Invisible Morbidity: When government and business come together to decide health policy, one danger is that there will be no protocols that determine what is or is not a health problem. For example, is lack of food a health

problem that is to be solved by provision of industrially packaged nutritive mixes, or is it a problem of impoverishment that is to be solved by providing access to healthy food? Or, is the threshold of blood glucose, blood pressure or lipid profile to be reduced by 10 units in order to make it a healthier body or to increase drug sales so as to profit pharma? What actually is a healthier body? And the mirroring question, what is an important disease that needs to be tackled? Who decides? One problem here is economic—what is the best way to spend tax money to achieve the well being of Indians? The deeper question is what is a priority as a health problem? What is not? Undefined medicalization and invisible morbidity are the two poles of mismatch between medicine offered and needed.

Medical hazard and iatrogenic morbidity: The 'discovery' of new diseases, the finding of new health risks, and the introduction of tighter thresholds to known health parameters would lead to one level of medicalization. The second hazard is that of iatrogenic complications introduced by, often unnecessary, medical intervention. Governmental benchmarking and insurance compensation cannot curb the overenthusiasm of medical and surgical enterprise. The third closely related danger is that this positioning of health care as the next stage in economic growth will find systematic links with the liberalization of clinical trials as part of the research arm of universal access to health care. In the haste to make markets succeed, the stage is comprehensively set for the vulnerability of different uninformed populations to medical experimentation, and to iatrogenic complications and morbidity, not to mention mortality, due to ill-controlled introduction of 'scientific care'.

Medicine's contract: Foucault points to the unusual contract medical science offers the poor in early nineteenth century Europe – 'We will take care of you and in return, you provide society access to your body for the development of medical knowledge'. If we remember that in those days, most people who entered general hospitals died in them, the strangeness of this contract becomes evident. It is again toward this broad direction he hints, when he says that after the NHS and state run health care policy come to determine medicine and its problems, there is a curious stagnation of health – I would interpret this to mean that the logic of the 'public private partnership' and of biomedical science runs

away with the agenda of taking care of the health of the people. On our current horizon, the following spectrum of risks emerge for populations: as people for whose health problems there is neither visibility nor treatment; as patients treated by invasive procedures with consequences they don't understand; as consumers of medical drugs with poor comprehension of their long term effects; as participants in medical insurance contracts that they have no control over; as population samples of subjects for clinical trials. It is perhaps with these new connotations that we as health care professionals and activists need to complicate the meaning of the statistical term 'populations'. These multiple connotations should in turn reverberate to the mantra about 'demographic dividends' that emerges around the year 2000: 'India's population is her strength'.

Some tentative proposals

It should be clear that there are no immediate policy or advocacy actions available when we describe the situation thus. However some tentative directions emerge from the Introduction and the other chapters of *TCMP* either directly or as implications.

1. Perhaps we need a community based process of determining the kind of medicine actually necessary, in order to both encourage and devise protocols for new medical practices and solutions. Given the biomedical orientation of current medical science, and the structure of expert knowledge it is likely that uncontrolled hubris in neoliberal health care will lead to undefined medicalization and its risks. There is also no clear articulation of what medicine is needed most desperately. At the same time, it is also clear that people do not know enough about medicine and health care to establish the proper direction right away. However and therefore, it is imperative that community discussion, control and audit of health care begin.

2. Devising protocols to monitor and control medical practices would imply a research in medicine, not as biomedical science driving specialty medicine and tertiary care, but as effective cultural, political and economic practices of meeting health care needs in our context. We would need to learn from the kind of doctors who meet the needs of the community and gain its confidence, even if they are

private practitioners (or even ‘quacks’) in small towns. Underlying this is a reversal of emphasis on medical politics from one that is seen as an expert scientific discourse, to one that has an everyday significance where the layperson can speak. For this purpose we would need to develop skills to listen to what people ask for as medical care on a daily basis.

3. It is clear that many large-scale interventions against government and business policy often are successful only when taken up through party politics and electoral commitment. So far, in independent India, routes of direct action and civil societal politics have had limited purchase and scope. It is also amply clear that elected representatives do not often represent the people who elect them. Yet generating a measure of accountability to that process would be an important aspect of a politics of health in the twenty first century. It is necessary to see the Arogyasri programme as an explicit political response to a felt need (whatever its difficulties and flaws) and this is especially evident from the enthusiastic reception of the programme.

4. Finally, it requires fresh thinking on the part of experts in medical education to draw the pedagogic consequences of a reorientation of medicine towards the patient’s needs in terms of a requisite medical curriculum. This reorientation is essential given the current thrust in medical education towards equipping the student with the ‘most advanced scientific knowledge’.