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TWO YEAR MASTER'S DEGREE COURSE

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SEMESTER - I

SOCIOLOGY OF HEALTH AND ILLNESS

Surya Kumar Bhuyan School of Social Sciences

KRISHNA KANTA HANDIQUI STATE OPEN UNIVERSITY

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COURSE INTRODUCTION

The course ‘Sociology of Health and Illness’ attempts to introduce to the learners the ideas of health, illness, medicine, etc. from a sociological perspective.

This course comprises of 14 units. The course provides a holistic understanding of the social dimensions of health and illness. It begins with a discussion on the broad arena of sociology, medicine, health. It is followed by an understanding of the basic concepts, the different theoretical perspectives to understand health. Then, the course attempts to contextualise the ideas of health, disease in the colonial roots of India.

Further, the course progresses with special emphasis laid on the gender dimension of health, the cultural understanding of health, health care institutions, public health, etc. It also throws light on the aspects of social inequality in health, and the idea of social control over the body.

UNIT 1: INTRODUCTION

UNIT STRUCTURE

1.1 Learning Objectives
1.2 Introduction
1.3 Meaning of health
1.4 Meaning of sociology of medicine
1.5 Origin and development of sociology of medicine
1.6 Difference between sociology of medicine and sociology in medicine
1.7 Let Us Sum up
1.8 Further Reading
1.9 Answers to Check your Progress
1.10 Model Questions

1.1 LEARNING OBJECTIVES

After going through this unit, you will be able to –

- understand the meaning of health
- know the meaning, origin and development of sociology of medicine
- know about the difference between sociology of medicine and medical sociology

1.2 INTRODUCTION

Over the years the promotion of heath care has became one of the supreme focus of the health care policies at local, national and international levels. The World Health Organisation has promoted for the global health care initiative. Most people are increasingly becoming concerned about healthy lifestyle. Sociology of health and medicine critically examines the health situation and its developments and tries to locate them within a set of wider socio-cultural changes. Sociology of health analyses the contemporary health policies, lifestyle, consumption, risk and health. It tries to critically examine the implication of the health policies on the

society, the way those policies are practiced, the impact of the various diseases on the social life and on other aspects. Earlier, diseases and conditions were attributed mainly to genetic predispositions. Now, health issues are looked at from a more global prospect keeping in mind the factors such as family, education, religion, economic conditions, etc. It is essential for us to know both the positive and negative aspects of the sociological factors on diseases, as it helps us to explore the core issues and obstacles to the progress of humanity. Adequate knowledge will help in better policy making. As we progress as a society, it is vital that we fully acknowledge potential healthrisks and make a joint effort to share and spread knowledge about preventability and curability of diseases.

The interaction between society and health is studied under sociology of health and illness. For example, sociologists will examine how social life impacts morbidity and mortality rates, and how morbidity and mortality rates in turn have an impact upon the society. The discipline of sociology looks at health and illness in relation to various social institutions such as the family, school, organisation, religion, work, etc. It also looks into the reasons for types of care for various diseases, the compliance and noncompliance of the patients towards the care and services of the health system. In the past, good health or lack of good health were thought to be related only to biological or the natural conditions. Sociologists broke that thought process and demonstrated that the spread of diseases is also influenced by socioeconomic status of individuals, ethnic traditions or beliefs, and other cultural factors. The sociology of health and illness has a global approach of analysis because the influence of societal factors varies from society to society in the world. Diseases are examined and compared based on the traditional medicine, economics, religion, and culture that are specific to each region. Regional disparity of practices is also taken into account while understanding health and illness holistically.While it is extremely problematic in certain areas, in others it has affected a relatively small percentage of the population. Sociological analysis can help to explain why these discrepancies exist.

In this unit, we will know about the sociological approach to health and illness, in details.

1.3 MEANING OF HEALTH

Health is the one of the basic human rights. Overall activity of a person depends on his/her health system. The Universal Declaration of Human Rights stated in Article 25: 'Everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family' (United Nations, 1948). The Preamble to the World Health Organization (WHO) Constitution affirms that it is one of the fundamental rights of every human being to enjoy the highest attainable standards of health. Article 21 of the Constitution of India also identifies health as an integral aspect of human life. Further, Article 47 (Part IV: Directive Principles of State Policy) states: "The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health".

To understand the meaning of health, few points have to be kept in mind. Health is a metaphor for well-being of a person. To be healthy means to be in sound mind and body as an integrated whole. The concept and understanding of health may vary from society to society. Many societies believe that being balanced is a symptom of good health. According to Gilman, one of the perspectives on health is oriented by the cultural values. For example, contemporary Western medicine evaluates the health of a body organ or individual through a series of technological laboratory tests used to determine if indicators of structure, such as readings of radiographs, and function, such as kidney filtration rates, fall within a 'normal' range for this individual in these circumstances.The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well being, and does not consist only of the absence of disease or infirmity". Health is not just a matter of personal choice, nor it is only a biological issue. Health is a pattern of well-being and illness in a body which is also rooted in the organization of a society.

Health, by the definition given by WHO, is also regarded as a social issue and is borne out by evidence which demonstrates that standards of health varies over time and space. It not only differs from one society to another, but also from one culture of a country to another.

There are various approaches to understand health. Initially the concept of health was dominated by biomedical approach. Biomedical approach dominated the concept of health till the end of 19th century. This approach was based on the concept of 'germ theory of disease' which views health as an absence of diseases'.This approach to understand and define health almost ignores the role of environmental factors, psychological factors and other socio cultural factors in defining health.

Second approach to understand health is the ecological approach. This approach views health as a dynamic equilibrium between human beings and their environment. In ecological approach, disease is the maladjustment of the human being due to environment or change in the ecology.

Another approach to understand health is the psychological approach. According to the psychological approach, health is not only related to the body, but also to the mind and the attitude of the individual in certain situations.

The socio-cultural approach is yet another approach to understand health. According to this approach, health is considered as a product of social and cultural structure of a society.

According to the functional approach, health refers to the ability of a person to participate in normal social roles.

The sociological understanding of health considers structural and social factors, rather than simply biological explanations of health and diseases. It describes the complex relationship between structural factors and personal choice in relation to health inequalities.

For the social welfare of common people at present times, it is necessary to facilitate, encourage, and secure individual autonomy and dignity. Defining health as an operational and working term is necessary

for creating policies and programs that will help in maintaining and improving health. The Ottawa Charter from the 1st International Conference on Health Promotion, held in Ottawa, Canada, in 1986, asserts that health is created in the context of everyday life and environment, where people live, love, work, and play. Thus, active and interactive understanding of health was introduced. Health promotion has the goal to combine the approach for addressing the social determinants towards health with the resolution and commitment to motivate and encourage the individuals and the community for their active participation towards health and embracing healthy lifestyles. The definition given by WHO also underwent changes within last few decades. The definition of health has been amended and supplemented by the fourth dimension i.e. spiritual health. Spiritual health is a sense of fulfilment and satisfaction with our life, system of value, self-confidence and self-esteem, self-awareness and presence, peacefulness and tranquillity with proper emotional balance. Spiritual health is balance between internal as well as the external environment.

1.4 MEANING OF SOCIOLOGY OF MEDICINE

Medical sociology is a sub-discipline of sociology, which tries to understand the medical sector from sociological perspectives. It provides an analytical framework for understanding health, illness and health care in a social context. The subjective experiences of health and illness are included keeping in mind the political, economic and environmental circumstances that lead to ill health. The societal forces that may act as constraints to the medical care system, and individual response to illness comes under the study of sociology of medicine. The field of medical sociology draws from the traditional sociological issues and contributes to the field through reformulations of basic concepts as social systems, institutions, social movements, social change, social interactions and negotiation. From a pluralistic perspective, the field of medical sociology is concerned with sociological research and its implication on the health policy.

Medical sociology is a sub-discipline of sociology that draws on the methodological substances and middle range theories of sociological perspectives to elaborately understand the importance of health, health services and health care issues. Medical sociology also analyses the medical organizations and institutions. It emphasises on the production of knowledge and selection of methods for health care. Medical sociology also attempts to understand the actions and interactions of healthcare professionals with the patients, and how the social or cultural factors affect medical practices. This field of study commonly interacts with the sociology of knowledge, science and technology studies, and social epistemology. Medical sociologists inquire on the qualitative experiences of patients, people who often work at the boundaries of public health, social workers, etc. They also try to understand the demography and gerontology to explore the phenomena at the intersection of the social and clinical sciences. Health disparities in our society are commonly related to different class, caste and race. Sociological research on medical sociology tries to understand such disparities and sometimes findings become a normative and political issue. Medical sociology is the study of the effects of social and cultural factors on health and medicine. Specializing as a medical sociologist helps individuals view the healthcare system as a function of the society and serve it by examining and improving all its facets.

1.5 ORIGIN AND DEVELOPMENT OF SOCIOLOGY OF MEDICINE

The intellectual lineage of medical sociology can be traced to the late 1800s. In the 19th century disciplines of sociology and allopathic medicine started to cross paths in a significant way. Allopathic medicine witnessed the beginning of medicine's ongoing attempts to consolidate its professional powers and social legitimacy. Simultaneously, Sociology began to emerge as a distinct discipline to understand society and its interrelated elements. Herbert Spencer's book *The Principles of Sociology*

(three volumes, 1876–1896) was a seminal publication, along with the establishment of the first American sociology course called “Elements of Sociology” at the University of Kansas, Lawrence, in 1890, and the founding of the first department of Sociology at the University of Chicago in 1892 by Albion Small. Albion Small also launched the first sociology journal called the *American Journal of Sociology*, in 1895. There are a number of works from those times which formally linked “medicine” and “sociology”. For example, Charles McIntire’s *The Importance of the Study of Medical Sociology*, Elizabeth Blackwell’s *Essays in Medical Sociology (1902)*, James P. Warbasse’s *Medical Sociology: A Series of Observations Touching Upon the Sociology of Health and the Relations of Medicine* (1909). The initial period of developing links between medicine and sociology reflected a much broader aspect of transformation that took place within allopathic medicine and between medicine and society.

There are many ways in which the development of medical sociology in the second half of the twentieth century can be traced. The development of medical sociology can be comprehended by understanding the fluctuating strengths of the various theoretical approaches to the subject during that period. The trace can be made by looking into the achievements and failures judged by different criteria. As the effectiveness of medicine grew in clinical spaces and organizational complexity of the health care grew, the social-psychological and the behavioural sides of medicine started occupying the field of medical sociology. While scattered “sociology of medicine” articles continued to appear in medical journals between 1920 and 1950, few of them had an impact on sociology than on medicine. In 1960, E. Gartly Jaco published a paper that became the first disciplinary journal in medical sociology. The development of medical sociology as a sub discipline of sociology went through certain phases and processes. In 1967, the American Sociological Association (ASA) took the *Journal of Health and Human Behaviour* (JHHB) under its organizational wing where it was renamed as *Journal of Health and Social Behavior* (JHSB). Eliot Freidson was the first editor. The same year the first issue of Social Science & Medicine (SS&M) was published

with its distinctively international and multidisciplinary social science focus. In 1970s, the field of medical sociology section of the British Sociological Association established its own organization and in 1979 published its own medical sociology journal called *Sociology of Health & Illness*.

Between 1950s and 1960s, the field of medical sociology underwent extensive growth before reaching the peak in early 1970s. During that period the field enjoyed considerable academic growth and success and also got support from both private foundations and the federal government. In early 1970s, the National Institute of Mental Health subcommittee for social science training awarded 1,500 graduate students 80 percent of stipends of the year to sociology departments. The amount was more than what was needed to support medical sociology graduate students, and the field was much benefitted from that act. Also, the foundation of medical sociology and adaptation of various journals related to medical sociology received funding from external sources. In less than a year, the medical sociology section grew to 561 members. By 1964, membership had risen to nearly 900. In less than a half dozen years, the field went from publishing introductions to the field, to summative reviews (one notable example is Eliot Freidson's *"The Sociology of Medicine: A Trend Report and Bibliography"* published as a special issue in *Current Sociology* (1961). By mid 1970s, the signs of trouble in the discipline started to show up. The established funding sources of the boom time of the field started to dry and the field had to look for other alternative sources of funding. The publication of articles related to medical sociology started becoming less frequent in sociology journals such as the American Journal of Sociology and the American Sociological Review. Meanwhile, colleges and universities, due to their own upheavals and considerable financial pressures, began to drop programs, and sociology was high on a number of lists. Yale University's Department of Sociology, which housed the first medical sociology program in the United States, decided in the 1990s to eliminate that program. The 1980s and 1990s were also difficult times for allopathic medicine. The rise of managed care, the commodification of medical services, and the discovery of medicine by

Wall Street and corporate America during the "go-go" years between 1985 and 1997 had earth-shattering implications for the future of medicine as an autonomous profession. The 1970s and early 1990s were also time of debates within academic sociology about the fate and future of allopathic medicine as a profession. Beginning with the work of Eliot Freidson's *Transformative Profession of Medicine and Professional Dominance,* a number of distinguished medical sociologists in the United States started to debate on the changing fortunes of organized medicine's status as a profession. Once again medicine and sociology crossed paths. The discipline of sociology again started looking into issues of health from a sociological perspective.

1.6 DIFFERENCE BETWEEN SOCIOLOGY OF MEDICINE AND SOCIOLOGY IN MEDICINE

In 1955, Robert Straus highlighted a division of medical sociology into two categories, the sociology of medicine and sociology in medicine. Sociology of medicine is concerned with studying the organizational structure, role relationships, rituals, and functions of medicine as a system of behavior. Sociology in medicine consists of research involving the integration of concepts, techniques, and personnel from many disciplines where the sociologist is collaborating with the physician in studying a disease process or factors influencing the patient's response to illness. For Straus, sociology in medicine had a strongly applied component, in that the social sciences could be employed to inform and instruct medical professionals in recognizing and responding to the social factors associated with health and disease.



CHECK YOUR PROGRESS

Q1. What is meant by health?

.....

.....

Q2. Define sociology of medicine.

.....

.....

Q3. State the definition of health given by WHO.

.....

.....



1.7 LET US SUM UP

- The promotion of heath care has become one of the supreme focus of the health care policies at local, national and international levels. The World Health Organisation has promoted for the global health care initiative.
- Sociology of health and medicine critically examines the health situation and its developments and tries to locate them within a set of wider socio-cultural changes.
- The interaction between society and health is studied under sociology of health and illness. For example, sociologist will examine how social life impacts morbidity and mortality rates and how morbidity and mortality rates in turn impact upon society. The discipline of sociology looks at health and illness in relation to various social institutions such as the family, school, organisation, religion, work, etc.
- The Universal Declaration of Human Rights stated in Article 25: 'Everyone has the right to a standard of living adequate for the health and well being of himself and his family' (United Nations, 1948). The Preamble to the World Health Organization (WHO) constitution affirms that it is one of the fundamental rights of every human being to enjoy the highest attainable standards of health.
- Article 21 of the Constitution of India also identifies health as an integral aspect of human life. Further, Article 47 (Part IV: directive principles of state policy) says: The State shall regard the raising

of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injuriousto health.

- The World Health Organization (WHO) defines health as “a state of complete physical,mental and social well being, and does not consist only of the absence of disease or infirmity”.
- Biomedical approach dominated the concept of health till the end of 19th century.This approach was based on the concept of ‘germ theory of disease’ which views health as an ‘absence of diseases’.
- The ecological approach views health as a dynamic equilibrium between man and his environment.
- According to psychological approach, health is not only related to the body but also to the mind and the attitude of the individual in certain situations.
- According to the functional approach, health implies the ability of a person to participate in normal social roles.
- The sociological understanding of health considers structural and social factors, rather than simply biological explanations of health and diseases. It describes the complex relationship between structural factors and personal choice in relation to health inequalities.
- Medical sociology is a sub-discipline of sociology, which tries to understand the medical sector from sociological perspectives. It provides an analytical framework for understanding the health, illness and health care in a social context. The subjective experiences of health and illness are included keeping in mind the political, economic and environmental circumstances that lead to ill health.
- The intellectual lineage of medical sociology can be traced to the late 1800s. In the 19th century disciplines of sociology and allopathic medicine started to cross paths in a significant way. For allopathic

medicine witnessed the beginning of medicine's ongoing attempts to consolidate its professional powers and social legitimacy.

- In 1955, Robert Straus first highlighted a division of medical sociology into two categories, the sociology of medicine and sociology in medicine. The first is concerned with studying the organizational structure, role relationships, rituals, and functions of medicine as a system of behaviour. The second consists of research involving the integration of concepts, techniques, and personnel from many disciplines where the sociologist is collaborating with the physician in studying a disease process or factors influencing the patient's response to illness.



1.8 FURTHER READING

1). Freidson, E. (1962). 'The Sociology of Medicine,'*International Sociological Association*, Sage Publication, 11:123-14



1.9 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No 1: Health is a metaphor for well-being of a person. To be healthy means to be in sound mind and body as an integrated whole.

Ans to Q No 2: The sociology of health and medicine critically examines the health situation and its developments and tries to locate them within a set of wider socio-cultural changes.

Ans to Q No 3: The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well being, and does not consist only of the absence of disease orinfirmity".



1.10 MODEL QUESTIONS

A) Short Questions (Answer each question within 150 words)

Q1. How does the notion of health vary from the perspective of a physician and that of a sociologist?

Q2. Differentiate between sociology of medicine and sociology in medicine.

B) Long Questions (Answer each question within 300-500 words)

Q1. Explore the development of medical sociology.

Q2. Discuss the approaches to understand health.

*** ***** ***

UNIT 2: BASIC CONCEPTS

UNIT STRUCTURE

2.1 Learning Objectives

2.2 Introduction

2.3 Medicalization

- 2.3.1 Genesis and the Rise of Medicalization
- 2.3.2 Medicalization- A Boon or A Bane

2.4 Demedicalization

2.5 Illness Narrative

- 2.5.1 Rise in Illness Narratives
- 2.5.2 Dynamics of Illness Narratives

2.6 Medical Tourism

- 2.6.1 Factors and Developments in the Field of Medical Tourism
- 2.6.2 Definitions of Medical Tourism

2.7 Let Us Sum Up

2.8 Further Reading

2.9 Answers to Check Your Progress

2.10 Model Questions

2.1 LEARNING OBJECTIVES

After going through this unit, you will be able to -

- understand the basic concepts relating to Sociology of Health and Illness.
- understand in detail the process of medicalization and demedicalization.
- analyse the concept of illness narratives
- explicate the concept of Medical Tourism and its position in the global market with emerging, developing and developed nations competing for health tourists

2.2 INTRODUCTION

In the previous unit, we have obtained a general overview of the area of sociology of medicine. This brief overview shall now enable us to understand some basic concepts of this area of study. In this unit, particular focus shall be laid on the ideas of medicalisation, demedicalisation and illness narratives.

2.3 MEDICALIZATION

Medicalization is a process by which non-medical problems become defined and treated as medical problems, usually in terms of illness or disorders. According to Conrad, medicalization is a term used to define the behaviours which were once taken as immoral, sinful or criminal, as something which has a medical meaning, thus moving them from badness to sickness. Examples of medicalization include conditions such as alcoholism, eating disorders, sexual dysfunction, learning disabilities and so on. Along with these it has also included categories such as Attention Deficit Hyperactive Disorder (ADHD), Premenstrual Syndromes (PMS) and so on. Certain common life processes like anxiety, birth control, menstruation, childbirth, death etc have been medicalized.

Medicalization need not be total; there are degrees of medicalization. Some conditions like death, childbirth and severe mental illnesses are fully medicalized. Others such as menopause and drug addiction are partly medicalized. Again, sexual addiction and spouse abuse come under conditions which are taken as minimally medicalized. Thus, this has become an important emerging issue in health care with the availability of medications to treat such conditions which have otherwise been regarded as normal range of human emotions and reactions. Over the past half- century, the social terrain of health and illness has been transformed. Some observers have suggested that the process of medicalization has moved more into the scientific realm with the demise of traditional values and change in social attitudes.

2.3.1 Genesis and the Rise of Medicalization

The ideas behind the concept of medicalization have their beginnings with Michael Foucault and Ivan Illich. The term entered academic and medical publications in the 1970s. Analysts have long pointed to social factors that have encouraged medicalization. Some of these include an abiding faith in science, rationality, the increased prestige and power of the medical profession and a general humanitarian trend in Western Societies.

The growth of medicalized categories suggests an increase in medicalization, but it is not simply a result of medical colonization. Barsky and Boros point out that the public's tolerance of mild symptoms has decreased, thus needing for these symptoms to be classified as diseases. Most early sociological studies took a social constructionist approach in investigating the rise of medicalization. The focus was mainly on the creation of new medical categories with the expansion of medical jurisdiction. Concepts like moral entrepreneurs, professional dominance etc were central to analytical discourse. According to Conrad, studies on the medicalization of child abuse, menopause, alcoholism among many others broadened the understanding of the range of medicalization and its attendant social processes. Michael Foucault tried to analyse the impact of medical discourses on people's lives. But most studies inclined towards social-constructionist approach rather than Foucauldian orientation

Conrad also argued that medicalization is a form of collective action. Along with doctors, patients and other lay people are also active collaborators in the medicalization of their problems or an eager need for medicalization.



LET US KNOW

Pharmeceuticalization- Process by which social, behavioural, or bodily conditions are treated, or deemed to be in need of treatment with pharmaceuticals by doctors, patients or both.

2.3.2 Medicalization- A Boon or A Bane

Many have argued that the process of medicalization does bring health benefits for millions of people around the world. One such benefit is that, in recognizing a condition as a disease, certain conditions can be treated that affect the quality of life. Also, it is taken as an easy way to learn about new drugs and it promotes morale for the clinic staff. However, the process of medicalization has also received criticism from those who are worried about the increasing jurisdiction of the biomedical profession.

Most analysts of medicalization have written in a critical mode, either emphasising the problems of over-medicalization or its consequences. Broom and Woodward (1996) maintained that medicalization can be both helpful and unhelpful to patients. They distinguish medicalization from medical dominance; which they see as problematic for patients. Talcott Parsons in his classic formulation of the sick role pointed out that medical diagnosis can legitimate a range of human troubles. Elsewhere, Illich argued that dependence of medicine would make people obsessed about health as a value and lead to gradual loss of the right of people to self determinism. Thus, most medicalization analysts contend that increasing parts of life have become medicalized and that medical remedies are sought for expanding range of human difficulties. Conrad in his studies has also talked about the shifts in medicalization to a new techno-scientific era of biomedicalization and pharmaceuticalization (cited in Arunima & Kohli, 2012: 256). To put it crudely, medicalization of all sorts of life problems is now a common part of our professional, consumer and market culture.

After going through the various intricacies, it can be said that medicalization is probably neither good nor bad. It is like a "two edged sword" as Conrad (2007) refers to in his study, since the very definition of quality of life has to be questioned.



LET US KNOW

Biomedicalization- It refers to the medical interventions designed not only to extend life and promote health but to enhance our biological selves (via cognitive enhancements or cosmetic surgeries). It places a significant emphasis on genes.

2.4 DEMEDICALIZATION

Medicalization is two directional, in the sense that there can be both medicalization and demedicalization. According to many scholars demedicalization is simply the obverse of medicalization. For demedicalization to occur, the problem must no longer be defined in medical terms, and medical treatments can no longer be deemed appropriate interventions. A classic example is masturbation, which in the 19th century was considered as a disease but by the mid twentieth century was no longer seen as requiring medical treatment. Another example is homosexuality which was officially demedicalized in the 1970s. Although the general trend over the past one hundred years has been towards the medicalization of human problems, there are a small number of cases of demedicalization. Homosexuality remains the exemplary case of nearly complete demedicalization.



CHECK YOUR PROGRESS- A

Q 1. Talcott Parsons formulated the concept of sick role.

True/False.

Q 2. Homosexuality is not an example of demedicalization

True/False.

2.5 ILLNESS NARRATIVE

There is considerable renewed interest in narrative analysis in humanities, social sciences and medicine. Illness narratives, particularly those of patients or lay people are a particular focus in health related settings. In medical anthropology, scholars often use illness narratives to explore how individuals embody the memory of an illness experience. This is in contrast to traditional medical case histories that present patients' illness as generalised diseases with a focus on the symptoms and pathological processes. Illness narratives differ from medical case histories because narratives focus on the patient's subjective experience and understanding of the illness, and they can highlight the social and cultural factors that may have influenced the symptoms.



Sick role : It is a term used in medical sociology regarding sickness and the rights and obligations of the affected.

2.5.1 Rise in Illness Narratives

Writings in the history of medicine make clear the importance of illness narratives particularly with the rise of doctor-patient relationship in early modern times. Before the advent of 'bio-medical model of illness' in understanding the disease during the mid and late 19th century, the doctor used to take the history from the patient which included his/her lifestyle, moral stance and the wider environment in which the patient lived. This was in the 17th and the 18th century when the doctor was expected to attend to patients' narratives and treat them accordingly.

However, with the rise of scientific bio-medicine, the importance of illness narratives diminished. As the study and treatment of disease became separated from the individual, and located within systems only understood by the experts, the need to attend to the patient was reduced to taking information about the signs and symptoms of the disease. The task of the doctor, in the 19th and 20th century was to translate these pieces of information into a definite diagnosis that linked to the biological causes and outcomes, rather than the patient's lifestyle. Thus

illness was separated from everyday life by professional medicine, and the patient's suffering was silenced.

But overtime, various factors have acted to bring lay narratives back to focus. With the growth in chronic illness, the heterogeneous character becomes the focus of both lay and professional concerns. Also, illness narratives and links with 'history taking' in medicine have been associated with moves to improve care that do not entirely depend on a narrow view of scientific medicine.

2.5.2 Dynamics of Illness Narratives

Illness narratives are 'performed' by patients who are characters in their ongoing stories, actors constantly influenced by their social environments. Thus, studying illness narratives and medical histories can provide insights into a patient's society, specifically about the following aspects.

1) How group experience moulds individual experiences: This can be explained through the ethnographic study done by Skultans (1997) concerning the health of Latvian people after the collapse of the Soviet Union. While studying a medical condition, 'Neurasthenia' which causes fatigue and emotional disturbance, Skultans observed that the narratives by those people brought together the past, present and future. The narratives encompassed terrible events that occurred half a century ago which the Latvians used as foundations to construct their life stories, functioning as a medium for their anxieties and hopes for the future. Narrators drew upon stories and fragments of stories to translate their brutal tales into a meaningful story, and Skultans could identify cultural values and knowledge of identity through individual accounts. Testimonies came from witnessing awful events, but in doing so, the informants speak from solitary experience and yet they also speak for others. Thus it can be said that societal trauma are commemorated in the lived experiences of individuals who are

suffering. It is through these common narrative forms that one can better understand the personal and social memory of a given people within a society, as well as their collective experience.

2) How cultural values and social relations shape the body's illness experience: This can be understood by taking into account the study done by Good (1994) on people suffering from seizure disorder in Turkey. The study was initially designed to look at the prevalence of epilepsy and the social disability associated with it, yet, through the stories he heard, Good learned much more about the sufferers. He explains one instance in which a lady described her experience of 'fainting'. She said when she was a young woman, she had resisted her father's wish for her to marry a particular man and instead chose another husband far away. When she saw her father with a knife in his hand, she received a "shock," she was frightened, and from that day until today, she has been fainting''. This story revealed more than a biomedical diagnosis. In her narrative she used the word 'fainting' instead of 'epilepsy' which reveals that in her society fainting is associated with acute distress or suffering. So in this case questions arose as to whether this condition of hers was caused by epilepsy or due to some psychological trauma.



Chronic illness : A long lasting condition which can be controlled but not cured.

3) How societal influences may trigger the body's memory of an illness: Illness narratives and case histories may reveal not only how suffering is situated in an individual's world, but also how it might be triggered by broader societal influences. This can be explained further with the ethnographic work done by Eli (2016) on Israeli women who had recovered themselves from eating disorders. After listening to their narratives she found out how the memories of their past illness are triggered by social pressures and affect their present day recovery. She explains this with one particular case of Tamar, a recovered anorexic, and how the social pressure to exercise caused her body to remember her troubled past. She and her partner started a new training programme,

years after she was classified as 'recovered,' until one day she realized what she was doing to her body after which she quit. What illness narratives thus reveal are not only how a disease manifests itself in one's own world, but the societal-cum sensory pressures that may activate it.

4) How the society helped create illness: This can be understood with the help of Steffen's (1997) study on members of a Danish organization of Alchoholics Anonymous (AA). Here one can see the purpose of illness narratives in merging individual and group experiences in a therapeutic process that gives meaning to the individual sufferers' lives. In this work, Steffen recounts short summaries of several individuals who lost part of their lives due to excessive drinking. After each narrative, together they would recite the prayer: 'God grant me serenity, to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference'. Telling a story/personal narrative helps an individual process what happened, processing events being the first step towards recovery. Such openness is a therapeutic necessity as well as a moral duty for members, who find solace in knowing that their story is quite similar to the stories of those around them.

Together, these narratives offer a lens into a patient's sociality, as well as providing a more holistic understanding of a patient's condition, illustrating the ultimate causes of suffering and helping determine more productive ways to help the patient. By contextualizing meaningful events, illness narratives contribute to the understanding of individual experience by showcasing social relations and cultural values. In this regard, they offer much more than a brief medical history of a patient, they offer patient perspectives not only about the illness but about the patient's perceived role in society. They also allow for a better understanding of the ultimate causes of a disease that cannot be boiled down to mere pathological description. Finally, they demonstrate how

society becomes embodied in illness, and which societal values may outweigh others in the shaping of an illness experience. Narratives show how collective societal experiences mould individual experiences, how values may embed themselves in the body in periods of sickness, and how suffering is tied to larger societal triggers.



CHECK YOUR PROGRESS- B

Q 3. Illness narratives are ways to explore how individuals embody the memory of an illness experience.

True/False.

Q 4. The coming of biomedicine in 19th century diminished use of illness narratives.

True/False.

2.6 MEDICAL TOURISM

Sociological studies of tourism have largely categorized tourism as a leisure-related activity separated from the everyday, whereby the tourist gazes upon the 'other' in a foreign locale. Health and medical tourism, however, challenge such understandings. Firstly, medical tourism does not necessarily involve a retreat from everyday experiences. Secondly, this reveals tourism is not necessarily a passive activity, but an embodied experience. For the health and medical tourist, their 'tourist experience' is partially or solely motivated by their health or perception of their health. In today's scenario, healthcare has become a global market, with emerging, developing and developed nations competing for health tourists. Consequently, the political interest in health and medical tourism is based on the financial benefits it can bring. Such economic incentives for the state has also led to increasing options for medical tourists, who have more disposable incomes and in some cases portable health insurance policies. Therefore, while medical tourists still predominately flow from

the developed world, medical tourist sites are found globally, with many medical tourists flowing to world-class facilities in the developing world.

2.6.1 Factors and Developments in the Field of Medical Tourism

Starting from the late 20th century, there have been various changes in the field of tourism for health purposes. There has been the emergence of a new term, 'medical tourism', which is sometimes differentiated from health tourism and sometimes not. Medical tourism is opted because of different reasons which include- Better quality care for medically necessary procedures, most advanced technology, lower cost care and quicker access for medically necessary procedures, trust in the healthcare system of the target country and so on. In addition, there are some other developments in the field of medical tourism, which are explained below.

i) Types of health and medical interventions have considerably diversified, ranging from superficial treatments (such as facials and massages) to highly invasive and risky surgical procedures (such as open heart surgery) and, in some cases, a combination of both (for example cosmetic tourism, which encompasses cosmetic and reconstructive surgery and some forms of dentistry).

ii) Another important development in health and medical tourism appears in the emphasis placed on marketing, and the varied priority placed on health. While health concerns may have been a primary motivator for health tourists prior to the 19th century and in particular the 20th century, today the 'tourist experience' appears to take precedence over health. Healthcare and beauty treatments may form part of a tourist package in international resorts or on cruises, which often include site-seeing to major destinations.

iii) Health may also remain the primary - or only - motivator for travel. This can be influenced by delays in or the unavailability of medical treatment/s at home. Transplant tourism, for example, occurs because of the long waiting lists for kidney transplants in the developed world that may lead to death before the individual can receive a transplant, an apparent willingness of people in the developing world to sell their kidneys and so on.

These considerations reveal that health and medical treatments can be considered an addition to the traditional tourist site-seeing experience as stated by Goodrich and Goodrich (1991), and a significant or sole motivator for travel.

2.6.2 Definitions of Medical Tourism

After going through a brief on medical tourism and the factors behind it let us delve into some of the definitions by scholars on health and medical tourism. Mc Kinsey (2008) defined it by stating- When a person, whose primary and explicit purpose in traveling is to obtain medical treatment in foreign country, it is called medical tourism.

Lubowiecki-Vikuk (2012) described it as a conscious activity, in which a traveler (a medical tourist) aims to receive healthcare services – in his or her own country or abroad to preserve (or acquire) a better health condition, and/or aesthetic appearance of his or her own body, sometimes combined with relaxation, regeneration of physical and mental strength, sightseeing and entertainment.

From the above definitions we can see that there are many differing definitions of health and medical tourism. Some of these appear to be influenced by the previously explored history of health tourism, which is largely based on resorts, spas and general wellness. These understandings largely replicate the traditional understandings of mass tourism in sociology, where tourism is understood as a binary structure that operates as escapism from

the everyday life. Whereas, there are other perceptions which acknowledge health tourism as a very broad category that encompasses a wide variety of treatments and services. In such understandings, medical tourism becomes a subset of health tourism. For example, some scholars view health tourism as 'travel where the primary purpose is treatment in pursuit of better health' that may involve 'hedonistic indulgences of spas and alternative therapies', while medical tourism 'incorporates health screening, hospitalization, and surgical operations'. Thus answers to the similarities and dissimilarities on health and medical tourism seem a little confusing. All in all, this is a relatively recently recognised, unregulated industry with speculation-based insight. However, this is not to subsume the importance of tourism and the growing political, economic and social interest in health and medical tourism. Rather, it appears more relevant and important to examine and understand these phenomena subjectively and socio-culturally, including the political tensions arising between competing interests.



CHECK YOUR PROGRESS–C

Q.5. Medical tourism is opted for better medical facilities.

True/False.

Q.6. Define medical tourism.

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2.7 LET US SUM UP

- Medicalization is a process by which non-medical problems become defined and treated as medical problems.
- The ideas behind the concept of medicalization have their beginnings with Michael Foucault and Ivan Illich. The term entered academic and medical publications in the 1970s.

- Medicalization is two directional, in the sense that there can be both medicalization and demedicalization.
- For demedicalization to occur, the problem must be no longer be defined in medical terms, and medical treatments can no longer be deemed appropriate interventions.
- Illness narratives are 'performed' by patients who are characters in their ongoing stories, actors constantly influenced by their social environments. Thus, studying illness narratives and medical histories can provide insights into a patient's society.
- In medical tourism, the 'tourist experience' is partially or solely motivated by their health or perception of their health.



2.8 FURTHER READING

1. Bury, M. 2001. "Illness Narratives: fact or fiction?" in *Sociology of Health and Illness* 23.3.
2. Conrad, P. 2007. The Medicalization of Society. Baltimore. John Hopkins University Press.
3. Cook, Peta S. 2007. "What is health and Medical Tourism", in Humanities Research Program Queensland University of Technology.



2.9 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q. No A: 1) True 2) False

Ans to Q. No B: 3) True 4) True

Ans to Q. No C: 5) True

Ans to Q. No 6: Medical tourism involves people who travel to a different place to receive treatment for a disease, an ailment, or a condition, or to undergo a cosmetic procedure, and who are seeking lower

cost of care, higher quality of care, better access to care or different care than what they could receive at home.



2.10 MODEL QUESTIONS

Short Questions (Answer each question in about 150 words)

Q1. Define medicalization.

Q2. What is meant by illness narrative?

Long Questions (Answer each question within 300-500 words)

Q1. Write a short note on demedicalisation.

Q2. Discuss the idea of tourism for health purposes.

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UNIT 3: THEORETICAL PERSPECTIVES TO UNDERSTAND HEALTH

UNIT STRUCTURE

3.1 Learning Objectives

3.2 Introduction

3.3 Functionalist Theory

- 3.3.1 Parson's Sick Role
- 3.3.2 Durkheim's study on Suicide

3.4 Marxist Theory

3.5 Post-Modern Theory

- 3.5.1 Advent of Post modern theory
- 3.5.2 Foucault's theory in the context of post-modernism
- 3.5.3 Dynamics of knowledge and power
- 3.5.4 Health, Culture and Society
- 3.5.5 Limitations

3.6 Let us sum up

3.7 Further Reading

3.8 Answers to Check Your Progress

3.9 Model Questions

3.1 LEARNING OBJECTIVES

After going through this unit, you will be able to -

- understand why sociologists study health and illness
- discuss the study of health and illness from a functionalist perspective
- understand health and illness through Marxist analysis
- discuss and analyse health and illness through post modern theory.

3.2 INTRODUCTION

Sociological theories provide frameworks and insights that allow for the systemization of knowledge of the social world. This is why theory

is fundamental in empirical investigation and the scientific explanation of events. While medical sociology is moving closer to Sociology, it has removed itself from a subordinate position to medicine. There are four reasons for this development-

- Medical sociologists bring more expertise to the analysis of health related social conditions than physicians who typically receive little or no training in this area.
- Medical Sociology has a significant body of literature which is relevant to clinical medicine and health policy.
- Success in research has promoted the professional status of medical sociologists both in relation to medicine and Sociology.
- Medical Sociology has set its own research agenda which includes medical practice and policy as an object of study.

Changing social conditions associated with the transition of society from the post industrial to post modern period requires sociology to account for the various transitions taking place in the society, as well as the health sector and thus formulate new concepts. Under these conditions medical sociologists are making great use of Social theory because it promotes explanatory power to their empirical findings.

In this unit we will try to understand some of the major theoretical approaches to understand health and illness. Here, we shall know about the functionalist perspective to health and illness which is dated to the works of August Comte, Emile Durkheim, Herbert Spencer, and many other scholars. Then, we will move on to the Marxist Perspective followed by the Post modern approach to health and illness.



LET US KNOW

Sickness is culturally constructed and defined by the society. Five dominant perspectives to understand health and illness are: Functionalism, Symbolic Interactionism, Marxist, Feminist and Foucauldian perspective.

3.3 FUNCTIONALIST THEORY

The Functionalist approach considers the society as a whole comprised of its constituent elements; namely norms, customs, traditions, and institutions, etc. A common analogy, popularized by Herbert Spencer, presents these parts of society as “organs” that work towards the proper functioning of the “body” as a whole. This approach looks at society from a macro perspective, which is a broad focus on the social structures that shape society as a whole. This approach looks at both social structure and social functions. Auguste Comte, Herbert Spencer, Talcott Parsons, Emile Durkheim and Robert Merton amongst others, are some of the prominent functionalist theorists.

In the 1940s and the early 1950s, the field of Medical Sociology was almost completely an applied area of research. However, a notable change occurred in 1951 with the growing orientation of medical sociology toward theoretical concerns. In this context, Talcott Parson’s book, *The Social System*, based on a structural-functionalist model of society attracted great attention because it contained the concept of sick role. It was the first time when a major social scientist included an analysis of the function of medicine in his view of society.

3.3.1 Parsons’s Sick Role

The term ‘Sick role’ is used in medical sociology to refer to the idea of sickness and the rights and obligations of the affected people. Parsons argued that the state of being sick means that the sufferer performs “sanctioned deviance”. This is because, from a functionalist perspective, a sick individual is not a productive member of society. Therefore this deviance needs to be policed or treated, which is the role and responsibility of the medical profession.

In the functionalist model, Parsons thus argued that the best way to understand illness sociologically is to view it as a form of deviance that disturbs the social function of the society.

The general idea is that the individual who has fallen ill is not only physically sick, but adheres to the specifically patterned social role of being sick. In Parsons' definition, the sick person had two rights and two duties to fulfill. The first duty was to recognize that sickness creates dysfunction in the life of the affected. This lead to the second duty of seeking technically competent assistance to cope with their sickness, whereby it was assumed that advice would be followed. The fulfillment of these two obligations guaranteed the sick person the rights of being exempted from normal obligations and from usual blame.

This definition captured the culturally and socially accepted patient behavior during the 1950s. However, it had many limitations. One of the limitations is that the rights and obligations do not apply to patients with chronic illnesses, such as diabetes, heart disease, epilepsy and others. While patients with chronic illnesses are expected to seek medical help and to comply with recommendations, they are also encouraged to learn how to continue with their activities of daily life independently. Furthermore, if a patient with chronic illness exercises the rights prescribed to him/her under the Parsonian sick role for an extended period of time, then the individual contributes less to the functionality of both the personal life and society at large. Additionally, the Parsonian definition of the sick role assumes that people living with ailments accept their status as being sick or their willingness to act the prescribed role. However, that is not always the case. For example, deafness is considered by many to be a physical limitation. However, they do not consider themselves living with a dysfunctional attribute, and refuse to participate in the Parsonian sick role.

Therefore, the combination of these factors and the greater understanding of modern diseases led to a situation where his role was no longer valid and a new sick role was needed. However, the great contribution of Talcott Parsons could be his analysis of

sick role in the context of Sociology. He also tried to suggest how a sick person should behave in the society.

3.3.2 Durkheim's Study on Suicide

Another structural functionalist whose work can be cited in medical sociology is Emile Durkheim. He mainly emphasized on the importance of macro–level social processes, structures, norms and values which are external to the individuals that integrated them into the society and shaped their behavior. One of his works which had direct application to medical sociology was his theory of Suicide (1951). In this study he argued that the act of taking one's life was determined by the individual's ties to his her community or society.

This can be seen in his typology of three major types of Suicide :

- Egoistic- which arises from social detachment
- Anomic- which arises from the state of normlessness and
- Altruistic- A normative demand for suicide.



LET US KNOW

Mechanical solidarity- Mechanical solidarity is the social integration of members of a society based on common values and beliefs which constitute a collective conscience.

Organic Solidarity- Organic solidarity comes from the interdependence that arises from specialization. It is a social cohesion based upon the dependence of individuals on each other in advanced societies.

The merit of his concept is that it shows the capability of the larger society to create stressful situations where people are forced to respond to conditions not of their own choosing. Thus, Durkheim helps us to recognize that macro-level societal events (like economic recessions) can affect health in a variety of ways through stress and that the effect of stress can be mitigated through social support. Indirectly Durkheim also influenced the study of health professions

in noting the transition from mechanical to organic solidarity, with its emphasis upon specialization in the modern division of labour.



CHECK YOUR PROGRESS

Q 1. Who introduced the concept of sick role?

Q 2. Cite one work of Durkheim relating to the field of Health and illness.

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3.4 MARXIST THEORY

The Marxist perspective derives from the ideas of Karl Marx who believed that class conflict is the driving force which bridges changes in society. He believed that the main conflict in society was entirely economic. The Marxist tradition regarding health and health care completely rejects the views of the functionalists that society is tied together by values and norms. The conflict theorists believe that these values and norms benefit only the rich and the powerful. They feel that social and economic factors are the root cause of health and health care disparities in society. The rich and the affluent get access to health and health care facilities because of their financial status in society.

Marxists claim that capitalism moves healthcare professions to privatization of healthcare services and establishes the drive to increase profit and power for a certain social class. This economic tendency makes the medical field a profit oriented organization. Therefore, Marxism focuses on political and economic determinations of medical care in capitalist societies. Marxism has contributed to the healthcare field. Medicine is viewed as 'bourgeois' which aims to maintain dominance of certain groups in society. Marxists argue that health care systems are designed to satisfy the interests of the bourgeoisie rather than improve health conditions of the whole population. According to Marxism, inequality in distribution of healthcare services in capitalist society arises from the

marginalization of some categories of the population who do not contribute to economic system. This exclusion may include women, people with disability, elderly people and every person who doesn't contribute to the economy, regardless of the health status and needs of the person.

Along with class factors, Marxist theory pays attention to the role played by health care institutions and health care 'industry' in the economy; the impetus behind the ever expanding activities of large industrial and financial enterprises in the sphere of health and health care; its effects on shaping of health care services; role of a medical professional vis-a-vis the health 'industry' on the one hand and the patient- consumers on the other; the role played by these institutions in social control and perpetuation of values which are reinforcing the existing social order based on class, gender and racial domination.



LET US KNOW

According to Marxist perspective medical industry and state nexus can be deadly as the marginalized section of the society suffers the most.

Marxism also talks about monopoly capitalism which has entered the medical industrial complex. Increasing costs of medical care has led to the rise of medical insurance giants but per se medical care was still under the autonomous control of the medical profession. The same logic of capitalist accumulation that drives any other capitalist industry also drives these hospitals. All the management and financial techniques employed elsewhere are used here in order to derive maximum profits. Multi-hospital chains are being formed and mergers of small hospitals take place. Not only that, they are having collaborations with similar hospitals in many third world cities. With the rise of monopoly capitalism and given forthcoming industrialisation of health services, small- scale medical practice will become untenable and professional prerogative will erode slowly.

Thus, we can see that the theories based on conflict have the capacity to explain the politics associated with the health sector. It allows

us to chart the tactics of various entities, like medical profession, drug companies, insurance companies, business community etc as they struggle to acquire, protect or expand their interests. Other conflict approaches are connected more directly to classical Marxism by relying on class struggle to explain health policy outcomes and the disadvantages of the lower and working classes in capitalist medical systems where the emphasis is on profit.

However, there are also inherent limitations of the Marxist or the conflict perspective as a whole. While some health situations are affected by conflict related conditions, others are not. People may maintain their health or become sick and these outcomes can have little or nothing to do with conflict, politics, interest group competition, class struggles and so on. Moreover, Marxism began losing influence from the late 1970s onwards. By the beginning of the 1990s with the coming up of post modernism, and the collapse of the 'existing socialism' in Eastern Europe and the Soviet Union, the importance of Marxism declined.



CHECK YOUR PROGRESS

Q 3. Social and economic factors are the root cause of health and health care disparities in society.

True/False.

Q 4. Functionalism believes that society is tied together by values and norms. True/False.

3.5 POSTMODERN THEORY

The theories of both Poststructuralism and Postmodernism are crucial to our understanding of the relationship between health, culture and the society. They offer a critique to modernism, and, in relation to health, show how the micro-politics of power relate to medical knowledge and medical power. These two approaches also help to explain the resistance to techniques of power of a postmodern era.

Modernity is associated with the age of enlightenment in western societies which began around the 18th century. It involved social, economic and political upheaval with increasing secularization of societies and a growing dominance of philosophical and scientific rationalism. The basic assumptions of 'modernity' are that human order is essentially governed by general principles which can be elucidated by scientific analysis. Scientific knowledge was based on an empiricist epistemology and was believed to be the instrument by which true knowledge could be found. Modernism is associated with humanism which takes the human experience as the starting point for man's knowledge of himself. The aim of social sciences was thus to liberate humanity from prejudice and ignorance using scientific knowledge.

3.5.1 Advent of postmodern theory

Post Modern theory was seen to have born from within the democratic left of French politics in the 1960s. The postmodernists claim that the fundamental socio-historic changes cannot be adequately explained by the modern theories. Thus they call for new categories, modes of thought and politics to overcome the deficiencies of modern discourses and practices. Postmodernists favor social analysis which incorporates local, contextualized strategies that have a more practical or moral intent. Local narratives are preferred in place of grand narratives and theories.

3.5.2 Foucault's Theory in the context of post-modernism

Foucault's theory of Governmentality could be considered as an example of how poststructural and postmodernist ideas can help in understanding the relationship between health, culture and society. Governmentality describes the range of mechanisms that allow different groups and discourses to regulate, construct and constitute individuals, groups and society. It is drawn from discourse theory which focuses on how meaning is socially constructed semiotically.

Governmentality highlights the centrality of 'the body' and how it is disciplined, inscribed and subjected within the realms of power and knowledge of experts within the realms of governance. This is a major contribution by Foucault to medical sociology where he showed the social functions of medical profession, including the use of medical knowledge as a means for social control and regulation, as he studied madness, clinics and sexuality. Foucault found two distinct trends emerging in the history of medical practice; "medicine of the species" (the classification, diagnosis and the treatment of the disease) and "medicine of social spaces" (the prevention of disease). The former defined the human body as an object of study subject to medical intervention and control, while the latter made the public's health subject to medical and civil regulation. The surveillance of human sexuality by the state, church and medicine subjected the most intimate bodily activities to institutional discourse and monitoring. Thus bodies themselves came under the jurisdiction of experts on behalf of the society.

There is therefore a clear distinction between modernist and post modernist conception of the body. Modernist thought views body as independent of the various discourses which represent it, whereas postmodernist thought views 'the body' as discursively produced. The objective of the postmodernist 'de-centering' of the self in medical sociology allows analysis of the effect of inscription of health and illness.

3.5.3 Dynamics of knowledge and Power

Foucault believed that modern societies regulate and discipline their members by their 'expert knowledge' such as medicine, education, law, social work etc. The power/knowledge of the new disciplines was mediated through disciplinary mechanism which stipulated norms for human behavior. In terms of medical sphere, Foucault suggested that the basis for medical dominance lay in the knowledge claims of the medical profession about the 'body',

'health' and 'illness'. The new disciplines were seen as having insights into problems, knowledge and techniques and as a consequence were given license to diagnose, treat and thereby 'normalise' the population.

Medical discourses however have come under increasing criticism for being uncaring, stigmatized and disempowering. Despite the claims to objective scientific reasoning, these discourses have been shown not to be value-free but often prejudiced and socially-constructed. A postmodern perspective questions the knowledge claim of the new disciplines on how they claim authenticity, authority and how is it that people are willing to accept their knowledge of the character of health and illness. According to Foucault, sociological discourse is implicated in discipline and regulation, the discipline of the 'gaze' through examination, hierarchical observation and regulation.

Sociology itself therefore is implicated in the fabrication of discourses which make 'health', 'illness' and 'social problems' culturally defined phenomena despite the fact that it claims to be superior to biomedical discourse or lay prejudice. Ideas from postmodernism can help to analyze how sociology creates subjectivity through its discourse and supports the need for reflexivity in understanding the problems of representation in health illness and social problems which modernist sociology articulates.



LET US KNOW

Medical gaze- Informed way of looking at the human body. In other words, it refers to the scientific examination of the body.

3.5.4 Health, Culture and Society

Another idea drawn from Postmodernism which can help to understand the relationship between health, culture and society is that of the 'postmodern era' itself. There is considerable debate

about whether or not we are entering a new 'postmodern era' one which is characterized by pluralism, variety, contingency and relativism where beliefs in rational science, knowledge, truth and the universal state are undermined.

The principles of free-market competition and deregulation contained in the neo-liberal critique of 'welfarism' can be seen in changes in consumption patterns. This together with the commercialization of intellectual life and medicine, challenges the power/knowledge of traditional institutions. Turner states, we may expect the hierarchical division between scientific medicines and alternative medicines to collapse, as the traditional autonomy of medical profession is eroded through the invasion of corporations into the health market.



CHECK YOUR PROGRESS

Q 5. Who introduced the theory of Governmentality?

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Q 6. ———————— offers a critic to modernist theory.

Q 7. Postmodernists favor social analysis which incorporates local, contextualized strategies that have a more practical or moral intent. True/False.

3.5.5 Limitations

Postmodern theory has been criticized for a number of reasons including its failure to explain social conditions after the rupture with modernity is complete, lacking an adequate theory of agency, being too abstract, not providing clear conceptualizations, and not having empirical confirmation. While its demise has been announced in Britain, it is still popular in France and has gained adherents in the US. The advantage of postmodern theory is that

modern society is indeed shifting into a new form with social conditions different from the recent past and the perspective provides a theoretical framework, despite its complex literature for explaining the social changes.



3.6 LET US SUM UP

- In the functionalist model, Parsons thus argued that the best way to understand illness sociologically is to view it as a form of deviance that disturbs the social function of the society.
- Durkheim helps us to recognize that macro-level societal events (like economic recessions) can affect health in a variety of ways through stress and that the effect of stress can be mitigated through social support.
- Marxists claim that capitalism moves healthcare professions to privatization of healthcare services and establishes the drive to increase profit and power for a certain social class. This economic tendency makes the medical field a profit oriented organization.
- The theories of both Poststructuralism and Postmodernism are crucial to our understanding of the relationship between health, culture and the society. They offer a critique to modernism, and, in relation to health, show how the micro-politics of power relate to medical knowledge and medical power.
- Foucault's theory of Governmentality could be considered as an example of how poststructural and postmodernist ideas can help in understanding the relationship between health, culture and society.
- Governmentality highlights the centrality of 'the body' and how it is disciplined, inscribed and subjected within the realms of power and knowledge of experts within the realms of governance.
- Foucault found two distinct trends emerging in the history of medical practice; "medicine of the species" (the classification, diagnosis and the treatment of the disease) and "medicine of social spaces"

(the prevention of disease). The former defined the human body as an object of study subject to medical intervention and control, while the latter made the public's health subject to medical and civil regulation.

- Medical discourses however have come under increasing criticism for being uncaring, stigmatized and disempowering. Despite the claims to objective scientific reasoning, these discourses have been shown not to be value-free but often prejudiced and socially-constructed.



3.7 FURTHER READING

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2) Mitchell, D.P. 1996. "Postmodernism, Health and Illness" In *Journal of Advanced Nursing.* 23.

3) Reynolds, N. 2014. "The Sick Role- Sociology of Illness and Disease." http://clubrunner.blob.core.windows.net/00000050029/en-ca/files/sitepage/global-scholar-nathan-reynolds/final-sociology-paper/Final%20Sociology%20Paper_Nathan%20Reynolds.pdf.



3.8 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No 1: Talcott Parsons

Ans to Q No 2: Suicide

Ans to Q No 3: True

Ans to Q No 4: True

Ans to Q No 5: Michel Foucault

Ans to Q No 6: Postmodern theory

Ans to Q No 7: True



3.9 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: What is meant by 'organic solidarity'?

Q 2: Define 'sick role'.

B) Long Questions (Answer each question within 300-500 words)

Q 1: Write a brief note on Post Modern theory to understand health, with reference to Foucault.

Q 2: Explain the Functionalist perspective towards the understanding of health.

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UNIT 4 : DISEASE, POVERTY AND COLONIALISM IN INDIA

UNIT STRUCTURE

4.1 Learning Objectives

4.2 Introduction

4.3 Meaning of disease

- 4.3.1 Objectivist view
- 4.3.2 Social Science view

4.4 Understanding disease in colonial India: A perspective from Cholera epidemic and Smallpox

- 4.4.1 Colonial perception of disease and relation to poverty
- 4.4.2 Interpretation of disease by the natives

4.5 Colonial Measures for prevention of disease

- 4.5.1 Measures for smallpox
- 4.5.2 Measures for Cholera

4.6 Nature of resentments by natives

4.7 Let Us Sum Up

4.8 Further Reading

4.9 Answers to check your progress

4.10 Model Questions

4.1 LEARNING OBJECTIVES

After going through this unit, you will be able to :

- apprehend how disease is not just a medical issue, but also has social and cultural dimensions
- interpret the colonial as well as a native understanding of disease from examples of Cholera and Smallpox
- know about the different modes of techniques used by the natives to deal with the disease
- critically analyse colonial interpretation of disease and measures they provided

- popular resentments against British imposition of western medicine versus indigenous knowledge system of medicine

4.2 INTRODUCTION

This unit is going to introduce the concept of disease and the complex meaning associated with it in the context of colonial India. To do so, the unit will take examples of two cases- smallpox and cholera epidemic that broke out in nineteenth and twentieth century India. Both smallpox and cholera have thrown insights to comprehend modern medical measures versus indigenous forms of knowledge critically. The Western-centric view of colonialist, governed by rationalism and scientific outlook tended to undermine the knowledge systems of their subjects as inferior. They often considered the Indian ways of looking into a disease as out-dated and governed by superstition. Therefore this unit points that the term disease is not just a medical terminology but also derives its meaning from various cultural, historical and political contexts. The first section of the unit will look into different ways to understand disease and argues that it has much more than objective medical definitions. This will be followed by a general understanding on how the disease was perceived in colonial India both by the coloniser and the colonised. To examine this historical trajectory of disease, the unit, with examples, will see how there was a conflict between the European notion of scientific rationality versus indigenous forms of knowledge systems. The unit will then comprehend various measures taken by the British to control these diseases and popular resentments it received from the natives.



LET US KNOW

Implementation of vaccination was a difficult task for the British. It was in 1804 that Lord Wellesley formally banned variolation in Calcutta. But this law had little impact as natives were more comfortable with variolation than vaccination

LET US KNOW

Objectivists view disease as a fact. It should be clinically identifiable, objective and a thing in itself.

Disease is not just a medical terminology but derives its meaning from cultural, historical and political context.

4.3 MEANING OF DISEASE

4.3.1 Objectivist view

Objectivists conceptualised disease as a discrete entity. It is understood as clinically identifiable, objective and a thing in itself. Therefore L Rhodes (1996) calls disease in modern medicine to have an "aura of factuality". According to objectivists, the human body is made of organ systems to function naturally. Sometimes these organs can depart from normal functioning in many ways. To have a disease, therefore, there should be a claim about the abnormal functioning of the bodily system. It should also have a judgement that abnormality associated with it has a negative impact. Similar views are also shared by a group of scholars who belong to the naturalist school of thought. They think that disease is a bodily malfunctioning that ultimately causes the body to deteriorate and if not treated, can eventually lead to death.



LET US KNOW

Michel Foucault in his book 'Birth of a Clinic' (1963) argues that there is not a particular way to define medical prescription. The disease has a context and time.

4.3.2 Social Science View

The medical sociologist and anthropologist have been long

critiquing the idea of identifying disease as objective and detached from other social variables. They contend that there is no objectively definable malfunction as disease. We judge certain bodily discomfort as abnormal because they do not adhere to our specific culture and share a similar conception of human nature. Michel Foucault (1963) writes that there is no fixed way to define medical perception. Hence the definition of disease also takes its shape according to context and time. The perception towards disease may change over time, related to wider socio-cultural transformation. Thus, many diseases of the past may not be a disease today. Or, many bodily disruptions may be a disease in one culture and may not be in another. Hence medical anthropologists argue that disease is not only biological but also socially constructed. Therefore numerous bodily disruptions which the British perceived to be disease were blatantly refused to be so by the Indians. Rather, they had other interpretations like the individual being possessed by a spirit or God's playfulness in the human body. Similar is the case of western medicine.



CHECK YOUR PROGRESS- (A)

Q 1 : L Rhodes comments that modern medicine has-----

a) Essence of rationality (b) aura of factuality (c) tendency of superiority

Q 2 : What is social science view of disease

(a) Not any objectively definable malfunction

(b) It is objectively definable malfunction

(c) Disease has a universal character

4.4 UNDERSTANDING DISEASE IN COLONIAL INDIA : A PERSPECTIVE FROM CHOLERA AND SMALLPOX

The cholera epidemic and smallpox breakout were the deadliest diseases among few others like plague, malaria or leprosy in colonial India.

These diseases were caused to have a notorious effect on both natives and the British in the nineteenth and twentieth-century India. Cholera infected persons would have severe watery diarrhoea, loss of fluid, loss of appetite, fever and cramps. Whereas symptoms of smallpox were painful eruption of skin with pustules, sloughing and scars left permanently. It was so severe that persons affected with smallpox died within two weeks. And even if survived, it could leave a deformed body. Both of these conditions have taken millions of life until it was reduced or eradicated through national/ international programmes. The strong connection of spreading the disease cholera was traced from Hindu pilgrimages. In India, the disease got widely spread through tanks and watercourses used by the contaminated person, as immersion in a tank or a river for religious purification is a ritual among the Hindus. Kumbh Mela of Haridwar is one such instance when pilgrims immerse themselves into the water. The situation becomes worst when the pilgrims bring this 'holy water' of Ganges for family members to consume. In 1867 almost three million pilgrims came to attend the Kumbh Mela. Although only nineteen pilgrims were treated in Haridwar, most of them have carried it with them while travelling back home through different parts of the country. On the way, the pilgrims used the tanks and wells and left the fatal disease behind. Here the attack on cholera was therefore also an assault on Hinduism. It was also another reason for more reluctance and resistance to western medical sciences. The pilgrims were made a 'dangerous class' that required special surveillance and regulations.



LET US KNOW

The colonial government regarded Hindu pilgrimages attending Kumbh Mela or Jaggannath Rath Yaatra of Puri as primary carriers of Cholera

Accurate statistical data of the period of the 1860s is not available, and therefore no accuracy of death could be found before that era. From the available statistics, David Arnold (1986) a prominent historian traces that at least twenty-three million people died in colonial India from 1865

to 1947 due to the cholera epidemic. Therefore it was regarded as one of the first deadly epidemics in the nineteenth century. Jameson's statistics of the 1820s suggested that mortality exceeded 10,000 in several districts. Likewise, for smallpox, Arnold estimates that in Calcutta mortality from smallpox was 11000 in between 1837 to 1851. The children were primary victims, and it was said not to count the children as a permanent members of a household unless and until they survive an attack of smallpox.

4.4.1 Colonial perception of disease and relation to poverty

Studies have reflected that the diseases were significantly more among the poorer sections in India. It does not mean that Europeans were unaffected, but they took precautions with healthier living style and a good diet. For example, Jameson in Calcutta in 1820 speculates that Cholera is more among the slum dwellers where sanitation hygiene is in worst condition. These places are crowded with water stagnation and polluted drinking water. Rural areas were doubly affected by the disease accompanied by famine. During the 'Guntur famine' in the Madras Presidency in 1833, cholera killed almost 2 million people. Therefore decline in famine after 1900 was a factor in the decline of cholera mortality in the 1920s and 1930s. Likewise, the breakdown of Bengal Famine in 1943-44 brought Cholera epidemic back, although it was temporary.



LET US KNOW

1) There was a relationship between poverty and disease in colonial India

2) Deadly diseases like smallpox and cholera were worsened by famines which hit the country

3) However, the colonial government was more interested in researching bacteriology or parasitology, paying no attention to the poverty factor.

A similar case was seen when the bubonic plague epidemic broke out in Bombay in 1896 and spread to larger western and Northern India. Poverty did have a direct impact on the major famines that shook the country. Poor housing, unclean neighbourhoods and insufficient diet were seen as major players in transmitting the disease. A popular English daily in Bombay said that plague mainly chooses to attack the poor. The wealthier also occasionally fall victim, but it is the poverty-stricken who usually suffer. Similar was the case of Malaria. Sir S.R. Christopher investigated into the 1908 Punjab malaria epidemic and argued that there was a direct relationship between malaria and high food-grain price that led to mortality among the poor people of the region. However later he changed his position about the relationship between malaria and disease. It was interesting to see how colonial government was least interested in relating the diseases that were prevalent in India with the factor of poverty. Rather, the common understanding seemed to be that the cause of poverty were the diseases, not the other way round. The colonial government attributed the primary cause of diseases mostly to the environmental and cultural factors.

Moreover, the rise in research interest in bacteriology or parasitology diverted the attention from poverty in the nineteenth and early twentieth century. It was only after the nineteen thirties when poverty gained worldwide discussion, the topics and interconnections of disease and poverty were brought to the table. Otherwise, the colonial government found no interest in studying poverty, ironically which was caused by their actions of exploitations.

4.4.2 Interpretation of disease by the natives

It is mentioned above that western outlook towards disease and medicine was in contrast to indigenous ideas of the knowledge system — epidemics like Cholera and Smallpox which were seen

to be diseases by the British, were comprehended by the natives as revenge by deities or playfulness of God. Though India is a diverse country regarding religion or culture, the native's views were not very different from each other. As a consequence, the colonialist regarded them to be superstitious and backward. Indians also had their interpretation. There was an episode where British administrator Warren Hastings's army was attacked by Cholera in Bundelkhand area of Northern India. The villagers believed that it is because they have offended a Hindu God. A cattle was slaughtered in a grove sacred to a prince called Hurdou Lal to feed the British army despite warnings from the local Brahmins. Therefore they believed that the epidemic outbroke as it offended the spirit HurdouLal and therefore they started worshipping him. Similar examples were seen from Southern and Eastern parts of India as well. Therefore in possible ways, the British were seen as responsible for spreading this disease, either through offending Indian Gods or by disrupting the Hindu cosmos by their military interventions.

Perhaps because there was no equivalent technique of inoculation for cholera (unlike smallpox) which would need Goddess' blessings, Cholera had no specific deity which was popular in the country. Only in Bengal, the place of Cholera origin, there was a Cholera deity called "Ola Bibi" by Muslims, and "Olai-Candi" by Hindus. Likewise, HurdouLal was pressed into service as a male cholera deity. Thus there was an effort either to manifest the deity as the power of existing deity like Maa Kali or as new deity known as 'jarimari' (sudden sickness) or "Kala mari" (black death). The Europeans took these as sickening examples of superstition and fatalism versus European rationality to treat disease. However, the colonial government was also worried that the association of deities with diseases might lead to panic among the people and can have political complexities. Hence apart from medical treatment, the British also saw the need for a political response to the popular reactions that the epidemic cholera had aroused.



LET US KNOW

- Diseases like Cholera and smallpox were seen as being related to 'revenge of God' in human body by the natives
- Cholera had a deity only in some regions but 'sitala' is known as the deity of smallpox in most parts of India
- The deity associated with smallpox is- Sitala. She is an embodiment of 'shakti' and is known by names such as- 'mata', or 'Aai'.
- The circulation of chapattis from village to village to keep away cholera in North-India was a kind of solidarity among the natives. The British feared it may be some kind of mass mobilisation and hence kept close vigilante on the items circulated.

Ceremonies that were done to get rid of or keep away cholera were also seen as having political connotation by the British. For example, on the eve of Sepoy Mutiny in 1857 chapatis were circulated from village to village. The British were suspicious that this could have latent meanings of organising people against the British. However, it was virtually certain that Chappatis were passed on from one village to another in North-India for protection from Cholera deity. Guha argued that the chapattis might have served this purpose to avoid cholera. It was also an expression to show their solidarity of the collective anxiety they have against British rule. Likewise whenever there was cholera outbreak one could see new tokens were circulated as a symbol to keep away the cholera deity from the village. It was established that this transmission was merely for the purpose to avoid Cholera and had no political meaning attached. However, the administration was asked to be vigilant over anything transmitted even though it seemed to be an innocent act devoid of political connotation.

Like Cholera, even smallpox was related to a deity called Sitala. Sitala is an embodiment of Shakti, female energy which

has both productive as well as destructive powers. Therefore the destructive part was needed to be prevented so that it does not cause mortal harms. When the disease showed up, it is said that the Goddess has taken rest in a human body. Therefore even the smallpox inoculation practised in the nineteenth and twentieth century was performed within a context of religious rituals. Sitala is worshipped in almost all over India in different names. Particularly in Assam and Bengal, she is also known as Goddess of Basant which means Goddess of the Spring and the disease known as 'Basanta Rog' (disease of the spring). It is to be mentioned here that although Sitala is known to be the Goddess of smallpox, the natives believed that smallpox is more of a manifestation of her personality and presence rather than the essential character. Hence the disease is the 'sport'or 'play' which should be respected with rituals and offerings.

Therefore smallpox was not regarded as a disease by the Hindus, but as a divine form of the 'Mata' or 'Aai'. The burning fever and pustules marked in the body, therefore, demanded rituals more than therapy. Sitala, thus, means the 'cool one'. Therefore the common offerings made to the 'Aai' are the cooler substances like 'cold rice, curd, plantains and sweets'. It was advised to avoid hot cooked food; domestic fires were needed to be extinguished,and the affected one should debar from sex as it is considered to be a heating activity. The body is washed with cold water and soothed with wet neem leaves, the favourite tree of the Goddess. Therefore Sitala was both the source and also means to gain protection from it.

David Arnold argues that smallpox occupied a paradoxical place in the history of European medical ideas in India. It was seen as a disease by the Europeans but not by the natives of India. Though the condition of smallpox was prevalent in both Europe and Asia, the cultural context associated with India made the case unique. The way Sitala was worshipped, despite being

a threat to human lives, looked obscure and absurd to the western medical practitioners.



CHECK YOUR PROGRESS- (B)

Q 1 : What was the native's view of Cholera outbreak in Bundelkhand?

(a) Bathing in Kumbh- Mela

(b) Killing of cattle and offending Hurdolal

(c) Offending deity Sitala

Q 2 : What was the food item circulated to keep away Cholera in North-India?

(a) Chapati (b) Rice (c) Bajra

Q 3 : By what name Sitala is known in Assam?

(a) Mahamari (b) Basanta Rog (c) Kala- Ajar

Q 4 : Who investigated Punjab's Cholera epidemic in 1908?

(a) Sir Warren Hasting (b) Sir Dalhousie (c) Sir S.R Christopher

4.5 COLONIAL MEASURES FOR PREVENTION OF DISEASE

4.5.1 Measures for smallpox

The religious texts of Hinduism did not have a much-prescribed form to treat smallpox. One way to deal with protection from it was through the method of 'variolation' or 'inoculation'. This was the most common way to deal with Sitala before it was displaced by Jennerian vaccination in the second half of the 19th century. The accounts suggest that it was more of a religious offering than a medical procedure. Variolation was widespread in Northern and Eastern India, but not very popular in Madras presidency. There is no one way to conduct variolation as it differed from region to region in India. The standard ways to do was by

taking pustules from a patient or a recently variolated individual and then rub or inoculate the material made from smallpox pustules into artificially scratched skin of the infected body. The patient would then develop pustules from this artificial method which are less severe than the naturally occurred smallpox. In the latter part of the nineteenth century, the British tried to suppress this method.

Soon there was a substitute to variolation that was invented by Edward Jenner in 1790s. Jenner is now regarded as the father of immunology. He observed that it was possible to have immunity against smallpox if they were infected with cowpox. His experiment was successful, and vaccination grew in prominence in Europe as well as in India's British Empire. First vaccination was adopted in India in the city of Bombay in 1802. However until 1890, the use of vaccination failed largely. It was because the vaccinations were to be imported from Europe by ships. And till the time it reached the probable destinations its validity expired. Through the use of vaccination, the Europeans were getting less vulnerable to smallpox. However, it was very poorly performed in Bengal. Many people from the poorer class of British died who were mainly soldiers and sailors. The wealthier were well protected with vaccinations, diet, spacious houses and gardens and most importantly in having lesser contact with Indians.

But vaccination was never intended only for the Europeans although large sections covered by it were the Europeans. Vaccination was introduced at a critical history of colonialism in India. It showed that the regime although established by force of arms was benevolent to the subjects and vaccinations offered were a good opportunity to portray their 'good intentions' towards Indian people. The first law on vaccination for India came in 1804. It was Lord Wellesley's government who formally banned variolation in Calcutta. But this law was not enforced with coercion, and hence fifty years later Lord Dalhousie declared that it was impossible to prohibit variolation in India given its wide practice.

The latter officials were also reluctant to take any other coercive means fearing political tensions in the air. By an Act IV of 1865, the government of Bengal recommended to implement the Smallpox Commission of 1850 and practise of variolation in Calcutta would lead to imprisonment of three months or fine of Rs.200. This was followed by underground variolation. By the end of the 19th century, even western educated Indian scholars like Sir Sayid Ahmad Khan, a leading Muslim leader during the period, asked the government to implement laws for compulsory vaccination. He introduced a compulsory vaccination bill in the Viceroy's Council in September 1879. He spoke wisely about Western rationality and argued that natives of India might have had prejudices against vaccination. He said that vaccination is needed to protect the infants who are easy prey to smallpox.

4.5.2 Measures for Cholera

The long persistence of Cholera led the British government in 1864 to appoint 'provincial sanitary commissioners'. Even after 50 years of 1817 epidemic, the government was still in considerable ignorance about the scale of cholera mortality. There were reports on problematic sanitation and hygiene, but there were fewer solutions to the problem. It was only in the 1890s that the contamination of cholera was recognised, and the state began to take serious measures. In April 1892 the government of North-Eastern Provinces took a bold step to ban Haridwar Kumbh Mela when cholera broke out. Before the first world war, the patients were injected with saline to compensate for the water loss, the body undergoes during the disease. It helped in reducing the mortality rate to some extent but at a mass scale, this measure was not possible in implication. In 1890s W.M Haffkine pioneered the anti-cholera vaccine. However, the British administration was reluctant to experiment it in India during 1894-95. They had

reservations partly for its doubt in effectiveness and also feared the public reaction the inoculations might instigate. Even till the 1930s the government was not in favour of compulsory inoculation to be used on the pilgrims on Allahabad Kumbh Mela. The primary objection to it was political as they did not want to risk un-necessary public outrage against the colonial rule.

4.6 NATURE OF RESENTMENTS BY THE NATIVES

As mentioned at the beginning of the unit, western medical sciences did not find an easy penetration into the Indian society. The people were satisfied with the traditional healers like the Hakims, Vaidyas or Bej. Therefore they were not readily accepting British means of healing, like vaccination or hospitalisation for cholera patients.

British saw the primary reason in associating diseases with religion and variolation. The inoculators were also seen as the main obstacle to vaccination. Therefore in between the years of 1803 – 06, only 11,000 to 18,000 vaccines were used in the whole of Eastern and Northern India. In 1818-1829 in Bengal it was 30,000 a year and reached 62,000 in 1828-29 but reduced again to 15000 in 1832.

The British commissioners called for the prohibition of variolation as they must save the wilful destruction of the subjects above whom the Europeans have taken charge. There were other reasons for which the native population was reluctant to use vaccinations. Once the vaccines were established in India efforts were made to give arm to arm vaccinations. But vaccine was lost in human transition as parents were not allowing their children. Again when calf lymphs were introduced, it was very expensive to fund. And above all the Hindus rejected to it for their belief that it involves cruelty to animals. Animal vaccination was first used in 1870 and 1880s, and the opposition was strong from Western India. However, in later years, the resistance softened because the people preferred calf vaccine instead of the painful arm to arm method. Greatest of all, the secular nature of vaccination was surpassing the caste taboos

which were not acceptable to Hindu caste societies. Moreover, it needed no Pujas or ceremonies to offer to Sitala.

Likewise in case of Cholera the natives were not happy for blaming Hinduism as a reason for Cholera. When the British tried to clean the streams near river Godavari, the natives stood fiercely against it. Likewise, they were not willing to accept the government's action of banning Kumbmela during the epidemic season. The natives were also not comfortable in secular modes of hospitalisation and social isolation they received from hospitals. Rather, they wanted to be taken care of by their families. Moreover, hospitals were more exposed where caste taboos of purity and pollution were not followed. The British did not opt for compulsory measure for Cholera because they feared political outrage.



CHECK YOUR PROGRESS–C

Identify if the statement is true or false :

Q 1 : In between 1803 to 1806 only 11,000 to 18000 vaccinations were used against smallpox

(a) True (b) False

Q 2 : British regarded variolation as a better option than vaccination.

(a) True (b) False

Q 3 : Natives refused to calf lymph because it was made of human postules

(a) True (b) False

Q 4 : Animal vaccination was first used in 1870s and 1871

(a) True (b) False



4.7 LET US SUM UP

- Disease is not just a medical terminology, but is socially and culturally constructed.

- Both the British and the Indian natives had their ways of interpreting a disease. There was also sharp differentiation between the western medical system and indigenous knowledge system of medicine.
- The colonial government, although to a large extent was trying to bring reforms in modes of treatment, they were not merely interested in saving the natives from the disease.
- The way they wanted to enforce western medicine of allopath discarding indigenous forms of medicine was seen as a political game of imposing their superiority of knowledge.
- The reaction of Indians to Cholera and Smallpox can be comprehended as signifiers of the cultural divide between the colonisers and the colonised.
- British initially did not forcefully impose their methods such as vaccination on the Indians fearing political consequences. Even for Cholera no compulsory hospitalisation or banning of religious sites was encouraged although they always portrayed that their knowledge of medicine was superior.
- The Indians had their resentments towards the western imposition of medicine. It was not just resentment for medicine but a message that British ways should not be accepted. The aversion towards colonial medicine and their understanding of disease was therefore religious, cultural as well as political.
- However gradually the significance and need of some modern measures to treat diseases were accepted by the society at large.



4.8 FURTHER READING

Q 1: Arnold, D.; 1993; Colonizing body : State medicine and epidemic diseases in Nineteenth century India; University of California Press.



4.9 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No A: 1) b
2) a

Ans to Q No B: 1) b 2) a
3) b 4) c

Ans to Q No C: 1) True 2) False
3) False 4) True



4.10 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: State the objectivist view towards diseases.

Q 2: State the significance of associating diseases with particular deities.

B) Long Questions (Answer each question within 300-500 words)

Q 1: Discuss the colonialist perception of diseases in India.

Q 2: Why did the natives of India resent the colonialist measures to treat or prevent diseases?

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UNIT 5 : CULTURE AND DISEASE

UNIT STRUCTURE

5.1 Learning Objectives

5.2 Introduction

5.3 Defining Culture

5.4 Understanding Disease: The Medical Perspective

5.5 Disease: A Cultural Understanding

5.6 Let Us Sum up

5.7 Further Reading

5.8 Answers to Check Your Progress

5.9 Model Questions

5.1 LEARNING OBJECTIVES

After going through this unit, you will be able to:

- understand the meaning of the word 'culture'
- understand 'disease' in medical and cultural terms
- understand the relationship between culture and disease

5.2 INTRODUCTION

This unit introduces you to the concept of culture, the concept of disease and the relationship between the two. It will look into the scientific or medical understanding of the concept of disease as well as the cultural understanding of it. It will address the notion of disease as a cultural construct as much as it is a medical condition.

In the common-sense understanding, culture is referred to as 'a way of life'. The term culture encompasses a host of material as well as non-material things that human beings use in their everyday life. It is a broad and inclusive term that refers to anything that human beings do that does not have a biological basis and are not the products of biological inheritance. In this sense, culture can be understood as something human-made or learnt by human beings. Culture, therefore, includes any skill,

any particular piece or pattern of behaviour, belief or value or any attitude that a human being learns as a member of a human group. It also includes all and any tangible material objects that have been manufactured or are used by humans, that is a derivative of the said human abilities. Although in the common sense understanding of the term 'culture', it is often taken to refer to a particular level of refinement in behaviour, taste in food, music or art, etc. one needs to understand it in broader terms.

The word 'disease' is usually used to refer to any deviation from the normal state of health of any human, animal or plant. Any condition that makes an individual feel discomfort, owing to a disorder of structure or function, but is not merely a direct result of any kind of physical injury can be called a disease. A disease usually produces certain specific symptoms or affects a particular area of the body.

The concept of disease has got as deep roots in the cultural context of a community as it does in the medical or biological context. One needs to understand that the notion of a biological pathology as a disease is defined by cultural norms of health and wellness too. The standard of what is understood as normal or pathological in terms of health and illness depends on the values within a society and so, it is important to understand the relationship between culture and disease. In this unit we shall look into certain effects that culture might have on the understanding of and approach towards disease.



LET US KNOW

Culture :

That complex whole that includes knowledge, belief, art, moral, law, custom and any other capabilities and habits acquired by man as a member of society.

It also refers to all historically created designs for living, explicit and implicit, rational, irrational and non-rational, which may exist at any given time as potential guides for the behaviour of men.

5.3 DEFINING CULTURE

In common parlance usage, when one refers to a person as 'cultured', one means to point out their taste for refinement in aspects of everyday life such as food, clothing, music, art, etc. However, culture encompasses much more than that. In sociological terms, 'culture' refers to every aspect of human life that does not have a basis in biology, but is something that human beings learn as members of a human group. The culture of different human groups or communities differs from one another, but they may influence each other when they come into contact with one another. The term culture has been defined by Sir E.B. Tylor in his book "Primitive Culture" (1871) as 'that complex whole that includes knowledge, belief, art, moral, law, custom and any other capabilities and habits acquired by man as a member of society'. A.L. Kroeber and Clyde Kluckhohn in their book "Culture: A Critical Review of Concepts and Definitions" (1952) defined culture as 'all historically created designs for living, explicit and implicit, rational, irrational and non-rational, which may exist at any given time as potential guides for the behaviour of men'. The culture of a group is the cumulative deposit of different aspects of everyday life which are followed by the members of the group within a particular geographical area. Culture includes norms, values, mores, folkways, laws, cultural institutions, artifacts, food habits, attire, art, music and dance etc. of a community. The various aspects of culture are inherited by people from the preceding generations but culture is not a stagnant thing. It may change over time with the addition or omission of certain aspects that form this cumulative whole. Moreover, any change or alterations in one part or aspect of culture causes changes in other related parts or aspects and the reverberations thus created, can affect the system as a whole.

The study of different human cultures across the globe has been a part of the subject matter of the disciplines of Anthropology, Sociology and Psychology. The origin of the word 'culture' can be traced back to the Latin word cultura which means "cultivating or agriculture," and figuratively

"to care or to culture" from past participle stem of colere which means "to tend or to guard; to till, cultivate". The figurative sense of "cultivation through education, systematic improvement and refinement of the mind" came into use by c. 1500. The Century Dictionary writes that it was, "Not common before the nineteenth century, except with strong consciousness of the metaphor involved, though used in Latin by Cicero." The use of the word to mean "learning and taste, the intellectual side of civilization" was by 1805; and the closely related sense of "collective customs and achievements of a people, a particular form of collective intellectual development" is by 1867. According to Kroeber and Kluckhohn, E.B. Tylor was the first scholar to have made the currently used meaning of the word 'culture' popular in academia through his definition of the word in his book "Primitive Culture" in 1871.

Different Aspects of Culture :

Any given culture has several important aspects. Some aspects of culture are highlighted below :

- Culture can be explicit or implicit. The explicit aspects of culture include those which the bearer of a culture is conscious about. The implicit aspects are those which the bearer knows on an unconscious level.
- The smallest meaningful unit of culture is called a trait. Ralph Linton stated that some traits are general to the entire population of the group (known as universal traits), while other traits are shared by only some members.
- The culture of a group may be learned directly by interacting with members of the group, or indirectly by reading about it or observing the group.
- Although culture is abstract and intangible, it has very deep influence on the people who follow it. They tend to internalize culture.

The process of cultural diffusion is an important aspect of culture. It refers to 'the process through which the cultural traits invented or discovered in one society are spread to another society over physical

(geographical) space whether directly (through actual physical contact between people or groups) or indirectly (through other means of communication like television, radio, books and other printed materials, exchange of goods in commerce)'. The processes of adaptation and assimilation bring about cultural diffusion. However, in a rapidly transforming society there arises the issue of cultural lag. W.F. Ogburn stated that 'cultural lag exists when two or more variables which were once in some form of agreement become dissociated and maladjusted by their differential rate of change'. For instance, rapid advances in technology in contemporary societies across the world today may be far more fast paced than the changes in the customs, values and beliefs that exist in the society.

Another important term related to culture is ethnocentrism. It was coined by W.G. Sumner in 1906 and it refers to the prejudiced views and attitudes that one might carry about another culture or the members of a culture other than one's own. When one takes the values attached to a certain trait of one's own culture and uses it to judge that of another culture, one can be said to be indulging in ethnocentrism. 'Ethnocentrism judges the worth of other cultures in terms of the standards of one's own culture'. Ethnocentric attitudes create a divide between an ingroup and an outgroup and discourage change within the ingroup. However, within the ingroup it may also have a positive effect of promoting group solidarity and continuation of the status quo. Here, it is also necessary to understand the process of acculturation. It refers to the process 'when a whole way of life undergoes change under the influence of another culture'. This process is different from cultural diffusion in the sense that diffusion refers to the process of transformation of a few traits of a culture, but acculturation refers to a transformation of the entire culture under the influence of another, more dominant culture.



ACTIVITY 1

Think of some examples of ethnocentrism?

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5.4 UNDERSTANDING DISEASE : THE MEDICAL PERSPECTIVE

The Encyclopedia Britannica defines disease as 'any harmful deviation from the normal structural or functional state of an organism, generally associated with certain signs and symptoms and differing in nature from physical injury'. A human being/ animal or plant affected by a disease exhibits signs or symptoms indicative of its state. Thus, the normal condition of an organism must be understood in order to recognize the symptoms of disease. The study of diseases is called Pathology . It involves the determination of the cause of the disease, the understanding of the mechanisms of its development, the structural changes associated with the disease process (morphological changes), and the functional consequences of those changes. In order to identify the course of action or treatment for a disease, it is important to first identify the cause of the disease.

In medical terms, disease refers to a definite pathological process which has a characteristic set of symptoms and signs. A disease is caused due to extrinsic influences like pathogens such as virus, bacteria, etc.

The concept of disease or illness is commonly understood as the opposite of the concept of health. Diseases can be broadly classified into two categories: (a) noncommunicable diseases and (b) communicable diseases.



LET US KNOW

Disease : *It is an impairment of normal physiological function affecting all or part of an organism, especially a specific pathological change caused by infection, stress, etc. producing characteristic symptoms, illness or sickness in general.*

It may be any harmful deviation from the normal structural or functional state of an organism, generally associated with certain signs and symptoms and differing in nature from physical injury.

Noncommunicable diseases

A disease may originate within the individual or might be caused due to a reaction to some medication, or as a side effect of a course of medication. It may also be caused by some external agent, such as a chemical that is a toxic agent. In such a case the disease affects only the individual organism exposed to it. Noncommunicable diseases generally are long-lasting and they progress slowly, and thus they are sometimes also referred to as chronic diseases. They can arise from environmental exposures or from genetically determined abnormalities, which may be evident at birth or which may become apparent later in life. The World Health Organization (WHO) has identified four major types of noncommunicable disease. They are: cardiovascular diseases like heart attack, stroke, etc.; chronic respiratory diseases like asthma; diabetes mellitus; and cancer.

Certain noncommunicable diseases arise out of inherited genetic abnormalities which can leave the individual in need of some form of treatment in order to survive. Some diseases that can be hereditary include down syndrome, cystic fibrosis, Huntington disease, certain forms of cancer like breast cancer, etc. Other noncommunicable diseases may be a result of metabolic faults within the body, such as those associated with aging (e.g.: osteoporosis), or due to environmental hazards such as those that arise out of a deficiency or excess of a certain mineral (e.g.: goitre, mottled enamel of teeth in humans) in one's diet or one's immediate surroundings due to environmental causes or geographical location. Some

noncommunicable diseases can also be caused by toxins in one's living or work environment, such as respiratory diseases, toxic metal poisoning or radiation poisoning etc.

Communicable diseases

Communicable diseases are also often called contagious diseases. The external agent that causes such a disease may itself be a living organism which has the capability of multiplying within the host, thereby infecting other organisms. These diseases are carried from one organism to another and are also known as infectious diseases. These diseases can spread from one host to another through direct physical contact, clothing or items of daily use if they are used by the infected person and are not disinfected before another person uses it. They can also spread through air, or water from the infected people to others. Some of the most common and harmful types of infectious diseases are lower respiratory infections, diarrhoea etc. Since the latter part of the 20th century, however, death rates from infectious disease have declined to a large extent, because of increases in vaccination and other methods of disease prevention.

Prevention of diseases

The extent of the affect that a communicable disease may have on the affected person depends on a number of factors like, the relationship shared between the host and the parasite, the particular type of parasite, the resistance capacity or immunity of the host, amongst other factors. Infectious or communicable diseases may be prevented in one of two following ways:

- by preventing contact with the infected being
- by making the host unsusceptible, either by selective breeding or by providing an effective artificial immunity.

Most diseases except the idiopathic diseases (such as the ones which occur due to inherited metabolic defects) are preventable to a certain extent. Other noncommunicable diseases such as those resulting from factors related to environmental exposures, can be prevented by reducing or diminishing the factors responsible in the environment.



CHECK YOUR PROGRESS-(A)

Q 1. Disease refers to a definite pathological process which has a characteristic set of symptoms and signs. True/ False

.....

Q 2. Except the idiopathic diseases, most other diseases are preventable. True/ False

.....

5.5 DISEASE: A CULTURAL UNDERSTANDING

Apart from the medical explanations, diseases can also be understood from a cultural perspective. Every society has its own understanding of disease and illness and have certain culturally approved methods of prevention or cure. Traditional healing practices or methods and alternative medicine, such as Ayurveda, acupuncture, aromatherapy, homeopathy, clinical hypnotherapy, massage, etc., are practiced in almost every society. These culturally accepted methods of disease control, prevention or cure may not always be scientifically or medically viable, but may act as psychological suppressors for certain ailments. In many cases, however, these traditional methods may lead to deterioration of health of the affected individual and sometimes death.

There exist a number of social and cultural constructs about disease and illness and these ideas about disease often affect our perception and our reaction to diseases. For example, in most parts of India, there used to be certain taboos associated with certain diseases, especially those that lead to physical impairment such as polio or leprosy. It was often believed that one suffers from a disease because of one's karma in the last birth, or because of some misdeeds by one's parents. There are also certain misconceptions related to some diseases which place the onus of the disease on the person suffering from it, rather than looking at the

medical or environmental factors that cause the illness. Some diseases (for instance, diarrhoea among infants) are labeled as 'the poor man's disease', and are believed to affect only those who are poor. Therefore, it gets attached to a particular cultural perception and carry a kind of stigma attached to it. But the fact which is overlooked in such a case is that the child suffering from such an illness does not have access to hygienic food, clean drinking water or proper sanitation, which are issues that need to be addressed. The poor economic and social conditions act as catalysts for the spread of the disease, but associating a certain disease with a particular community or group is a problem.

Social stigma is one of the cultural aspects of certain diseases. Stigma attached to a disease or disorder is most apparent in the case of sexually transmitted diseases (STDs), especially AIDS, all over the world. Talking about sex in public is a taboo in most cultures, and so diseases like AIDS are not talked about. People often do not understand the preventive measures because these measures are not discussed openly owing to the stigma attached to the topic of sex and sexual intercourse. Even in countries like the USA where talking about sex is not much of a taboo, there is a kind of stigma attached to AIDS because of the cultural belief in the association of the disease with homosexuality or having multiple sexual partners.

Social stigma is also one of the reasons that mental health disorders are not taken seriously or discussed openly in our society. In India, as Renu Addlakha has stated in her work, women, more often than men, fall prey to such an attitude towards mental health. There is a notion of shame and guilt attached to psychological disorders as the person suffering from it may not be able to hold a job, or participate in everyday activities the way a "normal" person would be able to. This labeling of a person as "abnormal" attaches a biased umbrella view about all kinds of mental health issues, and to stay away from such stigma, instead of seeking medical help people often overlook or try to hide any problems that they or their family members may be suffering from. Stigma is also associated with the visible marks that might be left on a person's body

after recovering from a disease, such as pock marks after recovering from chicken pox, especially for women who may not fit into the cultural notion of beauty any more if they have such marks on their body or face.

Another cultural approach towards disease which is often seen across cultures is the lack of empathy on the part of society towards the one who is suffering. This is not true for every member of the society, as there are a number of people who volunteer to help the sick and engage in charitable activities as well. Many cultures have a tradition of being empathic and helpful towards their fellow human beings. But we often come across individuals who express pity instead of empathy towards a disease or disorder. This might be a result of the lack of awareness about a certain medical condition, but it is more often a culturally formed attitude of apathy towards illness or the rehabilitation of survivors. For instance, in India many individuals who become physically impaired due to a bout of polio in their childhood or if they had suffered from Hansen's disease (leprosy) were seen begging on the streets and in other public places. The apathy of the society as a whole, as well as the government in rehabilitating those who have suffered such a condition is quite apparent. The lack of awareness about a certain disease combined with a lackadaisical attitude towards bio-medicine can also result in stopping medical care or intake of the prescribed medicines without completing the course, which doesn't cure the disease completely and run the risk of its recurrence.

Culture specific superstitions related to diseases also add to the problem of delaying diagnosis and cure of a disease. People often tend to prefer shamans, witch doctors, traditional or religious healers, or those who dabble in pseudoscience like quacks, over legitimate practitioners of bio-medicine. The lack of awareness about diseases, financial constraints, lack of proper medical care facilities, or the existing superstitions and beliefs about a certain kind of illness may contribute to such choices.

However, it is not always culture that affects our understanding of and experience with diseases. Diseases can and often do, affect the existing cultural rules. For instance, the way one feels grief due to the

suffering or death of a loved one owing to a disease may affect one's behaviour or actions and steer them away from the culturally acceptable behaviour. Moreover, caring for a loved one suffering from an ailment may result in the reversal of traditional roles within the family. Therefore, there is a nuanced relationship between culture and disease and it is important to understand the culture specific nature of diseases as well.



ACTIVITY 2

How does social stigma affect the understanding of diseases? Think.

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CHECK YOUR PROGRESS-(B)

Q 1. Name a few methods of traditional healing.

a) b)

c) d)

e) f)

Q 2. Some cultural understandings of diseases include

a). Disease as taboo b). Disease as stigma

c). Superstitions about the cause of disease

d). All of the above

Q 3. Caring for an ailing loved one can result in traditional role reversal. True/ False

.....



5.6 LET US SUM UP

- In the common-sense understanding, culture is referred to as 'a way of life'.
- In sociological terms, 'culture' refers to every aspect of human life that does not have a basis in biology, but is something that human beings learn as members of a human group.
- The process of cultural diffusion is an important aspect of culture. It refers to 'the process through which the cultural traits invented or discovered in one society are spread to another society over physical (geographical) space whether directly (through actual physical contact between people or groups) or indirectly (through other means of communication like television, radio, books and other printed materials, exchange of goods in commerce)'.
- Another important term related to culture is ethnocentrism. It was coined by W.G. Sumner in 1906 and it refers to the prejudiced views and attitudes that one might carry about another culture or the members of a culture other than one's own.
- Acculturation refers to the process 'when a whole way of life undergoes change under the influence of another culture'.
- The word 'disease' is usually used to refer to any deviation from the normal state of health of any human, animal or plant.
- Diseases can be broadly classified into two categories: (a) noncommunicable diseases and (b) communicable diseases.
- Apart from the medical explanations, diseases can also be understood from a cultural perspective. Every society has its own understanding of disease and illness and have certain culturally approved methods of prevention or cure.
- There exist a number of social and cultural constructs about disease and illness and these ideas about disease often affect our perception and our reaction to diseases.
- Social stigma is one of the cultural aspects of certain diseases.

Stigma attached to a disease or disorder is most apparent in the case of sexually transmitted diseases (STDs), especially AIDS, all over the world.

- Social stigma is also one of the reasons that mental health disorders are not taken seriously or discussed openly in our society.
- Another cultural approach towards disease which is often seen across cultures is the lack of empathy on the part of society towards the one who is suffering.
- Culture specific superstitions related to diseases also add to the problem of delaying diagnosis and cure of a disease.
- Diseases can and often do, affect the existing cultural rules. For instance, the way one feels grief due to the suffering or death of a loved one owing to a disease may affect one's behaviour or actions and steer them away from the culturally acceptable behaviour.



5.7 FURTHER READING

1) Affliction: Health, Disease, Poverty. Veena Das, New York: Fordham University Press, 2015, 255 pp.

2) Bisht, S. A Lester Coutinho, 2000; When Cure Is Better Than Prevention: Immunity and Preventive Care of Measles; *Economic and Political Weekly*, pp. 697-708

3) Sax, W.S. 2009; God of Justice : Ritual Healing and Social Justice in the Central Himalayas. New York: OUP



5.8 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No A :

1) True

2) True

Ans to Q No B :

1) a) Ayurveda (b) Acupuncture
   (c) Aromatherapy (d) Homeopathy
   (e) Clinical hypnotherapy (f) Massage
2) d) All of the above
3) c) True



5.9 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: Define culture.

Q 2: State the meaning of disease in medical or scientific terms.

B) Long Questions (Answer each question within 300-500 words)

Q 1: Explain the relationship between disease and culture with examples.

Q 2: Differentiate between communicable and non-communicable diseases.

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UNIT 6 : MEDICAL PLURALISM

UNIT STRUCTURE

6.1 Learning Objectives

6.2 Introduction

6.3 Meaning of medical pluralism

6.4 Issues of medical pluralism

6.5 Trends and Practices of medical pluralism

6.6 Let Us Sum up

6.7 Further Reading

6.8 Answers to Check your Progress

6.9 Model Questions

6.1 LEARNING OBJECTIVES

After going through this unit, you will be able to:

- understand the meaning of medical pluralism
- know the issues related to medical pluralism
- know about the trends and practices of medical pluralism.

6.2 INTRODUCTION

In this new century, the impacts of globalisation on health services and for formation of health policies brought the focus of researchers towards health sector. The new focus of the researcher is because of the growing globalisation and its exerting complex impact on public health, health related policy formulation and implementation. The question arose about the role of globalisation on health and it was thought that globalisation itself was a contributing factor for the worsening of global public health and the failure of global health initiatives. The impact of globalisation on health was extensive in the developing countries where there was slow, unstable and unequal pattern of growth, and stagnation in health indicators. The worsening condition of the global public health was a situation that led to the framing of global health agenda by World Health Organisation

to achieve health for all. The health for all was a landmark initiative that was taken in consideration with the inadequate biomedical heath care system and was influenced by the optimistic movement for a more holistic approach to development of that time. A new approach using local resources and knowledge was advocated. WHO endorsed the policies and integration (formalisation) of traditional medicine (TRM) into health care systems. They were required in order to achieve optimal health care coverage. However, implementation of this objective on national levels was hindered by a variety of factors, some of which were associated with globalisation. Despite consensus at the international level in the 1970s that such an approach was rational, practical, and offered social and economic benefits, it proved difficult to realise over the following decades. The policy of formalising traditional medicine in health care system was not taken seriously in the initial period but it became a trend in the developed countries in the later period. With time people started seeking alternative approaches to the biomedical system.

Biomedical system began to enter in a new era of development and progress. Traditional medicine became a subject of clinical and commercial interest. Although traditional medicine became intense but the lack of progress in policy formulation and implementation left it vulnerable to economic exploitation. In 2002, the WHO announced a global TRM Strategy. The TRM Strategy called for all member states to integrate and formalise the role of TRM/CAM in health care systems. Since the WHO originally promoted the role of TRM, only 25 out of the 191 member states had developed an associated policy. Over the period of time, it was seen that demographic changes, growing medical pluralism and changing economic and social trends lead to the creation of a policy convergence. The applicability of TRM/CAM in health care had broadened and forced a range of policy issues onto the global agenda. Traditional medicine strategy of WHO was seen as an example of one of the trends in a globalising world. There has been an increasing emphasis on global models, where policies from one part of the world are transplanted elsewhere. Therefore, the global-local interface in terms of policy transfer was created and the

role of international organisations in that process was worthy.

6.3 MEANING OF MEDICAL PLURALISM

Medical Pluralism can be defined as the employment of more than one medical system or the use of both conventional and complementary and alternative medicine (CAM) for health and illness. Since 1990 complementary and alternate medicine (CAM) was included within the state health administrations of the various countries and medical pluralism had become state sponsored. Medical Pluralism has become a modern phenomenon and is no longer confined to the deprived societies.Traditional medicine as defined by WHO as the “diverse health practices, approaches, knowledge and beliefs incorporating plant, animal and/or mineral based medicines, spiritual therapies, manual techniques and exercises, applied singly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness”. Traditional medicine in India has codified systems (Ayurveda, Unani, Siddha, Sowa-Rigpa and Homeopathy) as well as non-codified systems (Folk Medicine). In codified system of traditional medicine, “knowledge has been codified, either in the form of pharmacopoeias or ancient scriptures”. In non-codified system of traditional medicine, “knowledge is transmitted by oral means and is mostly acquired through trial and error approaches”. Non-codified system of medicine was developed according to local needs and resources available to local people. Therefore, the system differs from region to region and is given different names like folklore medicine, little traditions, indigenous medicine, ethnomedicine, bush medicine etc. To preserve the non-codified ancient knowledge, there is a need for proper documentation. The term, indigenous systems of medicine, is used to emphasize the civilizational origin of a particular system of medicine. For example, biomedicine, homeopathy and naturopathy have their origins in Europe and so are indigenous systems of Europe. The Ayurveda, Siddha and Unani systems of medicine have their civilizational origins in India.

Historically the concept of medical pluralism is against the official

definition of medical profession. Officially medical profession is defined as monopoly' with 'exclusive competence' over the exercise of its work, and its aim towards establishing itself as prime source for the criteria of medical qualification that should generate a 'general public belief in its competence' and expert authority. Medical professionals aimed at the monopoly but social scientists pointed towards the pluralism of the profession. Charles Leslie is said to have coined the term while talking about Indian medical system. Medical pluralism as a concept is regarded as cosmopolitan, western, modern, and scientific. Medical pluralism has emphasized on how social change had an effect on local medical care. They took into consideration the internal logic and coherence of other medical practice and also speak of 'medical theories', and highlight the related concepts of practitioner and patient and emphasized on their cultural embeddedness. Some also highlight, what they call syncretic ideas and practices, others call it fluidity between medical fields with overlapping jurisdiction. Some also highlighted similarities in treatment from different medicine-style professionals and it showed that practitioners advertising themselves as either 'Ayurvedic' or 'Western medical' prescribed much the same treatments. While studies on 'medical pluralism' had initially praised the systemic aspects of other medicines, with the post-modern turn authors working on the theme pointed out partial knowledges.

6.4 ISSUES OF MEDICAL PLURALISM

Medical pluralism is an advance perspective to deal with health care.The medical systems have a bird's eye view about the medical professionals and their medical learning. However, medical pluralism is all about understanding from the perspective of the health care consumer. In medical pluralism patients experience through the perceived choice of commodities on sale, such as drugs, and their colours, taste, and packaging, or stethoscopes or scissors, and choose from which are considered relevant. Amidst of all the possibilities and relevance of medical

pluralism, there are lots of issues related to medical pluralism that are being criticised. There are critique evident about the 'medical pluralism' from the perspective of a medical doctor working at a local hospital. There is criticism about the explanations about the medical pluralism in social sciences.From the patients' perspective, treatment choices were explained in terms of social pragmatism and social efficacy. Contrary to the cultural assumption intrinsic to some writing on medical pluralism, it became apparent that many healers and herbalists were marginal figures who often did not speak the language of their client, and derived their medical powers precisely from being associated with the other, the exotic or the wild. Healers thus emerged as brokers who straddle boundaries.

One of the core themes of medical pluralism is the 'health seeking behaviour' of the patient and his/her 'therapy managing group', which emphasises on the importance of the perceived severity of the condition, the way in which it was classified and the range of treatment choices on offer to the patients. Research into it often centred on the individual and often operationalised accounts of decision-making processes, frequently within cognitivist frameworks. Early studies had identified 'hierarchies of resort', which outlined the nowadays somewhat obsolete 'acculturative' (and 'counter-acculturative') sequences, from medical doctor to priest to local exorcist (and the not exactly 'symmetrically reverse') , but which remained important for pointing out that choices depended not merely on a treatment's perceived speed of recovery but also on its 'socio-moral functions'.

Another issue related to health pluralism is that most health care takes place within what is called the 'popular sector' through the application of home remedies. Health system can be differentiated between three sectors: the 'popular', 'folk medical' and 'professional medical sector'. There are explanatory models' which are used for explaining the choices of health care and it was initially developed in an attempt to assess and improve the doctor-patient relationship which became a well-known problem from medical sociology perspective. Research on 'health seeking behavoiur' and 'explanatory models' focused too much on the individual

and the micro-social and left aside the exploration of sociological issues, as, for instance, what Pierre Bourdieu in his book 'Distinction' called taste and habitus, which highlighted that patterns of consumption are guided by aesthetics particular to social groupings. The local healers have a relatively strong position in the local medical field due to their social and cultural capital, while the government health centre, which was by comparison higher in economic capital, and to a certain extent also symbolic capital, did not dominate the health field.Within the contexts of discussing health seeking behaviour, as well as in some contexts of applied medical anthropology, the notions of 'medical pluralism' and 'medical systems' tended to be used in historically, sociologically and politically less sensitive ways, and intrinsic differentials in power and authority within the medical field and society at large tended to be overlooked. Many studies also highlighted how medical pluralism is also related to race and ethnicity and the class structure and it also shows that 'medical pluralism' focused on health care without embedding it in problems concerning society at large. The concept of medical pluralism is also heavily criticised claiming that it had led medical anthropologists into a theoretical impasse. He framed his ethnography around the notion of 'healing powers', which embraced ideas about clinical effectiveness, moral authority, political coercion and collective identity.

Marxist scholars have their own way of looking into the issue of medical pluralism. The term pluralism as a concept or system which recognizes more than one ultimate principle' and gives as an opposite of 'monism', no doubt was appealing to anthropologists who in the 1970s and early 80s were caught up in debates of relativism and rationality. The first generation of medical anthropologists instantly embraced it, although Marxist authors had dismissed it, saying that it created a false consciousness within late capitalist society. Herbert Marcuse has stated that 'at the most advanced stage of capitalism, this society is a system of subdued pluralism, in which the competing institutions concur in solidifying the power of the whole over the individual' , and claimed that 'the contemporary form of pluralism would strengthen the potential for the

containment of qualitative change'. The term 'medical pluralism' was a 're-emergence' of 'alternative', 'unconventional' or what others have called 'heterodox' medicines in Britain, and the 'West' at large. This movement of the late twentieth-century, as they stressed, was neither trivial nor marginal, nor one that was likely to be short-lived. Based on a study of the interplay of 'the state', 'the medical profession' and patients as 'consumers', they suggested the diversity the 'new medical pluralism' referred to was far more structured than that observed in the 'rest' of the world. They claimed an 'ideal type pluralism' involved players on a level playing field and promised 'equity' and 'choice', which, as is obvious from the above, never was an assumption among the anthropologists who first used the term.

6.5 TRENDS AND PRACTICES OF MEDICAL PLURALISM

Biomedicine got well accepted in Europe and America during 19th century. But in India, the cultural ideologies supported indigenous system of medicine and it was not possible to ban these systems of medicine or even regulate them. Some of the early experiments related to medical pluralism was done in India. There were attempts at National Medical Institution in Calcutta. Later on, the institution was replaced by a modern medical college. The Vaids and Hakims were given training during 1860-70s and traditional midwives (dais) were also trained in 1900s. After independence there was different perspective on indigenous medicine and many debates opened regarding this topic. Even though there were debates but there was a positive perception about the indigenous systems among policy makers.The various merits of indigenous system recognized by policy makers were; a) the people of country had faith and belief in these systems, b) the country had rich biodiversity to provide for traditional medicines, c) the emphasis of indigenous system of medicine was on ensuring prevention of diseases and adopting healthy lifestyles.

As a result of recommendations made by many committees, there emerged a "compromise" between Allopathy and the indigenous system

of medicine. The prime focus was given to modern medicine in a hierarchical order, at the same time making the pluralism “official”. The indigenous system was marginalised in terms of budget allocation also. In 1978 Primary Health Care approach was adopted with its principles being community participation, appropriate technology, comprehensive healthcare, and universal accessibility. It recognised traditional medical practitioners as important allies and recommended their training and engagement in primary health care. It was a paradigm shift in the Indian medical system. In National Health Policy of 1983 indigenous system was defined as, “our rich, centuries old heritage of medical and health sciences”.The policy recommended the integration of indigenous systems and their services to the overall healthcare delivery system at various levels.The department of ISM&H (Indian Systems of Medicine and Homeopathy) was created in March 1995. The department was renamed as AYUSH (Ayurveda, Yoga, Unani, Siddha and Homeopathy) in November 2003. The Central Council of Indian Medicine was set up under Indian Medicine Central Council Act 1970.In 2005, National Rural Health Mission (NRHM) was launched, “to provide accessible, affordable and quality healthcare to the rural population, especially to vulnerable groups”.The strategy of NRHM was to “mainstream” AYUSH in the health service system and to “revitalise” it. Under NRHM, one AYUSH doctor was to be posted at primary health centre (PHC) and two at community health centre (CHC). The separate department of AYUSH was created. At the level of CHC, separate room was allocated to AYUSH doctors with separate paramedical personal and AYUSH medicines. This is a new trend in Indian medical system, which is giving scope to the old age medical practices of our country a new hope and strategy.



CHECK YOUR PROGRESS

Q.1. What is meant by medical pluralism?

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Q.2. Explain about trends in medical pluralism.

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Q.3. What are issues related to medical pluralism?

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6.6 LET US SUM UP

- The impact of globalisation on health was extensive in the developing countries where there was slow, unstable and unequal pattern of growth, and stagnation in health indicators.
- The worsening condition of the global public health was a situation that led to the framing of global health agenda by World Health Organisation to achieve health for all. The health for all was a landmark initiative that was taken in consideration with the inadequate biomedical heath care system and was influenced by the optimistic movement for a more holistic approach to development of that time.
- Biomedical system began to enter in a new era of development and progress. Traditional medicine became a subject of clinical and commercial interest.
- Medical Pluralism can be defined as the employment of more than one medical system or the use of both conventional and complementary and alternative medicine (CAM) for health and illness.
- Traditional medicine is defined by WHO as the “diverse health

practices, approaches, knowledge and beliefs incorporating plant, animal and/or mineral based medicines, spiritual therapies, manual techniques and exercises, applied singly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness".

- Traditional medicine in India has codified systems (Ayurveda, Unani, Siddha, Sowa-Rigpa and Homeopathy) as well as non-codified systems (Folk Medicine).
- Historically the concept of medical pluralism is against the official definition of medical profession. Officially medical profession is defined as monopoly' with 'exclusive competence' over the exercise of its work, and its aim towards establishing itself as prime source for the criteria of medical qualification that should generate a 'general public belief in its competence' and expert authority.
- While studies on 'medical pluralism' had initially praised the systemic aspects of other medicines, with the post-modern turn authors working on the theme pointed out partial knowledges
- One of the core themes of medical pluralism is the 'health seeking behaviour' of the patient and his/her 'therapy managing group', which emphasises on the importance of the perceived severity of the condition, the way in which it was classified and the range of treatment choices on offer to the patients.
- The concept of medical pluralism is also heavily criticised claiming that it had led medical anthropologists into a theoretical impasse.
- Marxist scholars have their own way of looking into the issue of medical pluralism. The term pluralism as a concept or system recognizes more than one ultimate principle' and gives as an opposite of 'monism'. No doubt was appealing to anthropologists who in the 1970s and early 80s were caught up in debates of relativism and rationality.
- Biomedicine got well accepted in Europe and America during 19th century. But in India, the cultural ideologies supported indigenous system of medicine and it was not possible to ban these systems of medicine or even regulate them.

- In 1978 Primary Health Care approach was adopted with its principles being community participation, appropriate technology, comprehensive healthcare, and universal accessibility.
- In National Health Policy of 1983 indigenous system was defined as, “our rich, centuries old heritage of medical and health sciences”.
- The department of ISM&H (Indian Systems of Medicine and Homeopathy) was created in March 1995. The department was renamed as AYUSH (Ayurveda, Yoga, Unani, Siddha and Homeopathy) in November 2003.



6.7 FURTHER READING

1) Hörbst, Viola& Rene Gerrets, Pino Schirripa(2017). ‘Revisiting medical pluralism,’ L’Uomo: pp. 7-26.



6.8 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No 1 : Medical Pluralism can be defined as the employment of more than one medical system or the use of both conventional and complementary and alternative medicine (CAM) for health and illness.

Ans to Q No 2 : Biomedicine got well accepted in Europe and America during 19th century. But in India, the cultural ideologies supported indigenous system of medicine and it was not possible to ban these systems of medicine or even regulate them.In 1978 Primary Health Care approach was adopted with its principles being community participation, appropriate technology, comprehensive healthcare, and universal accessibility.In National Health Policy of 1983 indigenous system was defined as, “our rich, centuries old

heritage of medical and health sciences".The department of ISM&H (Indian Systems of Medicine and Homeopathy) was created in March 1995. The :department was renamed as AYUSH (Ayurveda, Yoga, Unani, Siddha and Homeopathy) in November 2003.

Ans to Q No 3 : While studies on 'medical pluralism' had initially praised the systemic aspects of other medicines, with the post-modern turn authors working on the theme pointed out partial knowledges. Medical pluralism is an advance perspective to deal with the health care. The medical systems have a bird's eye view about the medical professionals and their medical learning.Another issue related to health pluralism is that that most health care takes place within what he called the 'popular sector' through the application of home remedies. Health system can be differentiated among three sectors: the 'popular', 'folk medical' and 'professional medical sector'.



6.9 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: When was AYUSH formed?

Q 2: Why was NRHM formed?

B) Long Questions (Answer each question within 300-500 words)

Q 1: Explain Marxist approach to medical pluralism.

Q 2: What is the trend in medical pluralism in India?

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UNIT 7 : GENDER AND HEALTH

UNIT STRUCTURE

7.1 Learning objectives

7.2 Introduction

7.3 Meaning of gender

7.4 Gender and health

7.5 Nutrition and gender

7.6 Differential health practices and gender

7.7 Let us sum up

7.8 Further Reading

7.9 Answers to check your progress

7.10 Model Questions

7.1 LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Differentiate between sex and gender
- Understand the relationship between gender and nutrition
- Understand the differential practices of healthcare and its relation to gender
- Know the impact of gender on healthcare

7.2 INTRODUCTION

In the previous units, we have known about the significance of the socio-cultural dimension to understand health and disease. That health and disease are not merely biological phenomena has been established by the sociological approach to study health and medicine. In this unit, we shall know about the gender dimension to the ideas of health and nutrition. Here, you will be able to obtain a sociological understanding of the concepts of health, nutrition and gender, and the significance of the interrelationship among them.

7.3 MEANING OF GENDER

It is essential to distinguish between sex and gender when we are looking at the gendered idea of health. Sex and gender are different from each other. Sex is biological and physiological whereas gender is social and cultural. While male and female are sex categories, masculine and feminine are categories of gender. Health policy and health research should keep in mind the differences between sex and gender to properly develop ways to prevent and treat various kinds of diseases. Some might argue that health inequalities between men and women are natural because of the biological differences between the two.But this is a misunderstanding and needs to be corrected. Social and cultural factors influence biological aspects. For instance, globally, men are more prone to road accidents than women as more men drive and are more susceptible to driving while being drunk. Thus, death is linked to not just exposure to driving, but also riskier forms of doing it.



LET US KNOW

Gender and sex are different but related to each other.

The right to health is recognized by the Universal Declaration of Huamn Rights (United Nations, 1948).

Therefore, intersectoral action to address gender inequality is crucial to the recognition of the Millennium Development Goals (MDGs) of the United Nations.Promoting gender equity and empowerment of women is the third goal of the MDGs. The right to health is recognized by the Universal Declaration of Human Rights (United Nations, 1948) and is also a vital portion of the World Health Organizations' (WHO) main principles. The WHO created a women's health unit, which in 2000 evolved into the Department of Gender, Women and Health (GWH).

What is gender?

It is a common misconception that gender is equated to women and women's issues. But gender is much more than that – it is a socially

constructed term that refers to roles, behaviours, activities, and characteristics that are generally associated with men and women as considered appropriate by a particular society.

In the past, gender has been looked in two aspects – the masculine and the feminine. The masculine is generally associated with men while the feminine is associated with women. But in the present, the term gender is used more inclusively as it also includes the third gender, who are categorized as neither men nor women by society.They are more commonly known as the intersex people.

Gender may or may not be physiologically or biologically encompassing at all times, but generally, it is. It is also cultural and differs from society to society. For instance, healthier women in some parts of Africa are considered physically desirable, whereas, in most parts of the West, thinner women are considered physically attractive. Therefore, the notion of gender differs from society to society. Gender relations are the norms, values, attributes, attitudes, and expectations that guide how men and women should behave in any society.



LET US KNOW

Gender is the social role, norms, practices, behaviour,activities and expectations associated with one's sex category. It is culturally determined.

Historically speaking, men have been considered superior to women in almost all societies, and as such, the masculine has been seen as more powerful compared to the feminine. Men's work is considered more valuable than the work that women do. The third gender has been further marginalized.

Women have less land, wealth and property in almost all societies but more burden of work. Girls, in some contexts, are fed less, educated less, and more physically restricted. Women are mostly employed in lower paid jobs. Gender hierarchy governs how human behaviour operates. Even in places where extreme gender inequality does not exist, women

have less access to political power and participation, and economic and social opportunities.

Speaking about the relationship between gender and health, one's gender impacts their health conditions.One's health relations reflect the differences that exist between the genders. Having briefly outlined the meaning and kinds of gender, and the gender inequality that exists in society, we will now move on to describe how gender and health are connected.



CHECK YOUR PROGRESS – (A)

Q.1. What is the main difference between gender and sex?

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Q.2. Are gender categories rigid or fluid?

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The primary objective of this unit will be to show how the differential and unequal gender relations in society adversely impact women's and men's health. Gender plays a specific role in both the prevalence and treatment of diseases. This is because of interconnections that exist between biological and social factors. The gender perspective in health is a way of analysing and interpreting health situations from a perspective that takes into account gender constructs in society and searching for solutions to overcome gender-based inequities in health.

7.4 GENDER AND HEALTH

As already stated in the previous section, differences in the status of gender impact one's health. In societies in which higher gender inequality exists, there can be a disparity regarding access and understanding of

knowledge about disease management, prevention, and control for men and women. Men and women experience different kinds of illnesses subjectively,and attitudes towards treating diseases also differ for them.

Since men are seen as more important in most societies, their health is considered more important than women's. Therefore, within families in unequal societies, men seek more healthcare than women. Improvement in the status of women will enhance their healthcare facilities and reach. Many health conditions affect both men and women in varying degrees and ways.

Although women live longer compared to men in most countries, they have more age-related disabilities. With an aging population, the risk of chronic diseases such as diabetes and mental health problems - dementia, Alzheimer's disease, and depression - is amplified, among women.Moreover, some diseases such as breast cancer, osteoporosis,and eating disorders are more common in women, while others, such as endometriosis and cervical cancer, affect women exclusively. Men are more likely to die from lung and colorectal cancers, heart diseases and traffic accidents. Some diseases, such as prostate cancer, affect men solely (EIGE 2016: 3).

Mental health is also related to biology and gender. Women who have non-communicable diseases like diabetes and Polycystic Ovarian Syndrome (PCOS) are more likely to suffer from depression as these diseases are associated with gaining weight and suffering from fertility issues. This can lead to low self-esteem and feeling undesirable and as such depression.Women's depression is also related to pregnancy and menopause. Mental health problems linked to puberty, like identity crises, on the other hand, are common amongst boys. In many cases, sex and gender interact to contribute to create certain health risks. For instance, women's high risk of depression is influenced by genetics and hormones, but gender plays an instrumental role in magnifying the relative risk.

While biological differences between men and women impact their health differently, in this unit, we will be talking about health in social terms; that is, looking at how social factors affect health. For instance,

nutrition is one factor that is heavily impacted by the social status of gender. The next section discusses how one's gender affects one's diet.



LET US KNOW

Social and Biological ideas of health are inter-related. For example, in many societies women's lower position affects their health.

7.5 NUTRITION AND GENDER

The World Health Organization (WHO) defines nutrition as the intake of food in relation to the human body's dietary needs. Good nutrition – an adequate well-balanced diet – is fundamental for good health. Body shape and nutrition are also dependent on one's material and social conditions.

In this section, we will locate the factors that have an impact on the nutrition of men and women.

Many of the factors responsible for differences in the quantity and quality of food that a household gives to male and female children are interlinked and can be traced to the values and ideas generated in the kinship system, family structure, and ideology linked to them. The different rates of mortality and morbidity for girls and boys are explained in part by discrimination in nutrition and health care. While men are encouraged to eat appropriately to fill their stomachs, it is believed that women can starve if the need be. Women who might crave for food are laughed at by others and seen as greedy. Women and girls are not only the last to receive food, but they also get less of it and lower quality. Immunization rates are also very low for women. Many girls and women have high levels of anemia as a result of poor nutrition. Anemia affects pregnancy and increases the risk of maternal deaths.

For instance, meat is often made selectively available to males, and more specifically, preferred cuts of meat are reserved for men in some cultures.Physical strength, an attribute more characteristic of males,

requires optimal nutrition and meat is often seen as the most nutritious and strength-inducing of foods.

Another example that highlights the differential relationship that exists between health, nutrition,and gender is the consumption of milk. Customarily in many places,a girl is not given milk to drink. This is a typical pattern among Marathas and Brahmins in western Maharashtra and is, in fact, a general feature of Indian culture except among educated upper 'middle class' and well-to-do sections (Dube 1997: 137). Women are entitled to milk only in special circumstances such as lactation or illness, and sometimes pregnancy (ibid 138). There is differential access to food determined by one's gender which is altered during special times like illness and pregnancy.

Therefore, from the above argument, it is clear that one's gender has an impact on one's nutrition and health. However, it is not just nutrition, but gender also results in other kinds of differential health practices amongst men and women. In the next part, we will converse in detail some of the reasons why men and women have different access to healthcare services.

7.6 DIFFERENTIAL HEALTH PRACTICES AND GENDER

Let us now look at the various influences that lead to varying health practices amongst the two genders. First, we will discuss how specific gender barriers exist for women to access healthcare and then move on to those for men.

- **Gender barriers for women to access healthcare**
  - **Limited decision-making power** : Women generally and specifically in South Asian countries have very less or no decision making power within families, especially in rural areas. They are not able to decide who to marry, when to marry and when to give birth. Early marriage and childbearing pose health risks like complicated pregnancies, unsafe child deliveries, and

miscarriage.Many women also do not have access to abortion facilities.These are crucial decisions that can affect a woman's health and thus, create hindrances in women taking proper care of their bodies. There are also instances in which women cannot decide how many children they should have and this leaves a long-lasting adverse impact on their bodies. Control on women's movement, reproductive health, sexuality and decision making are seen as natural and in many cultures, rewarded. Women are taken as objects rather than subjects and as second class citizens.

- **Time Constraint** : Most women are busy with household chores throughout their day, and in urban areas, they do double duty in the sense that they have to work both outside and inside their homes. They hardly find time to take care of themselves and going for health check-ups is considered non-important. For many women, going out of their homes is also a concern, especially in rural areas. They are dependant on their husbands or other family members to take them to the hospital. For many married women, the health of their children and husbands become more important.
- **Economic reasons** : In many countries, although public healthcare facilities exist, they are overloaded, and people have to rely on private healthcare. However, it is expensive and not accessible to people from all classes and genders. Since women are not seen as equal members of society, their health needs are not considered as essential as men's and children's, and when there is money involved, their health issues are even more neglected. Economic barriers like user fees for maternal health services and a dearth of affordable primary healthcare means that women do not get adequate care. Increasing women's education can change this situation as it is directly linked to bettering women's economic opportunities. Education for women also influences the age of marriage,

fertility, number of children, nourishment, and health.

- **Intimate partner/domestic violence** : Violence against women is a result of macho male behaviour and unequal power relationships between men and women. It includes domestic violence, trafficking of women, rape, sexual harassment, female infanticide, female genital mutilation, dowry and honor killings. Domestic and intimate partner violence against women shows how men exercise dominance over women. Many women face intimate partner/domestic violence at the hands of their partners and husbands and families which impacts their physical and mental well-being. In a ten-country study on women's health and domestic violence which was conducted by WHO, between 15-71% of women reported sexual and physical abuse at the hands of a partner.

  Women tend to hide this fact, and as such both, their physical and mental scars go untreated. It takes a toll on their lives and their physical and emotional well-being as such women need legal protection from violence. Many governments have made policies to protect women from cases of domestic violence. For instance, India has a Protection of Women from Domestic Violence Act 2005 that gives women legal protection against domestic violence from their partners.

- **Health system barriers** : WHO defines health systems as all the activities whose basic function is to promote, restore or maintain health. Women in most places need more health services than men but do not have access to them. These barriers are a reflection of women's low position in society. Many women treat pain as a minor inconvenience and do not see it as a health issue that needs medical treatment. Many women do not talk about their health issues because it might mean lower chances of marriage.Women in some situations are reluctant to use existing health services because the overcrowded health systems do not ensure respect, privacy,

and confidentiality about treatment.

The WHO has embarked on a journey of changing health systems by focusing on building Primary Health Centres (PHCs) to make these systems more equal, fair and accessible.These PHCs are intended to pay special attention and care to women's health issues and needs. These PHCs are supposed to correct the gender imbalance in men and women accessing healthcare.

Let us now look at some of the factors that impact men's access to healthcare services. While we have seen that women neglect their health for social reasons like their inferior position in society and financial dependence, men face the risk of health hazards because of their superior status. Until recently, gender in relation to health meant women's health. But an inclusive approach also needs to take into account men's health. Therefore, a discussion on gender and health cannot be complete without paying attention to men's health.



ACTIVITY - I

Why do women have less decision making power compared to men in issues related to their bodies? Think.

ACTIVITY - II

What are the health system barriers that exist in women accessing healthcare? Find out.

- **Gender barriers for men to access healthcare**
  - **Notion of masculinity** : Rigid gender norms and the idea of masculinity that exists in every society act as a barrier in men accessing proper healthcare. Characteristics associated with masculinity like toughness, control, strength, etc. govern men's bodies and emotions. They are taught to see themselves as strong and hence a lot of times; they do not seek help from the doctor. In cases of issues related to mental health, men's suppression of their needs is even more as it involves emotions. They do not talk to even people close to them about their concerns, and that is why many men suffer from emotional crises. Men are expected to be aloof, unemotional and aggressive. Expectations of masculinity mean that men practice more risk-taking in accessing healthcare.
  - **Health system barriers** : The health system itself, particularly in India, acts as a barrier for men to access healthcare services. Shortage of human resources for health and lack of gender sensitization among health workers, especially about men's health means that men do not feel comfortable seeking medical help. This is all the more true when it involves mental and sexual health. The staff in most hospitals, public or private, are not sensitized to handle gender-based health issues. Reducing gender bias in health systems needs systematic approaches to generating awareness and changing values among service givers, processes to enhance health facilities and operative apparatuses for accountability. Advancing the local health centres, setting up systems for reliable emergency transport and making it possible for patients and their attendants / caretakers to stay near a health facility can yield positive results.
  - **Time constraint** : While many women work both inside and outside their homes, most men work outside in various kinds of jobs and have to put in long hours. They hardly get time for themselves and their families. As such, just like women, men

are hesitant to do routine health check-ups and take care of their health when they get some time off from their busy lives. For married men, their children's health becomes more important and as such their health becomes neglected. Another issue is the long waiting time in hospitals. When basic services are available at the primary care level, the over crowding in hospitals can be considerably reduced and this can save time and motivate people to come for regular check-ups.



CHECK YOUR PROGRESS–B

Q.1. Name two gender barriers that are common to both men and women in accessing healthcare facilities.

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7.7 LET US SUM UP

- Sex and gender are different from each other. Sex is biological and physiological whereas gender is social and cultural.
- In the past, gender has been looked at in two aspects – the masculine and the feminine. The masculine is generally associated with men while the feminine is associated with women. But in the present, the term gender is used more inclusively as it also includes the third gender, who are categorized as neither men nor women by society. They are more commonly known as the intersex people.
- Speaking about the relationship between gender and health, one's gender impacts their health conditions. One's health relations reflect the differences that exist between the genders.
- The World Health Organization (WHO) defines nutrition as the intake

of food in relation to the human body's dietary needs.

- Many of the factors responsible for differences in the quantity and quality of food that a household gives to male and female children are interlinked and can be traced to the values and ideas generated in the kinship system, family structure, and ideology linked to them.



7.8 FURTHER READING

1) 2010. *Gender, Women and Primary Healthcare Renewal: A Discussion Paper.* World Health Organization.

2) 2016. Report on *Gender in Health*. European Institute for Gender Equality. Luxembourg: Publications of the European Union.

3) Kawachi Ichiro, Bruce P Kennedy, Vanita Gupta, and Deborah Prothrow-Stith. 1999. Women's Status and the Health of Women And Men: A View from the States. *Social Science and Medicine.* 48(1): 21-32.

4) Sen, Gita and Piroska Ostlin. 2010. *Gender Equity in Health: The Shifting Frontiers of Evidence and Action.* New York: Routledge.



7.9 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No A :

1) Sex is biological whereas gender is social and cultural.

2) Gender is fluid.

Ans to Q No B (1) :

a) Health system barriers and time constraint.



7.10 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: How are nutrition and gender related?

Q 2: Highlight some gender barricrs which affect man's access to health care.

B) Long Questions (Answer each question within 300-500 words)

Q 1: Discuss the relationship between gender and health.

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UNIT 8 : HEALTH CARE INSTITUTIONS

UNIT STRUCTURE

8.1 Learning objectives

8.2 Introduction

8.3 What is a social organization?

8.4 How is hospital a social organization?

8.5 Understanding the profession of medicine

8.6 Let us sum up

8.7 Further reading

8.8 Answers to check your progress

8.9 Model questions

8.1 LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Understand the meaning of a social organization.
- Explain why hospital is considered as a social organization.
- Comprehend various nuances present in the profession of medicine.

8.2 INTRODUCTION

This unit will provide you brief idea about the nature of health care institutions. In this unit you will be introduced to the idea of social organizations and understand various features of these organizations. Further, it will explain the functioning of a hospital as a social organization. It will introduce you to the historical development in the organization of hospitals and explain its working. A brief explanation of the profession of medicine is also provided to highlight various changes that this profession has undergone since its inception due to the rise in technological advancements.

8.3 WHAT IS A SOCIAL ORGANISATION?

Every society consists of numerous kinds of groups, which interact with each other for the proper functioning of the society or the social system. Each of these groups further have a proper organization within themselves, which basically means that there exists a clear set or pattern of interaction within these groups which facilitate their smooth functioning. The discipline of sociology calls such a pattern of relationship that exist between social groups or among groups and individuals that constitute the group as social organization. Thus, it can be argued that the term organization basically refers to the interdependence of various parts in a group. A group can also be of numerous types. It can vary depending on size, nature and composition such as workers in a factory, members of a family, or nurses in a hospital. In the contemporary scenario, the usage of the word social organization has dramatically reduced. Instead, sociologists prefer using the term 'social system' to refer to the society. For example, Talcott Parsons, G.H Homans, R.K Merton and many others used the term social system to refer to society instead of using social organization. Since the term social organization stresses the importance of interdependence of parts in a group or in a society, it can be best understood by analyzing how a human body operates and functions. All the organs in a human body are arranged in a particular order and located at a particular place and perform a particular function assigned to them. Any discrepancy in any single organ disrupts the equilibrium of the human body resulting in various illnesses. Similarly, the society consists of various groups or parts which are akin to a human organ. The smooth functioning of these parts is extremely essential for the survival of a society. Social organization thus ensures this smooth functioning of the various groups or parts of the society. Since some form of organization is present in every aspect of our society, social organization constitutes an important topic in various sociological theories and research. There are many theorists who have given various definitions of social organizations. Some of these are mentioned below:

Duncan Mitchell : "Social organization means the interdependence of parts which is essential characteristic of all enduring collective entities, groups, communities and societies."

Ogburn &Nimkoff : "An organization is an articulation of different parts which perform various functions, it is an active group device for getting something done."

Eliott and Merrill : "organization is a state of being, a condition in which the various institutions in a society are functioning in accordance with their recognized or implied purposes."

H.M Johnson : "organization refers to an aspect of interaction systems."



LET US KNOW

Social Organization basically refers to the interdependence of various parts in a group. This interdependence is necessary for smooth functioning of the society

Every organization consists of members who have an assigned status in that organization and perform the role relative to their status

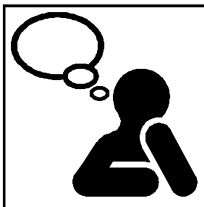
There are various characteristics or features of these social organizations. These include a well-defined structure, goal or purpose, division of labor, system of communication within members, sexual composition of the members, leadership, spatio temporal cohesion and many more. These features help in the proper monitoring of various forms of interaction that occur within these organizations. The interaction (called 'role') of individuals within these organizations is dictated by their position which is generally called 'status'. To put it simply, the role of individuals in an organization is based upon the status assigned to them. Since, organizations are made up by interacting individuals and groups, all social institutions are thus organizations. The family, state, church, banks, etc. are therefore various types of social organizations. As mentioned earlier,

these social organizations vary according to their size, members and the goal they serve. To put it broadly, social organizations are of two types. These include Formal and Informal organizations.

Informal organizations are defined as a small group where the members share interpersonal relationship among each other. The interaction between the members consists of informal ways without adhering to any strict norms or rules of behavior. Members of such organizations share companionship with each other and there are no assigned statuses to any member. They share their joy, sorrow, fears with each other. These include friendship, family, bands, etc. On the other hand, formal organizations are those which are characterized by the features listed above. These are: a specific function, division of labor, a hierarchy of authority, rationality and a proper arrangement of statuses and role. The working of these organizations is systematically and carefully planned out. The major difference between these two types of organization is the system or order present in the formal, which is lacking in the informal. This system of order is sociologically termed as bureaucracy. Max Weber is one of the pioneers in the field of sociology who provided the first conception of bureaucracy in his analysis of formal organizations. In his book on 'Theory of Social and Economic organization', Weber notices the increasing rise of formal organizations in the modern, capitalized society and thereby the increasing rationality in these organizations. As the interpersonal relationship between the members diminishes substantially in a formal organization, Weber terms them "iron cages" which take over an individual's life and traps them in a forever vicious cycle of rationality and control. Despite these major differences, the two types of organizations however are not mutually exclusive. Within every formal organization, there exists many informal organizations as well. For instance, a school or a university consists of various groups of friends or debate team, sports team etc. Similar kind of interpersonal relationship exists in all kinds of formal organizations, be it a church, an office and so on. In fact, for the proper functioning of a formal organization, it is necessary that its members share a cordial and friendly relationship

with each other rather than having animosity or hostility towards one another. Such cordial relationship ensures one way of achieving higher efficiency in these formal organizations. Charles Page, in fact argues that due to various forms of association and interaction among members of a formal organization, there emerges a form of informal relationships and roles. Thus, the relationship between formal and informal organization is complicated and complex.

From the above discussion, it can thus be inferred that society consists of varieties of organizations, both formal and informal. The society, as Ogburn and Nimkoff argue, in fact, itself is a larger organization which functions due to the interdependence and interrelationship between various large and small organizations, which consist, as stated above, of both formal and informal ones. Some of these organizations include factories, corporations, banks, schools, prisons, post office, etc. The State can also be categorized as an organization which has a major political goal. A university similarly represents another social organization which shares educational responsibilities. This unit will focus on one specific type of formal organization- the 'hospital'. The next section will explain in detail, the features and functioning of the hospital as a social organization.



ACTIVITY -1

Think how a university is a social organization. What are its functions?

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LET US KNOW

A large general hospital, prototype of modern-day hospitals facilitates provision of medical care, space for clinical research and education.

8.4 HOW IS HOSPITAL A SOCIAL ORGANIZATION?

This section would provide an analysis of hospital as a large-scale formal organization that exists in our society. While there exist various kinds of health care institutions, such as a private clinic, small rural hospitals, or the common ones which focus only on patient care, in this section, we will generally be discussing about a particular model of hospital which is a large general hospital typically found in an urban setting (not necessarily though) and which caters to three main functions: health care, teaching and research. While the other models of health care institutions exhibit various attributes of a social organization, it is these large general hospitals which are the closest to the other modern-day organizations and display latest medical trends. In fact, the World Health Organization (WHO) defines hospital as "they are instrumental for care coordination and integration and have a key role to play in supporting other health care providers (including primary health care) and in community outreach and home-based services. They also often provide a setting for education of doctors, nurses and other health care professionals and are a critical base of clinical research." A large general hospital itself is made up of various smaller social organizations which ensure a proper division of labor, leading to higher efficiency. For example, every hospital has a nursing staff, a surgery team, a pathology team (those who conduct various tests), etc. Large general hospitals additionally have other organizations that comprises of its teaching staff, students and its research team as well. One can notice all the attributes of a social organization which have been discussed in the above section in the working of a hospital.

Since, a hospital consists of numerous small organizations, it is highlighted by multitude of interactions that takes place among its members. Each member or actor in a hospital has a designated status and thereby performs his/her role based upon the position/status he/she holds. This designated status is a clear example of the intrinsic division of labor that exists within a hospital. Such a division of labor points to the

intrinsic form of professionalization or specialization that characterizes a hospital. These specializations are references of how work is distributed among the members of a hospital, based on their educational credibility. For instance, a hospital consists of a general physician, surgery specialist, neurologist, neuro surgeon, endocrinologist, cardiologist and so on. This is just a small example of how the doctors are categorized in a hospital and assigned their role. A hospital consists of various members other than doctors; such as nursing staff, non-clinical staff, managing committee, etc. Each of these are further categorized by their own organizational structure. Only when all these smaller organizations or departments within a hospital perform their designated role, the hospital functions smoothly. Robert Wilson, in this context argues that the basic interaction that typifies a hospital takes place between the staff and patient and between the staff themselves. He further asserts that while the patient constitutes an important component in the hospital, he however doesn't belong to it. He is in a state of transition as his identity gets ripped off once he enters the hospital. Thus, the patient, who is one of the most important actors in the hospital, according to Wilson is only a guest, who has a temporary role in the hospital.

The formal structure of a large hospital generally consists of three major forces: the administration, the board of managers or trustees and the medical staff. Beneath these lay the nursing staff, and other kinds of groups like social work, pharmacology, etc. Although the nature of authority is distinctly laid out in the hospital, there however exists certain confusion in its enactment. For instance, ideally, although the administration is the head of the hospital, there exists a clear uncertainty when it comes to the notion of authority between the administration and the medical staff. Wilson is of the view that hospital becomes a complex social organization because of such uncertainties in its authority. Since, administration is comparatively a new aspect in hospitals, it lacks the required occupational prestige that is given to medical staff which is the repository of maximum expertise. This expertise, of course, gives them absolute medical authority. It has been argued that without proper medical assistance, a hospital is akin to

a hotel for sick people. It is only with proper medical care and diagnosis that hospitals tend to perform their major function of providing health care. Hence, the occupational prestige accorded to the medical staff is quite above the administration. However, this is not to say that the medical staff has only limited administrative role. In fact, on various occasions, the line separating medical and administrative role diminishes. Such occasions arise during recruitment processes and compensation of nursing staff. Although these are the functions of an administrator, but the medical staff or the doctor also has a major say in it. Hence, it can be argued that there are two underlying themes that characterize the organization of a hospital: diffusion of authority and struggle for occupational prestige.

The role of hospital as a social organization which is a part of the wider society is not only confined to treatment of patients or provision of health care. The hospital can be regarded as a dynamic institution which has undergone major changes through various phases of history. Such changes are reflected in the social roles that this organization performs today. Cockerham provides a historical model of development of hospital that consists of four phases. Initially, hospital was started by members of the clergy, the nuns who along with providing care were also engaged in charitable services to the 'needy'. During renaissance, these religious centers became secularized and soon turned into places where the poor were fed and provided shelter along with provision of treatment. From the 17th century, there were noticeable developments in technology and medical knowledge, which was followed by an increase in number of hospitals as well as role of physicians in them. It is only in the 19th century that hospitals functioned as institutions solely dedicated for providing medical care, however not with much positive outcome. Finally, by the end of 19th century, as the society had held on to the pace of faster industrialization, the condition of hospitals changed drastically, and they became centers of medical technology and medical care open to all kind of people. This model helps us in understanding the modern-day functions of a hospital.

In the contemporary society, hospitals are providers of medical care, thereby aiding to community life. They also contribute to public welfare by acting as centers of research that bring about various inventions in the field of medicine. Moreover, as institutions that provide medical knowledge to students, they also enact as educational centers or universities. For instance, AIIMS, which is one of the leading hospitals in our country, is also a medical college and center for research bringing about new inventions in the field of medicine. Thus, in this capitalist economy, hospitals can be regarded as one of the largest employers of both clinical and non-clinical staff. As buyers of health care services, products and many other goods, they are also one of the prominent contributors to a country's economy. Hence, there has been a rise in the concept of 'medical tourism', which has been discussed in another unit. Despite these major functions that hospitals perform, they have been subjected to various kinds of criticisms. These include the rising callousness among medical professionals often leading to wrong diagnosis, the extreme rationalization in these organizations which has dampened the humanitarian aspect of it. Goffman criticizes hospitals by referring to them as 'total institutions.' He argues that since, in hospitals (mainly mental asylums) patients lead an administered life away from the society, they form new attachments which are based on these institutions (referring to this process as institutionalization), which makes it difficult for them to reintegrate into society again. He asserts that hospitals by depending on medicines, further this process of institutionalization which is extremely harmful for a patient's wellbeing. In the contemporary society, it is true that hospitals have undergone a drastic change, in fact Wilson calls a "large general hospital is the prototype of the multipurpose organization; it is a hotel and a school, a laboratory and a stage for treatment." However, the process of institutionalization still remains in hospital albeit its intensity has decreased.



ACTIVITY -2

Visit your near-by hospital and observe its organizational structure and functions. Write an analysis of it.

8.5 UNDERSTANDING THE PROFESSION OF MEDICINE

The discipline of sociology has always been interested in the concept of profession. There exist various theoretical traditions that provide analysis of professions or professional groups such as the functionalist theory or the neo-Weberian theory. In fact, Talcott Parsons is often regarded as the father of the study of professions. Although, having a single definition of profession is not quite possible, theoretical traditions in sociology have charted out various characteristics for a proper understanding of the idea of profession. Some of these features include provision of a definite, exclusive and necessary social service; possession of intellectual techniques and skills by practitioners of the profession; the methods used in the profession must be well researched and based on theoretical traditions; practitioners must exhibit lifetime commitment to their profession and should never engage in any form of malpractice. Every profession is awarded with social prestige and rewards. Certain level of public trust is attached to a profession. Every profession is attached with ideals of altruism and they also portray self-regulation, which basically means that professionals form their own organization keep a check on their practicing standard and licensing. Based on the above features, this section would analyze the profession of medicine and chart its historical development to understand its prominence in the contemporary society.

Humphry Rolleston has argued that “Medicine, in the ordinary sense namely, the supervision and cure of the sick is not, and probably never will be, an exact science; it is an art aided by the application of several sciences, in which philosophy, religion, and sometimes commercialism also play some part. The degree in which science is applied varies, not only in the hands of

different individuals, but also in the various branches or departments of medicine." Such a notion of medicine points to the fact that in order to understand the development of medicine as a profession, one needs to revisit the history or emergence of idea of medicine. Looking into the history of medicine, one can notice the change that has come up in the society, in its approach of dealing with health and illness. Some of the earliest medical traditions belonged to that of India, China, Babylon and Egypt. Medicine then, did not possess a universalistic feature, instead was quite dependent on the element of culture. The early forms of medicine were generally derived from the principle of 'humourism', also called as humoralism. This principle argues that in every human being, there are four kinds of humours or fluids: blood, phlegm, black bile and yellow bile. These fluids needed to be in equilibrium for a human being to be healthy. Thus, any kind of disease was treated as condition of disequilibrium of the four fluids in the body. The rise of modern medicine owes its discovery to the 'germ theory of disease' which indicated the fact that rather than humors, there are various kinds of germs-bacteria, viruses, fungi, etc., that cause infection in the body. Such discoveries were possible in the 19th century due to advancement in science and technology. Thus, similar to hospitals, the profession of medicine has also undergone through various phases. Today as our society has reached the epitome of technological advancement, the usage of these new technologies in medical care has been ever rising. Small pox has been entirely terminated, and there have been cures for many other deadly diseases. With the growth of modern medicine, various kinds of vaccines also were invented, which led emphasis on the idea of 'prevention' rather than 'cure'. Thus, the notion of "prevention is better than cure" came up. Hence, the role of science or scientific application of medicine is ever increasing in contemporary society. In fact, the extent of this scientific meddling in day to day lives has intensified so much that there have been numerous protests or criticisms against the process of medicalization. Medicalization generally refers to a process whereby any kind of human condition is treated through medical diagnosis only. Health care activists and various scholars have been speaking openly about the dangers of

increasing medicalization of human lives. Sociology of medicine is one such discipline that deals with the issues of medicalization and provides theoretical work based on various cultural and other forms of medicine to criticize it.

One such human condition, which is treated with extreme medicalization is the condition of pregnancy or the process of childbirth. Robbie E. Davis Floyd offers one such criticism of this process. She argues that obstetric rituals are nothing but a process of increased mechanization of the natural process of childbirth. She asserts that such rituals often tend to see women as the weaker sections, who are closer to nature and inferior, and hence are subjected to manipulation by men. Just as this natural world, hitherto considered as supernatural was brought under the control of man due to advancement in science, she argues women, who are closer to nature are also under the control of men and their technologies. She provides various conceptual dilemmas that are ingrained in obstetric rituals which exemplify the fact that these denigrate the female body and consider it as incapable of delivering a child naturally. For instance, the lithotomy position which is considered ideal for giving birth in hospitals is not the correct way or the healthy way for delivering a baby. It is considered the right way as it helps the doctor to be in proper control of the female body. Similarly, there have been numerous instances which have highlighted how every hospital has a designated number of caesareans to perform every day. This means that many times, doctors perform caesarean although there is no need of it, just for the sake of business. Such instances are not only limited to child birth but various other kinds of surgery or diagnosis also. Medicine today has abandoned its goal of altruism and health care and entered the capitalist world where the human body is seen as a commodity, which is under the control of doctor and his/her expertise or knowledge which the laymen lack. As the distrust between doctors and patients have increased today due to wrong diagnosis or surgeries, there has been an increase in the use of alternative medicine. The use of Ayurveda today has increased. In fact, many people have totally withdrawn from scientific medical care and are using alternative methods of Ayurveda, homeopathy along with yoga. Even today, with the advent of modern medicine and practices which apply to all societies,

one can still notice the influence of culture in the treatment of various kinds of medicine. For instance, in India, chicken pox was considered as a possession by the Goddess Sitala of a human body. Thus, the diagnosis involved numerous rituals and sacrifices to the deity Sitala which was believed to cure the disease. Even today, while there exists a scientific treatment of chicken pox, many of these cultural practices of pleasing the Goddess are still carried on in the Indian society. Also, there has been rising cases of home delivery these days, however with the supervision of a medical expert. Thus, today one can see a tendency of an amalgamation of both modernity and tradition in terms of medical care that people resort to.



ACTIVITY-3

Think how medicalization has affected every day life of human beings. Do you think there is an increase in the process of medicalization in the contemporary world?



CHECK YOUR PROGRESS

Q.1. Prison is an example of a social organization. True or False.·

Q.2. What other functions a hospital performs apart from provision of medical care?

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Q.3. What are the alternative forms of medicine which are being used in contemporary times?

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.....

Q.4. Name one natural human condition which has been extremely medicalized.

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.....



8.6 LET US SUM UP

- The term organization basically refers to the interdependence of various parts in a group.
- There are various characteristics or features of the social organizations. Few of these include a well-defined structure, goal or purpose, division of labor, system of communication within members, sexual composition of the members, leadership, spatio temporal cohesion and many more.
- Informal organizations are defined as a small group where the members share interpersonal relationship between each other. The interaction between the members consists of informal ways without adhering to any strict norms or rules of behavior.
- The role of hospital as a social organization which is a part of the wider society is not only confined to treatment of patients or provision of health care. The hospital can be regarded as a dynamic institution which has undergone major changes through various phases of history. Such changes are reflected in the social roles that this organization performs today.
- Goffman criticizes hospitals by referring to them as 'total institutions.' He argues that since, in hospitals (mainly mental asylums) patients lead an administered life away from the society, they form new attachments which are based on these institutions (referring to this process as institutionalization), which makes it difficult for them to reintegrate into society again.
- Medicalization generally refers to a process whereby any kind of human condition is treated through medical diagnosis only.
- Sociology of medicine is one such discipline that deals with the issues of medicalization and provides theoretical work based on various cultural and other forms of medicine to criticize it.



8.7 FURTHER READING

1) Floyd, R. E. (1990). The Role of Obstetrical Rituals in the Resolution of Cultural Anomaly. *Social Science & Medicine*, 175-189.

2) Rolleston, H. (1930). Medicine as a Career. *The British Medical Journal*, 699-702.

3) White, K. (2002). *An Introduction to the Sociology of Health and Illness.* London: Sage Publications.

4) Wilson, R. N. (1963). The Social Structure of a General Hospital. *The Annals of the American Academy of Political and Social Science*, 67-76.



8.8 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No 1 : True

Ans to Q No 2 : Apart from medical care, hospitals also act as educational institutions and centers of medical research. They are one of the leading employers in the capitalist world.

Ans to Q No 3 : Ayurveda along with yoga, Homeopathy

Ans to Q No 4 : Pregnancy or childbirth



8.9 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: What is meant by social organization?

Q 2: Highlight the historical transition in the organization of hospitals.

B) Long Questions (Answer each question within 300-500 words)

Q 1: Explain the rise of modern scientific medicine. Comment on the increasing medicalization of human conditions in contemporary society with an example.

Q 2: Explain how hospital can be considered as a social organization.

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UNIT 9 : PUBLIC HEALTH

UNIT STRUCTURE

9.1 Learning Objectives

9.2 Introduction

9.3 Meaning of public health

9.4 Emergence of the notion of public health

9.5 Community health

9.6 Meaning of social epidemiology

9.7 Let Us Sum up

9.8 Further Reading

9.9 Answers to Check your Progress

9.10 Model Questions

9.1 LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Know the meaning of public health
- Understand emergence and notion of public health, community health
- Know the meaning of social epidemiology

9.2 INTRODUCTION

In this century it is very easy to point the tremendous progress that is made in the health and life expectancy of the people. It is seen that many dangerous diseases have decreased, mortality rate has reduced and better family planning has started. While discussing health of people it is discussed in terms of the diseases they suffer from. Most people make full recovery from diseases, but some suffer damage to their bodies and may have permanent disability. With the changing health conditions, public health emerged as an important aspect of health care. The basic health services should be provided by dispensaries and health centres. They represent the minimum level of health services that should be

available to the majority of the population. They have also been called 'essential health services'and are incorporated in the most popular current term 'primary health care'.

9.3 MEANING OF PUBLIC HEALTH

Public health is the science and art of preventing disease, prolonging life and promoting physical health and efficiency through organised community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organisation of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health. Sir Donald Acheson in 1988 defined public health as: 'the science and art of preventing disease, prolonging life and promoting, protecting and improving health through the organised efforts of society'. Public health can be defined as the science of protecting the safety and improving the health of communities through education, policy making and research for diseases. The meaning of public health is different for every person. Whether you like to crunch numbers, conduct laboratory or field research, formulate policy, or work directly with people to help improve their health, there is a place for you in the field of public health.

The importance of this field is that it pays attention to social context of health and disease and focuses on improvement of health through social measures such as vaccinations, good drinking water and good policies. Public health is related to health of communities, not an individual's health. The concept of public health is unique in nature and is changing over time with years because of the health status of the population and the determining situations of health. The definition of health is widely linked with public health as found in the Preamble of the constitution of the World Health Organisation (1948), where health is referred to as "a state of complete physical, mental and social well-being and not merely

the absence of disease."The meaning of public health is to create a right condition to provide better health condition. Public health involves the application of many different disciplines such as biology, anthropology, public policy, mathematics, engineering, education, psychology, computer science, sociology, medicine, business and others.

9.4 EMERGENCE OF THE NOTION OF PUBLIC HEALTH

The history of public health is related to various historical ideas, trial and error, the development of basic sciences, technology, and epidemiology. James Lind's clinical trial of various dietary treatments of British sailors with scurvy in 1756 and Edward Jenner's 1796 discovery that cowpox vaccination prevents smallpox have modern-day applications as the science and practices of nutrition and immunization are crucial influences on health among the populations of developing and developed countries. History is a way of looking into the perspective of health by an understanding of health problems of communities and how to cope with them. Two factors have shaped the modern public health system i.e. the growth of scientific inquiry and research on sources and means of controlling disease and the growth of public acceptance of disease as both possibility and a public responsibility.

Throughout recorded history, epidemics such as the plague, cholera, and smallpox evoked sporadic public efforts to protect citizens in the face of dreaded diseases. By the eighteenth century, isolation of the ill and quarantine of the exposed became common measures for containing specified contagious diseases. During eighteenth century, cities began to establish voluntary general hospitals for the physically ill and public institutions for the care of the mentally ill. Even the physically and mentally ill dependents were cared by their neighbours in local communities. The nineteenth century is a beginning of new era in public health. "The great sanitary awakening" became popular and the identification of filth as both a cause of disease and a vehicle of transmission and the ensuing embrace

of cleanliness was a central idea. Awakening of sanitation paved a new way to see health. Illness came to be seen as an indicator of poor social and environmental conditions, as well as poor moral and spiritual conditions. Protecting health became a social responsibility. Disease control continued to focus on epidemics, but the manner of controlling turned from quarantine and isolation of the individual to cleaning up and improving the common environment. And disease control shifted from reacting to intermittent outbreaks to continuing measures for prevention. With sanitation, public health became a societal goal and protecting health became a public activity. Another major development in public health took place at the close of the nineteenth century. Rapid advances in scientific knowledge about causes and prevention of numerous diseases brought about tremendous changes in public health. Many major contagious diseases were brought under control through science applied to public health. Louis Pasteur, a French chemist, proved in 1877 that anthrax is caused by bacteria. By 1884, he had developed artificial immunization against the disease. During the following few years, discoveries of bacteriologic agents of disease were made in European and American laboratories for such contagious diseases as tuberculosis, diphtheria, typhoid, and yellow fever. During that time public health became an important issue that needed important attention.

The state and local health departments were started during 1890s and began to establish laboratories. These laboratories concentrated on improving sanitation through detection and control of bacteria in water systems. Some of the changes that are seen with the enthusiasm about public health is that people started embracing the new scientific foundation for public health. Scientific measures such as replacing earlier social, sanitary, moral, and religious reform measures to combat diseases were taken into account. Science was seen as a more effective means of achieving desirable social goals regarding public health services. Diseases were taken seriously and it was thought that proper public health service only can achieve good health condition. Use of scientific measures for

infectious disease control were taken seriously. The health officers were asked to concentrate on controlling specific routes of disease transmission. The new methods of disease control were found remarkably effective. The public health became a scientific enterprise, it also became the province of experts. Prevention and control of disease were no longer tasks of common sense and social compassion, but of knowledge and expertise. Health reforms were guided by engineers, chemists, biologists, and physicians. And the health department gained stature as a source of scientific knowledge in health. It became clear that not only public and individual restraint were needed to control infectious diseases, but also state agency, epidemiologists and their laboratories were needed to direct the way.

During twentieth century, new changes started to take over. It was seen that the role of the state and local public health departments expanded greatly. It was understood that individual persons are also a kind of source of disease transmission. Identification and treatment of individual cases of disease were taken seriously and it was believed that treating an individual will be a contribution towards treating the whole community. It is also seen from various data that providing immunizations and treating infectious diseases did not solve all health problems. Despite remarkable success in lowering death rates from typhoid, diphtheria, and other contagious diseases, considerable disability continued to exist in the population. There were still numerous diseases, such as tuberculosis, for which infectious agents were not clearly identified. The public agencies started to move into clinical care and education and from that the orientation of public health shifted from disease prevention to promotion of overall health. Epidemiology provided a scientific justification for health programs that had originated with social reforms. Public health once again became a task of promoting a healthy society. In the twentieth century, this goal was to be achieved through scientific analysis of disease, medical treatment of individuals, and education on healthy habits. From the 1930s through the 1970s, it is seen that the local and state responsibilities towards health increased. The role of state towards health also increased

prominently. The strong governments had strong moral values towards public health service. This shows that emergence of public health has came a long way. The government took interest in both state and local health agencies for providing and planning health services, in health promotion and health education, and in financing health services. The agencies also continued and increased activities in environmental sanitation, epidemiology, and health statistics. Expansion of state activities in health sectors is also seen.

State started expanding their activities in health to accommodate medical care, health promotion and education, and health planning. Maternal and child health, family planning, immunization, venereal disease control, and tuberculosis control are some of the key issues that were taken into account and local health departments were to provide these services. Many people were assigned for better performance of health care service. In current era the efforts are seen towards cost containment. Although health needs and health services have not diminished, political and social values of the time encourage fiscal constraint. Current values also emphasize state responsibility for most health and welfare programs. Changes also have been made in Medicare payment policies to restrain the increase in costs, especially for hospital care. Many new health problems started to surface with time. AIDS, a previously unknown contagious disease, is reaching epidemic proportions. Greater numbers of hazardous by-products of industry are being produced and disposed of in the environment. Many other issues are of growing concern—asbestos exposure, side effects from pertussis vaccines, Alzheimer's disease, alcoholism and drug abuse, and homelessness are just a few.

New health problems continue to be identified, conflicting with concerns about the growth of government and government spending in health. Although science provided a foundation for public health, social values have shaped the system. The task of the public health agency has been not only to define objectives for the health care system based on facts about illness and health, but also to find means to implement health goals within a social structure. The development of a scientific base for

public health allowed some consistency in the public health system. Health care included sanitation, laboratory investigation, collecting vital statistics, regulation of the environment, epidemiology, administering vaccines, maternal and child health, mental health, and care of the poor. How local systems conduct these programs differs greatly from area to area. Changing values over both time and place have allowed great variety in the implementation of public health.

9.5 COMMUNITY HEALTH

Before understanding the meaning of community health, it is important to understand the meaning of community. A community is a collection of people who interact with one another and whose common interest or characteristics gives them a sense of unity and belonging. A community is a group of people in defined geographical area with common goal and objective and the potential for interacting with one another. People belonging to same community have a sense of belongingness and shared identity. Some communities may share almost everything, while other communities (large, scattered and composed of individuals) who may share only their common interests and involvement in certain goals. A community is often defined by its geographic boundaries and is thus called a geographic community. A community demarcated by geographic boundaries becomes a clear target for analysis of health needs to form basis for planning health programs and a geographic community is also easily mobilized for action. Community can also be identified by a common interest or goal. A collection of people, although they are widely scattered geographically, can have an interest or goal that binds the members together, called common interest community.

Community health is the part of medicine which is concerned with the health of the whole population and the prevention of diseases from which it suffers. The process is done taking into consideration the whole community in mind. In this method, firstly, diagnosis of diseases is made at community level, preventive measures are taken, and then suitable

control programmes are organized. Limited amount of money is also an issue when it comes to community health care services. The limited amount of money makes it necessary to work out which among the important and preventable diseases are the priorities, and then to decide on the most effective control programmes that can be afforded. The medical services have traditionally been organized around curative medicine, like that carried out by dispensaries, outpatient departments, and hospitals. These services offer help to sick people who come and ask for it, but they do very little for those who do not come and do not ask. The people who come for medicine can cure some diseases, reduce some suffering, and prevent some deaths, but it can do very little to alter the number of new cases of an illness which occur in the community. To control the number of people who become ill, it is important to start before the people become sick. This is preventive medicine. To practise effective preventive medicine, it is necessary to make some simple health services available to all those who might get sick. Some communities appear to have more sickness and deaths than other communities. Problems such as more children with malnutrition, or more young people with tuberculosis or anaemia are taken care of in community health.Such observations about health and disease patterns in a community and what can be done about them lead to the practice of community health. In the case of individual person's illness, it is necessary to collect some basic information about illness, or what stage the illness that he/she may be suffering from has reached.This is done by history taking, physical examination, and investigations.This is followed by making a diagnosis of what is wrong. Same is with the community. First, it is important to collect information about the whole community and then diagnosis the health-related problem and decide on the most appropriate community health (treatment) programmes; and finally follow up and evaluate the programmes to see if they have done any good in making the community healthier.

9.6 MEANING OF SOCIAL EPIDEMIOLOGY

Social epidemiology is a branch of epidemiology that studies the distribution and determinants of health and disease in populations. Social epidemiology focuses particularly on the effects of socio-structural factors on states of health. Social epidemiology assumes that the distribution of health and disease in a society reflects the distribution of advantages and disadvantages in that society. Social epidemiology proposes to identify societal characteristics that affect the pattern of disease and health distribution in a society and to understand its mechanisms. Social epidemiology is a recent idea, and according to it the social conditions affect health.

Social condition influencing health is not a new concept. Durkheim explains that social norms and conditions affect risks of suicide in the population. Social epidemiology builds and expands on this literature by posing new research questions, utilising new research methods and influencing government policy agenda.Social epidemiology is a very systematic process to understand health, wellbeing, social conditions or problems, diseases and their determinants. In this way social science methods can develop interventions, programs, policies,and health institutions that may reduce the extent, adverse impact or incidences of health or social problems and also promote health. The approach of social epidemiology reflects the understanding that social variables or conditions can lie on either side of the equation determining the factors that affect health and illness.



CHECK YOUR PROGRESS

Q.1. What is meant by public health?

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Q.2. Define community.

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9.7 LET US SUM UP

- Public health is the science and art of preventing disease, prolonging life and promoting physical health and efficiency through organised community efforts.
- The importance of this field is that it pays attention to social context of health and disease and focuses on improvement of health through social measures such as vaccinations, good drinking water and good policies.
- The definition of health is widely linked with public health as found in the preamble of the constitution of the World Health Organisation (1948), where health is referred to as “a state of complete physical, mental and social well-being and not merely the absence of disease.”
- A major development in public health took place at the close of the nineteenth century. Rapid advances in scientific knowledge about causes and prevention of numerous diseases brought about tremendous changes in public health.
- Scientific measures such as replacing earlier social, sanitary, moral, and religious reform measures to combat disease were taken into account.Science was seen as a more effective means of achieving desirable social goals regarding public health services. Diseases were taken seriously and it was thought that proper public health service only can achieve good health condition.
- During twentieth century, new changes started to take over. The role of the state and local public health departments expanded greatly. It was understood that individual persons are also a kind of source of disease transmission.

- State started expanding their activities in health to accommodate medical care, health promotion and education, and health planning. Maternal and child health, family planning, immunization, venereal disease control, and tuberculosis control are some of the key issues that were taken into account.
- New health problems continue to be identified, conflicting with concerns about the growth of government and government spending in health.Although science provided a foundation for public health, social values have shaped the system. The task of the public health agency has been not only to define objectives for the health care system based on facts about illness and health, but also to find means to implement health goals within a social structure.
- A community is a collection of people who interact with one another and whose common interest or characteristics gives them a sense of unity and belonging.
- Community health is the part of medicine which is concerned with the health of the whole population and the prevention of diseases from which it suffers. The process is done taking into consideration the whole community in mind.
- Social epidemiology is a branch of epidemiology that studies the distribution and determinants of health and disease in populations. It asserts that health is affected or influenced by social conditions.



9.8 FURTHER READING

1) Greifinger,Robert (2007), Public Health Behind Bars : From Prisons to Communities, Springer Publication, New York.

9.9 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No 1 : Public health is the science and art of preventing disease, prolonging life and promoting physical health and efficiency through organised community efforts.

Ans to Q No 2 : A community is a collection of people who interact with one another and whose common interest or characteristics gives them a sense of unity and belonging.

9.10 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1 : What is meant by being healthy?

Q 2 : What is social epidemiology?

B) Long Questions (Answer each question within 300-500 words)

Q 1: Explain the emergence of the notion of public health.

Q 2: Write about community and community health?

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UNIT 10 : SOCIAL INEQUALITY AND HEALTH

UNIT STRUCTURE

10.1 Learning Objectives

10.2 Introduction

10.3 Equity and Inequality in Health: A Stratified Reality

10.4 Globalisation of Health and Diseases

10.5 Medical Tourism : Its Impacts in a Globalised World

10.6 Let us sum up

10.7 Further reading

10.8 Answers to check your progress

10.9 Model questions

10.1 LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Understand 'health' and its relationship to social inequality.
- Understand 'health' in the context of globalisation.
- Understand medical tourism as one facet of health in globalised world.

10.2 INTRODUCTION

Sociological studies in the field of health and diseases which come under the rubric of medical sociology or health sociology, attempt to look at the social causes and consequences of health and illness. Out of many aspects of this branch of study, a very important aspect is its understanding of the relationship between the social factors and the health of individual or groups or a larger society. Social conditions are an important determining factor of illness and prevention and can either enhance or hinder access to proper health care or even a healthy environment. Eero Lahelma explains that it is an inherent starting point of any medical sociological analysis that health and illness are embedded not only in the biological but equally in the social context. Therefore the issue of how

people's social environments contribute to the onset, course, and consequences of their illness and disease forms a key area of medical sociology. The question of how health, illness and death are socially produced and hence linked to the concepts of social stratification are made the focal point. In this domain, different forms of stratification such as socio-economic class, education, gender are all termed important in understanding the disparities in terms of providing health care and receiving the same. Eero points out that social stratification related to health is typically called socioeconomic inequalities in health or health inequalities. In this unit, we will learn briefly about the forms of stratification and how it affects health. Also we would look at the context of globalisation and a very popular trend of medical tourism to understand the relationship between social inequality and health.

10.3 EQUITY AND INEQUALITY IN HEALTH : A STRATIFIED REALITY

As given by World Health Organisation (WHO), " 'equity' in health implies that everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided". The policies and goals tend to focus on the concept of 'equity' and avoid possible biases so that no group or individual face any kind of disadvantage. Margaret Whitehead while discussing the concept and principles of 'equity' suggests that the aim of policy for equity and health is not to eliminate all health differences so that everyone has the same level and quality of health, but rather to reduce or eliminate those which result from factors which are considered to be both avoidable and unfair. Any approach using the notion of equity aims for equal access to available care for equal need, equal utilization for equal need and equal quality concern for all. Whitehead argues that in most of the discussions on equity, confusion arises since another concept 'inequity' gets implicated. 'Inequities' could be in the level and quality of health of different groups in the population

or inequities in the provision and distribution of health services. The term 'inequity' has a moral and ethical dimension too. Very similar but slightly different is also the term 'inequality' which in the context of health is used to indicate systematic, avoidable and important differences.

Students of sociology will be familiar with the system of stratification prevalent in a society. Scholars like Dipankar Gupta distinguishes between 'difference' and 'inequality'. He argues that differences between individuals are inevitable but to discriminate an individual or a group on the basis of their difference is 'inequality'. Systems that produce and re-produce inequality marginalise certain section of people and thus they often fail to get access to any kind of policies or rights even though the policies were intended to work on the principles of 'equity'.

Social stratification is a system based on inequalities. It divides society into different layers called strata and rank them in a hierarchy. Categorisation and division into groups is done on the basis of birth, race, gender, caste, class, ethnicity and so on. Stratification on the basis of caste, class (socio-economic), race and gender, are some common examples.



LET US KNOW

Social Determinants of Health (SDH) are the conditions in which people are born, grow, live, work and age".

In studies on community health, there has been an increasing focus on Social Determinants of Health (SDH). World Health Organisation's commission on Social Determinants of Health defined SDH as "the conditions in which people are born, grow, live, work and age" and "the fundamental drivers of these conditions." The 'social determinants' is used to denote factors which are available in one's social space, health-related features of neighbourhood, which can influence health-related behaviours. Socio-economic factors such as income, wealth, education serve as

fundamental causes of a wide range of health outcomes. Thomas Mckeown draws causal explanation between dramatic increase in life expectancy since 19th century and improved living conditions, including nutrition, sanitation, and clean water. When a group or individual fail to get proper access to these basic human needs, it ultimately leads to vulnerable health hazards. Large inequalities in health according to social class have also been documented in various studies and reports. For example, Whitehead in her article cites that in Finland, 42% of people with lower incomes suffer chronic illness, as opposed to 18% of the high-income group. She further sites another study carried out in the United Kingdom of people who died prematurely in different neighbourhoods. According to this report, men and women in poorer areas were likely to have been chronically ill or disabled for longer before death and to have suffered a greater number of distinct health problems than their counterparts in more affluent localities.

Bruce Link and Jo Phelan discussed how and why social inequality is a fundamental cause of health disparities. They also argue that the unequal distribution of socio-economic resources inevitably leads to health inequalities as those with more resources use them to obtain and act on new and better information. Other factors like racial discrimination, gender, education etc all contribute to health disparities.

In India where there is low female-male ratio, the mortality and morbidity indicators are unfavourable to the females. Maternal mortality in developing countries including India is unacceptably high. There is a failure of achievement of Millennium Development Goals in relation to maternal mortality and gender equality and empowerment of women. Global Gender Gap Index 2016 indicates that India is at 142nd rank in health and survival.

Social inequalities or forms of stratification hinder equal distribution of basic resources which then leads to non-accessibility to certain resources, health care and government policies to provide equal healthcare.



ACTIVITY 1

Q.1. Can you think of some forms of stratification and how it affects health?

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CHECK YOUR PROGRESS (A)

Q.1. How true is the statement "differences in health across the social groups reflect the fact that the better off lives a healthier lifestyle"?

a. Both lifestyle and social grouping interact to influence risk of ill-health

b. Absolutely true. The differences totally reflect lifestyle differences

c. Lifestyle and social group independently predict health

d. Absolutely untrue. The differences are unrelated to lifestyle.

10.4 GLOBALISATION OF HEALTH AND DISEASES

Generally, globalisation refers to the increasing interconnections among societies, regions, nations in terms of their economy, culture and other values at a global level. The world gradually moves towards becoming a signle whole where something happening at one place has an effect in most of the places since they are all interconnected. In terms of health, globalisation indicates an aspect of this phenomenon. World Health Organisation (WHO) has been working in this field where their attempt focusses on assisting countries to assess and act on the cross-border risks to public health security. They support collective action since domestic action often remain inefficent and thus ensure cross-border health risks. Scholars have been asking whether health-care is becoming more alike as globalisaiton connect the economic, political and social systems at a global level. Many have also approahced this with comparative study of health systems of different countries or regions

which serves as a reflection of a new academic interest re-inventing itself in a gobal context. Looking at globalisation's impact on health which can be easily fast-tracked through media exposure and technological informaiton resources, Mechanic and Rochefort described threads of connection derived from global shifts and called it 'emerging convergences'. It means that due to fast growing global links cross-national and dependent imperatives are growing in the case of

- Expansion of access to health care
- Financing of care
- Government roles
- Patient choice

Globalisation is affecting diseases equally. Paul Farmer has shown how global social inequalities are at the centre of many emerging diseases. According to his study, those in power use structural violence to erase history by discouraging scrutiny of the political-economic factors that bring humans into contact with pathogens. Globalisaiton, along with two other inter related factors- urbanisation and disease emergence, affect the disease and health.

George Armelagos and kristin Herper suggests that globalisation has a deep imapact on the use of anti-biotics. Common notion about anti-biotics is that a new one can be developed when a pathogen becomes resistant to a specific anti-biotic. But this should have been foretold that resitant anti-biotics were inevitable. There is a massive use and production of anti-biotics. Just as infectious diseases have been subjected to globalisation, antibiotic resisitance has met the same end. Globalisation thus, increases the vulnerability of disease threats from other countries and the anti-biotic resistant pathogens they carry. The pattern of anit-biotic resistance has been compared in China, Kuwait and the United states with the purpose of understanding the global threat of the phenomenon. Many have even put out strategies and collective actions for containing resistance. With globalisation going in full swing, international convergence of anti-biotic resisitance seems like a possibility. Emergence of diseases, which are resisitant to at least one anti-biotic and some

resistant to many antibiotics is a challenge in the era of globalisation. Globalisation is also coupled with unprecedented urbanisation and global warming which poses different kinds of threats.

WHO's initiative regarding globalisation and health mentioned earlier becomes very important where the world is collectively facing lots of health issues. One important part of their program is Global Public Goods (GPG) where they provide a framework for assesing and resolving problems of collective action at the global level. The concept of GPG offers a powerful lens to analyse and promote the health of the poor.

Since medical tourism offers an example to underestand globalisation of health and its related issues, the phenomenon of globalisation would be discussed extensively with the case of medical tourism in the next section.



CHECK YOUR PROGRESS (B)

Q.1. Define globalisation.

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ACTIVITY 2

1. Think of the major ways in which globalisation is affecting health and diseases.

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2. Do you agree that the governments should come together to face the global challenges in health? Think of reasons why you think so.

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10.5 MEDICAL TOURISM: ITS IMPACTS IN A GLOBALIZED WORLD

Medical Tourism is an emerging concept in the tourism industry. It refers to any form of tourism undertaken with the purpose of addressing a health concern at the same time receiving equal to or greater care than they would have in their home country. Medical Tourism has become an attractive option for potential economic growth in many countries across the world. Some of the countries that actively promote medical tourism include Belgium, Costa Rica, Cuba, Hungary, India, Jordan, Malaysia, South Africa and Thailand. The following are responsible for increased consumption for health care beyond borders.

a) Desire of healthy life

b) Advanced technology

c) Cost saving

d) Increasing availability of information and communication to consumers worldwide

The first ever recorded instances of medical tourism date back thousands of years to when worshippers of Asclepius, the Greco-Roman god of medicine, would make pilgrimages to his temple in Epidaurus, where they would undergo healing through “incubation rituals,” which were rooted in prayer, fasting, and ceremony. In later centuries, as travel and tourism increased, spas and health resorts in countries worldwide often attracted clientele from overseas. In India also, the hotsprings like Rajgir and Bakreshwar have been drawly visitors since time memorial. Since late 1970s health tourism has been widely accepted as an international phenomenon for individuals travelling, in which patients travel foreign countries. The practice of travelling internationally for surgery, however, is a relatively recent phenomenon. That growth appeared to parallel the worldwide boom in medical tourism that took place in the early 21st century.

Now, travel for medical treatment has enormously expanded and hence, many travel from developed countries to low or middle income countries, often to avoid high costs and long delays.

Globalization is regarded as a new phase of world integration with increased density and frequency of international or global social interactions relative to local or national ones. The globalization of healthcare, which includes medical tourism, has become a reality which has assumed increasing importance for developing countries, particularly in Asia.



LET US KNOW

Types of Medical Tourism

Outbound : This type of medical tourism occurs when patients travel from the home country to a foreign country to receive medical treatment.

Inbound : This type involves patients traveling from a foreign country to the home country in search of medical care.

Intrabound or Domestic : Refers to patients traveling to another part of their own country. No international travel happens.

The increasing privatization of health care and globalizing processes such as trade liberalization have enabled this industry to operate and grow, with corporations developing chains of medical facilities and other manufacturing and service activities that compliment medical tourism practices. Standardized information technology in the form of the internet, mobile phones, free web browsers and social networks means that more people are sharing information online about an expanding spectrum of their lives. Standardized information technology enables more businesses to offer information about their products and services in forms that other people can recognize, understand and use. These inexpensive communication technologies are creating global markets and collaboration among people located around the world. In addition, falling prices of air travel mean that it is increasingly fast, convenient and relatively less expensive to travel globally than ever before.

Liberalization of financial services enables people to pay for goods around the world much more easily than ever before. Growing demand

for health services is a global phenomenon, linked to economic development that generates rising incomes and education. Demographic changes, especially population ageing and older people's requirements for more medical services, coupled with epidemiological change, i.e. rising incidence of chronic conditions, also fuel demand for more and better health services. Waiting times and/or the increasing cost of health services at home, coupled with the availability of cheaper alternatives in developing countries, has led new healthcare consumers, or medical tourists, to seek treatment overseas. The correspondent growth in the global health service sector reflects this demand. The globalization of healthcare is marked by increasing international trade in health products and services, strikingly via cross border patient flow.



LET US KNOW

Intrinsic Factors (Push from home country)

- Demographic changes
- High cost of health care services
- Poor quality
- Long waiting lists
- Poor accessibility
- Inadequate insurance coverage
- International agreement

Impact of Globalization on Medical Tourism :

As Global competition is highly emerging in the health care industry, today, constraints and long waiting lines at home, as well as the ease of global travel, make medical tourism more appealing. The medical services industry hasn't been global historically but is becoming so now. There are several reasons that globalization can manifest itself in this industry :

- Patients with resources can easily go where care is provided. Historically doctors moved from Africa and India to London and New York to provide care. Now, it is the reverse which is true.

- High quality care, state-of-the-art facilities, and skilled doctors are available in many parts of the world, including in developing countries.
- Health care insurance companies within industrialized nations have begun considering medical tourism as a potential cost-saving measure, and are seriously considering the provision of round trip airfare to tourists for this kind of travel.
- Medical tourism holds the promise of reducing health care costs for individuals, companies, and governments, as the latter will likely offer discounts or rebates to their employees and constituents to prompt them to choose the medical tourism option and, in turn, reduce the insurer's and self-insurer's growing costs of providing quality health care.

There are also many companies that can help arrange patients' surgeries, travel arrangements and tours. Many of these companies partner with specific hospitals, thereby arranging a cheaper price for their patients than one could arrange on their own through the hospital directly. The emergence of a private sector that thrives by servicing a small percentage of the population that has the ability to afford medical care has changed the character of the medical care sector.



LET US KNOW

Extrinsic Factors (Pull to home country)

- Cheaper health care service
- No or Short waiting list
- High quality service
- Advance technology
- Ease of access to care
- Better transportation facilities
- Organised facilitators
- Social media and networking
- International agreements

POSITIVE IMPACTS

- **Social Impact :** When established as an industry, medical tourism is significantly instrumental in moulding the society. It contributes not just in terms of enhanced, speedier or affordable healthcare, but also lends itself to infrastructural betterments, more employment opportunities with an increased propensity towards overall wealth creation.
- **Financial Impact :** Manufacturing industries, foreign investments, business exports, agricultural, mineral products or information technology services, are currently among the most prominent and largest contributors to any nation's Gross Domestic Product (GDP). It has enormous potential as a service-sector industry and private hospitals stand to gain the most from it, provided they invest in the appropriate medical infrastructure and adequately promote their capabilities. As more and more foreigners troop into the country to avail cheaper, better and faster remedies for their illnesses, the chances of financial gain with a higher return on the basic investment is then guaranteed.
- **Industrial Impact :** Several industries, closely associated with the world health tourism sector are significantly impacted by its growth and development. These closely allied industries which are promoted as a result of the surge in medical tourism get a new foundation and recognition in the global sphere and are forever retained in memories, standing a chance of benefiting through future investments.
- **Tourism :** All medical tourists do not visit a country with the only purpose of a treatment or surgery. They also intend to tour the country's other historical or natural attractions. This trend is growing as tourists tend to invest the amount they save in healthcare, in sight-seeing. This serves as significant revenue for the tourism industry and forms a portion of total profits of the industry.
- **Pharmaceutical :** The pharmaceutical industry is very closely associated with the field of medical science. When one undergoes treatment or surgery in one country, he/she is bound to take over-the-

counter drugs sold in the same area. This increases the sale of medicines in a directly proportional manner such that, the number of surgeries or treatment conducted directly adds to the profits of the pharmaceutical company of the country that is a prominent medical tourism destination.

- **Medical Tourism Facilitator :** Because of the complexity of this decision-making process, some medical tourists seek help from travel agents or the international patient departments of hospitals, or concierge service providers.
- **Public and Private sectors :** The medical tourism industry is served both by private as well as public sector industries. While the public sector contributes to the overall infrastructure and associated processes like permitting medical visa, clearing foreign passports, facilitating foreign exchange etc; the private sector totally takes over the comfort & hospitality department as well as the healthcare facilities.

  The kind of medical care and amenities provided by private sector industries is generally far more superior to that offered by government establishments. Under such situations, a public private partnership tends to equalize profits, adds to overall infrastructural benefits and caters to the needs of the foreign medical tourist, in a balanced manner making the overall procedure smooth, rapid and economical.
- **Intellectual Impact :** A country that prospers in the healthcare tourism industry will experience less of the Brain-Drain phenomenon which commonly portrays the exit of trained professionals from their home country to a foreign nation availing better employment and financial opportunities. This phenomenon quite frequent among the medical community, is easily plugged because medical tourism pays ample impetus to the treatment of rare global disorders. Many intelligent or expert medical professionals generally look up to such challenges, as they get the required job satisfaction and financial fulfilment even when stationed in their native country.
  - ***Political Impact :*** When one country serves as a major tourism destination for another and there is constant exchange

of treatment and revenue between them, the political links between those nations are affected in a positive manner. Stronger bonds between those nations are forged when the host nation provides the foreign tourists with several amenities besides conducive medical treatment.

NEGATIVE IMPACT

- **Healthcare impact :** With patient travels, there is significant risk of corresponding bacterial travel. All industry professionals must understand the negative impact of communicable diseases. Hence, good strategies should be developed by global organizations to protect spread of such diseases. It is true that medical tourism escalates the per capita rates of the host country but it escalates several other detrimental factors as well. For infrastructural growth, the natural greenery or forest cover of a region is compromised in order to accommodate more buildings, hospital facilities, roads, treatment or diagnostic centres etc. To supplement the above, there is a continuous discharge of polluted air, solid -toxic medical waste, litters of sewage consisting of oil and chemicals. Architectural, noise and visual pollution also has a direct negative impact on the atmosphere.

  Health tourism also creates a dearth of local resources like power, food stock, fuel and other unredeemable natural resources, which could already be in short supply within the host country. Water, another non-replenishable natural resource, is commonly misused in hotels, spas and swimming pools through careless personal use by tourists.

  With an increased number of health tourists, the hospital adopts the policy of being paid in accordance to an overseas system. Such a structure, even though economical to a foreigner, tends to be expensive for the native. As a result, all sections of people within a particular nation are not able to avail the advanced treatment options available within the country. This creates a negative impact on the health infrastructure of a country.

- **Economic Impact :** Healthcare tourism in most countries runs through private institutions. Currently the private sector in most developed countries accounts for a larger number of surgical procedures, treatment operations, and ultimately in the overall number of patients from all over the globe. Thus the revenue generated by this sector is much greater compared to that generated by the government or the public sector. The latter shows low expenditure in healthcare sector, poor management of resources, corruption, infrastructure shortfalls, slower growth, etc., to name a few. The uncontrolled growth of the private sector leads to inequalities and profit imbalance across both sectors.
- **Ethical & Legal Impact :** Many medical tourism hospitals would tap into unethical practices to grab international patients, such as restricted regional treatments or several other medical services which are restricted, regulated or controlled in one region. Another issue in medical tourism concerns the illegal trafficking of organs. Countries with indigent or vulnerable populations frequently have a greater availability of organs for medical use, since members of these populations are often tempted to risk their health and give up an organ with the promise of monetary compensation. Combined with the lack of adequate resources for donor care, the practices surrounding organ obtainment have been targeted as an aspect of medical tourism in need of greater regulation and oversight. Likewise, the exploitation of medical procedures for which efficacy is unproven or for which safety is unknown is a point of discussion for standardization and regulation. Legal issues are also likely to rise as this industry presents unique problems and challenges for both consumers as well as providers.

  Inconsistency in quality of care is a major source of criticism for the medical tourism industry. One of the primary mechanisms implemented for the standardization of international health care is accreditation. Accreditation attempts to ensure that medical tourism facilities meet basic safety standards, are staffed

with trained personnel, and have appropriate medical equipment to perform the procedures offered. Those organizations charge fees to clients who want to have their facilities surveyed for accreditation, and each organization maintains a list of accredited hospitals to help persons wishing to travel internationally for health care select a facility that will meet their needs.

In sum, medical tourism does have both positive and negative impacts on healthcare, economic, social and environmental sectors in the globalized world which creates both opportunities and risk factor for this growing industry.



ACTIVITY 3

Q.1. What are your views about medical tourism?

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10.6 LET US SUM UP

- As given by World Health Organisation (WHO), " 'equity' in health implies that everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided".
- Social stratification is a system based on inequalities. It divides society into different layers called strata and rank them in a hierarchy.
- Social inequalities or forms of stratification hinder equal distribution of basic resources which then leads to non-accessibility to certain resources, health care and government policies to provide equal healthcare.
- In terms of health, globalisation indicates an aspect of this phenomenon. World Health Organisation (WHO) has been working

in this filed where their attempt focusses on assisting countries to assess and act on the cross-border risks to public health security.

- Globalisation is affecting diseases equally. Paul Farmer has shown how global social inequalities are at the centre of mnay emerging diseases.
- George Armelagos and Kristin Herper suggest that globalisation has a deep imapct on the use of anti-biotics.
- Medical Tourism is an emerging concept in the tourism industry. It refers to any form of tourism undertaken with the purpose of addressing a health concern at the same time receiving equal to or greater care than they would have in their home country.
- Liberalization of financial services enables people to pay for goods around the world much more easily than ever before. Growing demand for health services is a global phenomenon, linked to economic development that generates rising incomes and education.
- When established as an industry, medical tourism is significantly instrumental in moulding the society of a nation. It contributes not just in terms of enhanced, speedier or affordable healthcare, but also lends itself to infrastructural betterments, more employment opportunities with an increased propensity towards overall wealth creation.
- Medical Tourism also has negative impacts like spread of diseases, inequality in access to good health care facilities, etc.



10.7 FURTHER READING

1) Becker, Katja, Ying Hu, and Nickola Biller-Andorno. 2006. “Infectious Diseases: A Global Challenge.” *International Juornal of Medical Microbiology* 296: 179-85

2) Davey Smith, G. 1996. “Income inequality and morality: Why are they Related? *British Medical Journal* 312: 987-8

3) Hummer, R.A. 1996. “Black-White Differences in Health and Mortality: A Review and Conceptual Model” *Sociological Quaterly*, 37: 105-25

10.8 ANSWERS TO CHECK YOUR PROGRESS

A. Ans to Q No 1 : (b) True. The differences totally reflect lifestyle differences.

B. Ans to Q No 1 : Globalisation refers to interconnectedness among societies, nations, etc. in terms of economy, culture etc., at a global level.

10.9 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: Highlight the relationship between social inequality and health?

B) Long Questions (Answer each question within 300-500 words)

Q 1: How does globalisation affect health at a global level and how can one solve these problems?

Q 2: What is medical tourism? Briefly explain its merits and de-merits.

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UNIT 11 : SOCIAL CONTROL OF BODY

UNIT STRUCTURE

11.1 Learning Objectives

11.2 Introduction

11.3 Anorexia : Meaning and Causes

11.4 Consequences of Anorexia

11.5 Defining Bulimia

11.6 Consequences of Bulimia

11.7 Preventive measures of Anorexia and Bulimia

11.8 Let us sum up

11.9 Further Reading

11.10 Answers to Check your Progress

11.11 Model Questions

11.1 LEARNING OBJECTIVES

After going through this unit, you will be able to:

- understand Anorexia, its causes and consequences
- understand Bulimia, its causes and consequences
- know about the Preventive Measures of Anorexia and Bulimia

11.2 INTRODUCTION

Bodies are socially constructed in material and cultural worlds, which means they have both physical and symbolic significance. Though physical appearance plays an important role for both men and women, it is of much central importance when it comes to evaluating a woman. Women over the centuries have continuously tried to adapt and fit into the social construction of beauty. Body weight has long been a marker of social status. In most places, where food is scarce, corpulence signals high rather than low status. In these cultures, plumpness in women is especially prized. A young girl's girth is physical evidence of her father's and later her husband's wealth. Being fat signifies that her labour is not

needed, making fat women the ultimate “trophy wives.” Similarly, up until the early twentieth century, women in the United States and Europe strived to be fat, not thin at a time when food was scarce and plumpness signalled wealth, while thinness suggested illness Yet, while thinness was regarded as ungainly in these contexts, especially in women, it did not reflect on one’s moral character nor were individual women personally blamed for being too thin. Thus, one can see a transition in the notion of beauty, from preferring plump body to desiring a thin body. We also see that beauty is a social construct that varies depending on factors like class, race, ethnicity, etc. Thus, cultural values have all along shaped the construction of social problems and, in turn, reproduced social inequalities.

However, women have over the years fallen prey to this socially constructed idea of ‘beauty’ and ‘attractiveness’. They have all along been held by the hegemonic discourses of beauty standards that are socially prescribed and nearly unattainable for most women. The cultural ideology saturates our idea of ideal beauty. The mass media offer important primary sources for cultural and social research. Television, radio, magazines, newspapers, and Internet content provide a sensitive barometer of social process and change. Once created, these texts remain unchanged and available for analysis, making them ideal for the study of attitudes, concerns, ideologies, and power relations, and how they shift over time. Aware of these strengths, early feminist work examined the fashion media, demonstrating how fashion magazines and advertisements convey the audience on the importance of slenderness and the shame of fatness for women. Anthropologist Mimi Nichter (2000) has argued that such images contribute to negative body image and eating problems among young girls.This aspect has directly led to a boom in cosmetic industries, surgeries and dieting which has led to various lifestyle changes in women. In an era where thin body is celebrated and is often associated with ‘femininity’, dieting occupies a prominent place in lives of women who are repelled and terrified by the stigmatized stereotype circling fatness. Fat people are often, thought of as being self-induced, self-indulged, lazy and lonely. Obesity has significant associations with ill-health and shortened

life expectancy. Thinness on the other hand is associated with beauty. Thus, there is a constant desire among women to be thin, and a constant fear of becoming fat. Therefore, dissatisfaction with ones weight and shape is prominent from childhood which continues through to adulthood. This makes us question why eating and body weight are radicalized and gendered. Therefore, feminist scholars have avoided the term “eating disorder” because it situates “disorder” within individuals rather than in complex social structures. We do not use “overweight,” “obesity,” or “eating disorders” because we endorse a medical or public health framing, but because we seek to establish how these particular terms have been constructed in the news media.

Sociologists note that the body has today been reduced to a ‘site’ that people work on. Giddens (1991) argues that in contemporary society individual identity has been reduced to something on which people ‘work at’. People today often use their bodies to consciously construct an image which they want to present to others as their real ‘selves’. Giddens calls this ‘reflexive mobilization’. Chris Shilling (2003) found that people are increasingly seeing their bodies as ‘unfinished products’, or projects for improvement. Amidst such a scenario women are more at risk of eating disorders not only because of the cultural pressures of having a thin body, but perhaps they are also biologically at risk as a result of this change in neurochemical responsiveness. Compared to men, women are held to higher standards of thinness and suffer if they fall short, in terms of marriage prospects as well as employment, due to them being fat.

Dieting appears to be the key which unlocks this important biological consequence. Dieting is also the most preferred option among women as a means of losing weight as it provides an expensive means and little or almost no physical exercise is required.What is mobilized is a decision to diet. However, dieting has a role in the evolution of anorexia and bulimia. The consequences of dieting, which are mostly the product of physiological and psychological effects of starvation, are important perpetrators of the illness and serve to intensify dieting and so weight loss.

Due to such a socio-cultural emphasis on thinness among women, there has been a proliferation of anorexia or anorexia nervosa and bulimia or bulimia nervosa among young women. They are mostly accelerated due to eating disorder and dieting.Several factors have been identified as possible risks for the development of these eating disorders. Girls at the onset of puberty have higher chance of anorexia, while girls who are transitioning to adulthood may be more prone to bulimia.

Anorexia nervosa is defined by the persistent restriction of energy intake, intense fear of gaining weight and disturbance in self-perceived weight or shape. Individuals may control food and weight as a means of controlling areas of life that feel out of control, or as a way of expressing complex or concerning emotions. What characterizes anorexia nervosa is their strength, degree of personal significance and inflexibility. But looking at the connection between dieting and eating disorders, one may view anorexia nervosa as an extreme case of dieting. This willful refusal to eat, leading to extreme emaciation, is a circumstance which many find mystifying and beyond their own life experience. Thought most anorexics may gain back some weight within five years of becoming ill, it is one of the deadliest mental disorders which is seeing a rise among women. Even when an eating disorder is described as beginning with a choice, that is by starting a diet, the choice is depicted as a “normal” response to cultural pressures, rather than as an irresponsible or self-indulgent behaviour. This encourages more women to take up dieting which is socially accepted as normal and are mostly never discouraged.

We can view this from the identity theory that links identities to the role relationships and role- related behaviour of individuals. The self contains collection of identities, each based on the occupation of a particular role and having a role set of associated meanings and expectations for the self. An individual’s role identities are said to influence his/her behaviour, making him/her behave in a way that is expected of a person occupying his/her role. According to identity theory, women and men who adopt the stereotypical feminine and masculine gender role in Western culture will be influenced by the meanings and expectations of those particular roles.

Depending on how deeply these expectations are internalized, people will likely modify their behaviours so that they coincide with the behaviours expected of culturally determined, stereotypical female or male.



LET US KNOW

A careful assessment of a person's history on mental health, eating habits and behaviour is the prime pre-requisite to be taken in case of eating disorders like anorexia nervosa and bulimia nervosa.

Most individuals suffering from Anorexia and Bulimia do not consider themselves ill. They believe there is nothing going wrong with their eating habits and that they are leading a normal life.

Bulimia Nervosa is a psychological and severe life-threatening eating disorder described by the ingestion of an abnormally large amount of food in short time period, followed by an attempt to avoid gaining weight by purging what was consumed. Methods of purging include forced vomiting, excessive use of laxatives or diuretics, and extreme or prolonged periods of exercising. Often, in these binge/purge episodes, a person suffering from this disorder may experience a loss of control and engage in frantic efforts to undo these feelings.

Both anorexia nervosa and bulimia nervosa were first clinically described in 1979. Moreover, it is widely agreed that the number of sub-clinical eating-disordered individuals is now vast, and that the cases identified and treated are only the tip of the iceberg of eating pathology. People are usually diagnosed with anorexia and bulimia during their teenage years or early adolescent years. It can affect men and women of all ages, with women being more prone to such illness.

11.3 ANOREXIA : MEANING AND CAUSES

Anorexia also known as Anorexia Nervosa, is a syndrome of self-imposed starvation and relentless pursuit of thinness. Anorexics suffer from a fear of fatness and relentless effort of thinness. It is thus a complex

emotional disorder characterized primarily by an obsession with food and weight. Anorectic refers to persons who restrict their diet and do not exhibit symptoms of bulimia. Many theories have been postulated to understand the origin of anorexia nervosa. An anorexic patient is seen as being preoccupied with food and eating, yet obsessed with maintaining their weight. They are hence notoriously prone to sever diet regimes and food fads. While anorexia and obesity may both fall under medical categories related to body weight and eating, they however have strikingly different social and moral connotations. The social-cultural theory argues that the pressures on women to have a slim body is responsible for anorexia nervosa among them. However, what it fails to account for is why only a small proportion of women are exposed to such pressures which eventually develops into illness. The family pathology theory is of the opinion that anorexia is caused by interpersonal problems which must be understood under the family communication network. Even peer pressure can affect adolescent diet patterns. For example, high school and college students may resist treatment if their peers are actively involved in dieting or eating-disordered behaviour. The individual psychodynamic theory, on the other hand, focuses on the individual's struggle with their self-esteem and identity. Medical theories like the developmental psychobiological theory focuses on the need to stop the changes of puberty through starvation and to further avoid the turmoil of growing up. The primary hypothalamic dysfunction theory proposes a biological disorder of unknown origin as responsible for the illness. Anorexia nervosa is no more than a variant of affective disorder or depression. In spite of all these theories it seems unlikely that any single theory would adequately explain the causes in all cases.

Common to all these theoretical models is the fundamental role that dieting has in the evolution of anorexia. Moreover, the consequences of dieting, many of them direct products of the physiological and psychological effects of starvation, are important perpetrators of anorexia and serve to intensify dieting and in turn weight loss. One of the prominent symptoms of anorexia nervosa is the denial of illness and insistence on becoming thin.



LET US KNOW

A person with an eating disorder will very often also suffer from depression, anxiety and a lack of self-worth.

11.4 CONSEQUENCES OF ANOREXIA

Anorexia nervosa causes an increase in Serotonin. Serotonin is a chemical produced by our body for the nerve cell and the brain to function. However, excessive production of serotonin may lead to mild shivering, diarrhoea, muscle rigidity and high fever and will need immediate medical attention. Excessing dieting and eating disorder also leads to change in behaviour, emotional and cognitive change.Due to intensified and extreme dieting, self-induced vomiting, and preoccupation with shape and weight, as well as binge-eating, the body is denied the essential nutrients it needs to function normally. These include cognitive changes, altered behaviour and changes in emotional state. There are serious mental disorders with significant morbidity and mortality. Based on genetic and neuroimaging studies, anorexia nervosa appears to have a biological basis, analogous to what is observed in other serious mental disorders such as schizophrenia, bipolar disorder and addictive diseases. Eating disorders are associated with impairment in emotional and cognitive functioning that greatly limits life activities.

Anorexia can also be said to be a struggle with one's own identity, competence, and effectiveness. Anorexia is a life-threatening illness and is associated with numerous medical complications. Mortality rates for anorexia nervosa are the highest of any psychiatric disorder.

11.5 DEFINING BULIMIA

Bulimia or Bulimia nervosa (serious eating disorder) also known as bulimarexia is a dietary chaos syndrome, which involves the ingestion of a prodigious quantity of food in one or more eating "binges" which is

usually followed by attempts to purge oneself so as to rid the body of food. Bulimia, which is derived from a Greek word, is characterized by an episode of overeating or binge eating in which a person may consume food more than the recommended daily food allowance. Purging is mostly done through vomiting, laxative or diuretic abuse. Thus, two of the most prominent behaviours of bulimia are bingeing and purging. The cycle the bulimarexic endures can be physically damaging. It can also take a tremendous emotional toll and leads to severe, life-threatening conditions and hence it is also a mental health disorder that causes several mental health concerns. For the person who is struggling to meet unrealistic goals by imposing severe and ascetic control over herself/himself the binge is a release.

Bulimia Nervosa is mostly facilitated by dieting which is mostly related to the social emphasis on slimness. Therefore, bulimia is directly the result of rejection and societal pressure to be thin, which is high among women. Bulimia can also result from anorexia nervosa. This behavior of restricting food intake, bingeing and purging alters the brain structure, metabolism and neurochemistry which makes it difficult for individuals to discontinue the behaviors. Moreover, the binging brings about a union between the mind and body. There is a complete loss of control over oneself when indulged in binging. However, the giving over of one's self to this kind of experience results into guilt. Socialization and cultural pressures intrude to initiate the purification rites, purging or fasting. The purging relieving the guilt produced by. Thus binging carries with it the threat of ego dissolution and social humiliation. Moreover, it can turn out to be a vicious circle where the already frustrated woman may further her binging as an escapism from the social standards of beauty set by the society to which she is made to live up to.

Unlike anorexia, bulimia doesn't necessarily have symptoms of significant weight loss. It is important to be noted that Bulimia was identified relatively recently as an eating disorder separate from anorexia. It is to be noted that while everyone is exposed to similar societal pressures to be thin, only a small percentage develop eating disorders. Those who

succumb typically are prompted by extreme career pressures most often in cases of actors and models who are exposed to more emotional and physical vulnerability.



LET US KNOW

Patients with bulimia nervosa may hide their binging and purging and have no overt signs. Primary care physicians may be the first to suspect potential problems, including a patient's fixation on food, weight, dieting, physique, and exercise. Sometimes, patients who have struggled in silence for years turn to their trusted physician for support and understanding.

11.6 CONSEQUENCES OF BULIMIA

The regular binging and purging caused by bulimia can have an impact on the entire digestive system which leads to electrolyte and chemical imbalances within the body that affect the heart and other organ functions. Bulimia can lead to an imbalance in electrolyte that causes irregularity in heartbeats and failure of the heart. This can cause an irregular heartbeat (arrhythmia), and in some severe cases, a weakened heart muscle and heart failure. Electrolyte imbalance is caused by dehydration and loss of potassium, sodium and chloride from the body as a result of purging behaviour. Frequent purging can cause dehydration which makes the muscles week and causes extreme fatigue. Bulimia also causes low blood pressure, a weak pulse, and anaemia. In women, bulimia can interfere with the menstrual cycle or stop it altogether. Research indicates that while anorexia nervosa is associated with increased serotonergic functioning, bulimia nervosa is associated with reduced serotonergic functioning.

As bulimia is also a mental health disorder it also leads to depression, anxiety, apparent or obsessive-compulsive behaviours. Changes may come about due to lack of vitamins or behaviours that come along with bulimia.

Eating disorders probably result from a combination of emotional, physical and psychological factors that are encouraged by the society that values appearance above all. Once believed to be a problem largely among young women, the disorders are being found increasingly among children, young athletes, men, and elderly women. Often accompanied by depression, anxiety, and personality disorders, eating disorders may be difficult to diagnose. Patients with anorexia nervosa often deny that they have a problem, despite obvious physical signs. The first step in treatment is to address the medical complications caused by the unhealthy eating habits. Once nutritional health has been restored, patients need to reverse their entrenched and distorted body-image ideas.

11.7 PREVENTIVE MEASURES OF ANOREXIA AND BULIMIA

The aspect of prevention of anorexia and bulimia has received very little attention. This is ironic because many researchers and health care workers suggest that anorexia and bulimia become difficult to be treated if they become an individual's lifestyle. Most would agree that helping individuals avoid being affected by the factors perpetuating eating disorders like starvation which deprives one of the nutritional benefits, is the prime step towards preventing eating disorder from taking a toll on an individual. Psychological factors like striving towards perfectionism, feelings of ineffectiveness and interpersonal distrust may also lead to eating disorders.

Primary prevention should focus on eliminating the causes or predisposing factors. Here the primary goal of reducing anorexia and bulimia is by understanding what causes eating disorders in the first place. Few of the primary reasons for the inception of such disorders may be due to the societal pressure especially among women to be thin. Cultural attitudes towards weight are inculcated in a child from a very young age by their family members which later leads to the development of eating disorder among women. Thus it is important for the family to

examine their own perception towards societal construction of food, weight, shape so that their children do not become victims of anorexia and bulimia in the process of becoming thin. Individual factors like low self-esteem and insecurity mostly accelerated due to the cultural attributes of weight by their own family members may also lead to such eating disorders.



LET US KNOW

Many people with eating disorder usually eats faster than normal. They prefer eating in solitude so others do not judge their eating habits.

The secondary prevention, on the other hand, should focus on reducing the cause that perpetuates eating disorders like dieting and purging.

Thus, early detection and intervention is an important aspect for secondary prevention. However, doing the same is not an easy task as the individual with anorexia and bulimia most often attempt to conceal their problem. Therefore, it is of crucial importance to review every sign shown by an individual known to have an eating disorder and who shows higher risks of developing anorexia and bulimia. The individual should immediately be made to approach someone for help like a family member, peer or a health care professional, who may instrumentally help the individual to tackle the problem.



ACTIVITY

What are the causes of increase in eating disorder among women? Think.

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CHECK YOUR PROGRESS

Q.1. What are the two most prominent behaviours in bulimia?

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Q.2. What is the difference between anorexia and bulimia?

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Q.3. Anorexia is a result of obesity. True/False

Q.4. Bulimia does not always have symptoms backed by weight loss. True/False



11.8 LET US SUM UP

- Bodies are socially constructed in material and cultural worlds. Though physical appearance plays an important role for both men and women, it is of much central importance when it comes to evaluating a woman.
- Anorexia and Bulimia are psychogenic illnesses and are kinds of eating disorder, which pose great concern to the society.
- Women have all along been held by the traditional and hegemonic discourses of beauty standards that are socially prescribed and nearly unattainable for most women.
- This has in turn led to a boom in cosmetic industries, surgeries and dieting which have led to various lifestyle changes in women. While fatness is usually associated with ill-health and shortened life expectancy. Thinness, on the other hand, is associated with beauty, 'femininity'. It blames an individual for being overweight and obese, thus reflecting and reinforcing negative stereotypes on fatness.

- Thus, women from the inception of their teens are exposed to this idea of thinness, and thereby become a victim of it. They thereby practice dieting, which is seen as the easiest means of losing weight from a young age. This has led to a rampant increase in eating disorder like anorexia nervosa and bulimia nervosa among women.
- Anorexia nervosa is an eating disorder and an illness where an people see themselves as overweight, regardless of them being thin. This false belief justifies extreme cases of abstinence from food, to the extent of having serious health complications and forced treatments.
- Due to intensified and extreme dieting, self-induced vomiting, and preoccupation with shape and weight, as well as binge-eating, the body is denied the essential nutrients it needs to function normally. These include cognitive changes, altered behaviour and changes in emotional state. There are serious mental disorders and significant morbidity and mortality.
- Bulimia nervosa is an eating disorder in which people see themselves as massively overweight. While unlike in anorexia nervosa the individual may consume a vast quantity of food and purge later by vomiting. Frequent purging can cause dehydration which makes the muscles week and causes extreme fatigue.
- Bulimia also causes low blood pressure, a weak pulse, and anaemia. In women, bulimia can interfere with the menstrual cycle or stop it altogether.
- Thus, as a preventive measure to anorexia and bulimia early detection is important. This can be made possible through constant support from an individual's family, friends and concerned medical or clinical intervention at the earliest.



11.9 FURTHER READING

1) "Bird, C. E. (2010). *Handbook of Medical Sociology* 6th Ed.. Nashville: Vanderbilt University Press.

2) Boskind-Lodahl, M. (1976). *Cinderella's Stepsisters : A Feminist Perspective on Anorexia Nervosa and Bulimia. Signs*, Vol. 2, No.2, 342-256.

3) Davis, E. M. (2014). Gendered Personalities and Development of Eating Disorders in College. *International Review of Modern Sociology*, Vol. 40, No. 1, pp. 27-39.

4) Hill, A. J. (1993). Causes and consequences of dieting and anorexia. *Proceedings of the Nutrition Society*, 52, 211-218.

5) White, K. (2002). *An Introduction to the Sociology of Health and Illness.* New Delhi: Sage Publication.



11.10 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No 1 : Binging and Purging

Ans to Q No 2 : Anorexia is an eating disorder wherein in an individual fear weight gain and avoids eating as a result. Those with anorexia have a tendency to skip meals, adopt highly restrictive and unhealthy diets, obsess over thinness and food, and present abnormal eating habits due to the fear of gaining weight. Bulimia on the other hand, is an eating disorder wherein individuals go through a cycle of binging or overeating, followed by purging, often either by vomiting or using laxatives. It is also possible for a person to suffer from both disorders

Ans to Q No 3 : False

Ans to Q No 4 : True



11.11 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: What causes Anorexia?

Q 2: Why are women more prone to eating disorders like anorexia and bulimia?

B) Long Questions (Answer each question within 300-500 words)

Q 1: "Bodies are socially constructed in material and cultural worlds." Explain.

Q 2: How can you prevent an individual from developing an eating disorder?

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UNIT 12 : STATE AND HEALTH

UNIT STRUCTURE

12.1 Learning Objectives

12.2 Introduction

12.3 Concept of Bio-politics

12.4 Health Practices in India

12.5 Let Us Sum up

12.6 Further Reading

12.7 Answers to Check your Progress

12.8 Model Questions

12.1 LEARNING OBJECTIVES

After going through this unit, you will be able to:

- understand the concept of Bio-politics
- know about the health practices in Indian state to practice control over citizens

12.2 INTRODUCTION

India has 1.15 billion people which represent around 17% of the world's population.An assessment of performance of the country's health sector has pointed out some health-related indicators such as an uneven progress in health across regions, uneven health progress between male and female and also regional variation in heath.Bridging the gap needs extra attention from the government. Government should provide accessible, affordable, equitable health care and launch programs and schemes. The country is living under shadows of many familiar and unfamiliar diseases, the familiar one is infectious diseases like malaria, tuberculosis, etc and non-infectious are chronic diseases like cancer and coronary diseases. Available analysis on qualitative and quantitative data shows extremely uneven health and development progress in various parts of the country. Even within the reasonably well performing states,

there are regions where little has changed since Independence. The centralized pattern of government sector has many problems associated with it. The lop-sided planning, inadequate and unbalanced financial outlays, lack of accountability, low moral values and dereliction of duties by medical and nursing professionals are some of the issues faced by the health sector of the country. Recent trend shows that there is an unprecedented growth of the private sector, in both primary and secondary health care all over the country. As per the current ethical standards of the medical profession and free market technology-driven operational principles, the private sector generally does not provide quality health care at a reasonable cost.

At independence the private sector in India had only 8% of total health facilities. Currently 93% of all hospitals, 64% of all beds, 80-85% of doctors, 80% of outpatients and 57% of inpatients are in the private sector. The medical education and training, medical technology and diagnostics, manufacture and sale of pharmaceuticals, hospital construction and ancillary services and the provision of health services are mostly dominated by the private sector. Problems associated with compliance, contribution and collaboration has an immense impact on health sector despite the introduction of various new approaches. The health indicators of country are still not in good condition. India has to go a long way to achieve the required goals for good health service.

12.3 CONCEPT OF BIO-POLITICS

The concept of bio-politics was defined by Michel Foucault in1978. He talked about how the life and its mechanisms enter the explicit calculations of government. To understand the concept of bio-politics, it is important to be clear about what author meant by biopower. According to Foucault biopower is a double-edged technology that operates through two mechanisms and their intermediate relations i.e. “anatomo-politics” and “bio-politics”. Anatomo-politics refers to the configuration of the human body as a productive machine. In this sense it encompasses those

disciplines targeting the body and human anatomy. In the original formulation, such disciplines have the two fold sense of disciplines within knowledge, for example medicine, and practices of discipline which include forms of self-discipline and self-care. Biopolitics designates the regulations and interventions targeting the human population. In this framework of biopower, biopolitics assumes at its core the human body at the level of species, and therefore takes the shape of knowledge, practices, and forms of control relating to longevity, natality, mortality, morbidity, health, and hygiene. Modern medicine, reproductive control, national statistics, censuses, urban sanitation, and social hygiene are all examples of such interventions born with the modern state and its concern with governing life and population.

Bio-politics as a concept has been used and developed as a social theory even after Foucault. To understand the strategies and mechanisms through which human life processes are managed under regimes of authority over knowledge, power, and the processes of subjectivation are still undergoing process. As Thomas Lemke points out, a great deal of the inconsistency with which the concept of biopolitics has been deployed in more recent decades results depending upon whether one takes as their starting point the notion that life is the determining basis of politics, or alternatively, that the object of politics is life. Meanwhile, as Nikolas Rose and Paul Rabinow point out, the original interests in and conceptions of biopower drawn out by Foucault, quite usefully, do not grapple with these opposing positions- something that has remained underappreciated by many theorists who have worked to develop alternative conceptions of biopower to match more contemporary phenomena. As Lemke states most clearly, Foucault avoids this conflict by taking as his starting point the assumption that “life denotes neither the basis for the object of politics. Instead, it presents a border to politics- a border that should be simultaneously respected and overcome, one that seems to be both natural and given but also artificial and transformable.”

In the book “The Birth of Biopolitics”, Foucault theorized liberalism as a practice and as a critique of government. He further argued that the

rise of biopolitical technologies of governance, which have extended political control and power over all major processes of life itself, through a transferral of sovereign power into “biopower”- that is, technologies and techniques which govern human social and biological processes. Despite writing about many important concepts in academic writing, the concepts of “biopower” and “biopolitics” are the most compelling concepts of Foucault. Within his published work, these concepts featured only in the last chapter of the first volume of History of Sexuality. But the concept of biopolitics and biopower was dominant within broader conceptualisations and genealogies of power and governmentality of his lecture series at the Collège de France. Biopolitics and biopower occupies a significant role in his discussions on modern forms of governance and modes of subjectivation.

Before understanding the concept of biopolitics and biopower in the boarder context of Foucault’s work, a brief understanding of the concepts is important.Biopolitics can be understood as a political rationality which takes the administration of life and populations as its subject: ‘to ensure, sustain, and multiply life, to put this life in order’. Biopower thus names the way in which biopolitics is put to work in society, and involves what Foucault describes as ‘a very profound transformation of mechanisms of power’ of the Western classic age. As Foucault writes: power that exerts a positive influence on life, that endeavours to administer, optimize, and multiply it, subjecting it to precise controls and comprehensive regulations.In this instance Foucault talks about power, which he later identified as biopower and it has influence on life of people.In the last chapter of The Will to Knowledge named ‘Right of Death and Power over Life’, Foucault provides a brief genealogy of biopolitics. Foucault’s concept was a concept which is often associated with a tradition in continental history and philosophy. The notion of biopolitics has become an important word recently. It was not known to many people few years ago, but today many disciplines use this concept for discourse. Beyond the limited domain of specialists, it is also attracting increasing interest among the general public. The term is used to discuss political asylum policies, as well as the prevention of many diseases and

demographic change. Biopolitics may refer to issues as diverse as financial support for agricultural products, promotion of medical research, legal regulations on abortion, and advance directives of patients specifying their preferences concerning life-prolonging measures. There is a range of diverse and often conflicting views about both the empirical object and the normative evaluation of biopolitics. Through this archaeology of knowledge and power, Foucault tried to understand discourses and practices that worked as agents of transformation of human life. Topics like health, illness, and behaviour from a human and social sciences perspective are more approachable through this concept. Foucault's impact on this field was achieved through his research on the disciplines and institutions of psychiatry, medicine, sexuality, and imprisonment. Biopolitics is present in many contemporary research arenas like regimes of government and apparatuses, sociality and citizenship, etc.

Mark Duffield has analysed how the international agendas of human development and human security constitute forms of global biopolitics targeting health, demographics, territory, and power. The anthropologist Paul Rabinow considered the reversal of the two poles of biopower technologies he saw as a post-disciplinary rationality forming modes of bio sociality and bio-identity. In this way many scholars have their own way of understanding and interpreting biopolitics in different disciplines. Due to the conceptual richness of the concept of biopolitics it is open to research. In future new research on this concept will emerge with continuation of presented research. The deepening and substantive meaning of biopolitics will probably shift into new areas and use research methods from analytical to biographic and ethnographic studies. Such areas may well include and reinterpret issues of : political economy; global health; moral philosophy, subjectification, embodiment, and bodily transformation; reproduction and kinship; reconfigurations of age and life course; boundaries of health, enhancement, and performance; surveillance and monitorization; biosecurity and bio geographies; biostatistics and classification. When it refers to bio politics plural and divergent meanings will evolve as the term signifies.

12.4 HEALTH PRACTICES IN INDIA

The National Rural Health Mission (NRHM) launched in 2005 was a major landmark in the health system of India. It improved hospital care, decentralization at district level to improve intra and inter-sectoral convergence and effective utilization of resources in the system. The challenges the government is facing includes population growth, poverty, unexpected natural and manmade disasters, global pandemic of AIDS or influenza (H1N1), poor coverage in rural and remote areas and the constant threat of biomedical warfare. Many new lifestyles are emerging that have an impact on health of the people. Their rising incidence adds to the stress related to urbanization and industrialization. Due to population overgrowth and the limited opportunities people have to struggle to achieve their basic health needs. Increased cost of medical education has increased the cost of health care. These problems are related mainly to the physical infrastructure, medicines, funding, limited resources and accessibility to health services, etc. Issues regarding human resources are shortage of key cadres in rural areas, lack of motivation or will to serve in rural areas, absenteeism and irregular staff attendance, non-transparent transfer and posting policy, weak or non-existent accountability framework, inadequate systems of incentive for all cadres especially in difficult area postings, lack of career progression and standard protocols, etc.

Another new condition arising in India is Public-Private Partnership that emerged as one of the options to influence the growth of private sector with public goals in mind. It will help to change the landscape of healthcare in India.Other important issues associated with private sector are varied quality of service delivery, absence of formal accreditation systems, low penetration of Insurance, inadequate buying of services by Government and the fact that private sector is driven by curative and investigative care. Public distribution system became an important part of government development policy and government tried to implement in rural areas also. One of the main problems with this system is the inefficiency in the targeting of beneficiaries and the resulting leakage of subsidies.

With the growth of the Indian economy after 1991 economic reforms, the country has worked in the area of human development. Life expectancy and literacy rates have increased, poverty levels have declined and large-scale famines have all but disappeared. Many people in India live below poverty line, this has an impact on them. Heath is also a parameter to understand the level of poverty in India. Because of poverty, there is wide spread malnutrition and chronic hunger among them. Major disparities exist between urban and rural areas, regions, social groups and between men and women. Thus, while some western and southern states have regularly touched double-digit growth rates, many states in the north have continued to lag behind on most development indicators. While India's engagement with economic liberalisation and restructuring creates prosperity in the aggregate, it similarly presents the country with the continuous challenges of how to deal with multiple and overlapping forms of inequality and exclusion – spatial, social, economic and gendered. They inadequate amount of investments in health and education made by the Indian government has a limited capacity in lifting millions of people from notional poverty line, who still lack the basics for a decent life. There has been a process of political emphasis on empowering women, on removal of female disadvantage and unlocking the power of women's active role in society to reform both health care and education from the part of government.

Neo-liberal ideas and reform have extensively spread across many types of welfare and development regimes and policy sectors. The NRHM is one such initiative, focusing on health and human-resource development in rural areas. NRHM is one important manifestation of the new techniques of governance, centred crucially on this notion of 'the citizen', and epitomises the broader shift in Indian development policy from a perception of development as a welfare activity of the government, to recognition of basic development as a right of citizens. The current health policy of India seeks to create aware and active citizens out of rural poor and marginalised groups through new technologies of governance. But the tension between policies as formulated and policies as practised, between neo-liberal and

welfare ideas and between participation and compliance are still going on.

Foucault's concept argued that individuals, under neo-liberal regimes, are taught to govern themselves. Neo-liberal health reforms directed their attention towards changing individuals and individual behaviours. Human rights have, under neo-liberal reform, become a global standard or norm with reference to which states, health systems, health workers, communities,families and mothers may be evaluated and disciplined. But it is with respect to these same human rights norms that individuals increasingly also evaluate themselves, and change their behaviour in order to conform (at least officially) to the norm. This form of power creates a set of rules and standards that result from a constellation of discursive structures, and the (scientific) knowledge and practices that accompany them. Power, in this sense is positive, as it produces behaviour that is in conformity with the dominant standard of normality or acceptability mediated by a dominant view of what constitutes normality or deviance. Explicitly, Foucault draws our attention to how neo-liberalism as a political rationality induces dynamics of depolitisation of the public health regime, thus transforming political actors into clients, consumers and technologists of themselves.

Although the rights regime can individualise and de-politicise social struggle, the language of rights is also frequently used for mobilisation and structural change. The disciplinary power provokes counter tendencies, exercised within historically and geographically contingent forms. The NRHM focuses particularly upon the health of poor women and their children. The government focusses on the poorest segment of the population. NRHM is one such approach of government and is a specific-purpose grant funded and planned by central government to induce health system reform in the individual states to address these challenging health indicators. Within the new Indian state, citizenship is being constructed, invoked and substantiated as ways to soften – if not eliminate – gender, class and caste inequalities. Since Indian independence, social reforms have referred to the nuclear family as the new foundation for the developing state. To the modern state,traditional large family structures are a hindrance

to political democracy, development and social justice, all of which have been and still are India's national goals. Citizenship thus does not refer only to formal inequality but also to how citizens should behave to move forward and/or upward and become full citizens of the polity. The two-child norm introduced in some states of India through the Panchayat Raj institutions in the 1990s clearly demonstrates how the nuclear family is an effect of responsible citizenry. Health bureaucrats interpret, enact and form policies at all levels in the system. In addition, NRHM is widely acknowledged as an outcome of the grassroots pressure generated by India's vibrant democracy, which is capable of influencing government policy in pro-poor directions.Rather than understanding policies as instructions flowing down from above, policy implementation should be understood as practises that must be situated in the broader domains of knowledge and power in which they are embedded.



CHECK YOUR PROGRESS

Q.1. Mention indicators of health.

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Q.2. Define biopower.

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12.5 LET US SUM UP

- An assessment of performance of the india's health sector has pointed out some health-related indicators such as an uneven progress in health across regions, uneven health progress between male and female and also regional variation in heath.

- The centralized pattern of government sector has many problems associated with it. The lop-sided planning, inadequate and unbalanced financial outlays, lack of accountability, low moral values and dereliction of duties by medical and nursing professionals are some of the issues faced by the health sector of the country.
- The concept of bio-politics was defined by Michel Foucault in 1978. He talked about how the life and its mechanisms enter the explicit calculations of government.
- According to Foucault, biopower is a double-edged technology that operates through two mechanisms and their intermediate relations i.e. “anatomo-politics” and “bio-politics”.
- Anatomo-politics refers to the configuration of the human body as a productive machine. In this sense it encompasses those disciplines targeting the body and human anatomy.
- Biopolitics designates the regulations and interventions targeting the human population. In this framework of biopower, biopolitics assumes at its core the human body at the level of species, and therefore takes the shape of knowledge, practices, and forms of control relating to longevity, natality, mortality, morbidity, health, and hygiene.
- Bio-politics as a concept has been used and developed as a social theory even after Foucault. To understand the strategies and mechanisms through which human life processes are managed under regimes of authority over knowledge, power, and the processes of subjectivation are still undergoing process.
- In the book “The Birth of Biopolitics”, Foucault theorized liberalism as a practice and as a critique of government. He further argued that the rise of biopolitical technologies of governance, which have extended political control and power over all major processes of life itself, through a transferral of sovereign power into “biopower”- that is, technologies and techniques which govern human social and biological processes.

- The National Rural Health Mission (NRHM) launched in 2005 was a major landmark in the health system of India. It improved hospital care, decentralization at district level to improve intra and inter-sectoral convergence and effective utilization of resources in the system.
- Due to population overgrowth and the limited opportunities people have to struggle to achieve their basic health needs. Increased cost of medical education has increased the cost of health care. These problems are related mainly to the physical infrastructure, medicines, funding, limited resources and accessibility to health services, etc.
- Other new condition arising in India is Public-Private Partnership that emerged as one of the options to influence the growth of private sector with public goals in mind. It will help to change the landscape of healthcare in India.
- Public distribution system become an important part of government development policy and government tried to implement in rural areas also. One of the main problems with this system is the inefficiency in the targeting of beneficiaries and the resulting leakage of subsidies.
- Neo-liberal health reforms directed their attention towards changing individuals and individual behaviours. Human rights have, under neo-liberal reform, become a global standard or norm with reference to which states, health systems, health workers, communities, families and mothers may be evaluated and disciplined.



12.6 FURTHER READING

1) Thomas Lemke (2011), Biopolitics: An Advance Introduction, New York University Press, New York.



12.7 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No 1 : An assessment of performance of the country's health sector has pointed out some health-related indicators such as an uneven progress in health across regions, uneven health progress between male and female and also regional variation in heath.

Ans to Q No 2 : Biopower means the way in which biopolitics is put to work in society, and involves what Foucault describes as 'a very profound transformation of mechanisms of power'



12.8 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: What is meant by biopolitics?

Q 2: What is NRHM?

B) Long Questions (Answer each question within 300-500 words)

Q 1: Explain about the health system in india.

Q 2: What is the difference"anatomo-politics" and "bio-politics"?

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UNIT 13 : HEALTH POLICIES OF GOVERNMENT OF INDIA

UNIT STRUCTURE

13.1 Learning Objectives

13.2 Introduction

13.3 Introduction to health policies of India after independences

13.4 Introducing the National Health Policy (NHP) of 2017

13.5 Debates on the National Health Policy of 2017

13.6 Let us sum up

13.7 Further Reading

13.8 Answers to check your progress

13.9 Model Questions

13.1 LEARNING OBJECTIVES

After going through this unit, you will be able to:

- understand the history of health policies and programmes in independent India
- know the need for a National Health Policy (NHP) at various points of time
- understand the details of the National Health Policy 2017

13.2 INTRODUCTION

The state of health of people in a country is directly influenced by the governments approach towards the health sector. This aspect has been in earlier units. In this units, emphasis will be laid on health policies adopted by government of India since independence, with particulars focus on the National Health Policy.

13.3 INTRODUCTION TO HEALTH POLICIES OF INDIA AFTER INDEPENDNCE

Health after independence

Health and development of healthcare have not been priorities for the Indian government since independence. This is evident from the low expenditure and investment on health – only 1 percent or even less from the Gross Domestic Product (GDP) has been allocated to the health sector in the five-year plans. The social areas like health, water supply,and education were low in importance after independence was achieved. Industrial growth and economic development were the priorities.

Therefore, the first National Health Policy (NHP) was released only 36 years after independence. However, this does not mean that the health sector was not regulated or had no planning involved at all. It was monitored through the five-year plans. Till 1982, India had no formal health policy and health was part of the five-year planning process. Every five-year plan had specific programs and schemes that were designed to take care of the health sector.

The Central government designs programs which the states then accept and implement at their levels. The government at the centre ensures that the states follow and implement these programmes through the budget. Modern medicine and health care were introduced and developed in India during the period when India was under British rule. After the end of colonization, it was the Indian government's duty to nurture and expand this healthcare system. The result, however, has not been wholly positive. The post-colonial era has seen the growth of the private medical sector, even in villages and towns as a consequence of the expansion of the socio-economic infrastructure. But the private medical industry remains inaccessible to the poor and the marginalized as it is expensive. One thus feels that planning should have given equal emphasis to social services like health, water supply, sanitation, education, and housing along with industrial development.

Health in five-year plans

In the 1950s and 1960s, the primary function of the health sector was to manage epidemics as there were frequent outbreaks. There were mass campaigns to eradicate various diseases like malaria, smallpox, tuberculosis, leprosy, cholera, polio, etc. This was an extension of the

colonial policy that believed in removing the germ to get rid of a particular disease. However, many of these diseases were rooted in the social structure, i.e., inadequate nutrition, lack of clothing, housing and proper sanitation and a clean environment. But these causes were ignored,and this was one of the drawbacks of the health programs. Many of these programs were also dependent on international organizations like the World Health Organization (WHO) and the Rockefeller Foundation for funds for the supply of necessary medicines and vaccines. But the aid did not come for free. Along with support, these organizations also exercised political and economic power over India's health sector.

The first two five-year plans had a common structural framework. Urban areas got over three-fourths of medical care resources and the rural regions received 'special attention' under the Community Development Programme (CDP).The aim was the betterment of environmental hygiene, including the provision of water, proper disposal of waste, control of epidemics and provision of medical aid. However, this special attention was hardly received as the health sector has a dismal performance in rural parts of the country. While epidemics were controlled, the other goals like provision of sanitary environment, clean water and sanitation were not achieved.

There was a shortage of medical personnel and facilities in rural areas. Many villages did not even have proper hospitals and villagers had to travel miles to access primary healthcare. Hospital facilities were mainly unavailable in rural areas. While many villages did not even have hospitals, the ones that had, did not have medical staff. In many places, the team was not equipped to handle critical issues. Majority of the hospitals did not have beds, medicines, and instruments. Compared to this, the situation in urban areas was slightly better.

India was one of the first countries to implement a state-sponsored family planning programme in 1951. The country was facing a growing birth rate and a declining death rate,and therefore, family planning was seen as a necessary planned objective for the state. Thus family planning became an independent department in the Ministry of Family Planning.

This emphasis on family planning was also an influence of developed countries that had low rates of population growth. Population control was seen as a pre-requisite for development.

The third five-year plan (1961) looked into the problems that Primary Health Centres (PHCs) were facing. It directed attention to delay in construction of PHCs, lack of health personnel, lack of life-saving drugs, vaccines, etc. The fourth plan (1969) continued from the third one, with the focus on infectious diseases and the PHCs. The PHCs were given a special allocation in the fourth plan just like in the third one.

The fifth plan marked a significant change from the previous plans in the sense that the government admitted that the health sector had not achieved the desired results that it had hoped for in the rural areas. Therefore in the fifth plan, the government decided to focus on health in rural areas. The goal was to enhance the availability of health services in rural areas through the Minimum Needs Program (MNP) and correcting regional imbalances between urban and rural areas while eradicating communicable diseases. Water supply and sanitation were given priority too. Many illnesses that had plagued the populace in both rural and urban areas were water-borne –cholera, jaundice, diarrhea, typhoid, and dysentery. Therefore, providing clean drinking water became an essential target of the government to improve healthcare.

The sixth five-year plan was greatly influenced by the Alma Ata declaration of Health for All by 2020, and thus the plan suggested a community-based health system. It prioritised rural areas and training of health workers in PHCs. Although there has been progressive thinking on the part of the government, there has been inadequate action, and that is why in spite of health being a part of the five-year plans, the sector has not developed as well as it should have. And this is why the NHP was announced in 1983. The need was felt for a nation-wide health policy that could rejuvenate the dilapidated condition of the health system in the country and govern the public health sector. The NHP is based on the Directive Principles of State Policy of the Constitution of India recommending universal health for everyone.

After the NHP was introduced, rural healthcare received special attention,and the work of building PHCs was continued. Decentralisation and professionalism within the medical sector have been achieved to a limited level, but India is still lagging in community participation which the NHP 2017 wants to correct. The private sector received a boost after the 1983 NHP as it suggested privatisation of curative care. It talked about "healthcare that people can afford" which meant, health services were no longer free.

This also marks a shift in India's economic policy from one based on a welfare economy to one based on capitalistic principles.The private sector expanded phenomenally post NHP,and the state has played a major role in this, helping by giving subsidies for medical education, soft loans to set up a medical practice, etc.

The 1983 policy, however, did not achieve its goal of universal and comprehensive primary health coverage, especially in rural regions. The seventh five-year plan, therefore, wanted to correct this regional imbalance by building specialties and super-specialties, especially in rural areas. Population control was also another goal. Along with communicable diseases, the plan also directed attention towards other diseases like AIDS, cancer and heart diseases.



LET US KNOW

Modern medicine and health system was introduced by the British to India during the colonial era.

Health was not a priority area after independence and only received 1% of GDP allocation.

The focus of the five-year plans before 1982 was on communicable diseases.

The need for a NHP was felt to rejuvenate the health system that was not performing well.

India has had three NHPs – 1983, 2002 and 2017.

The eighth five-year plan was a departure from India's goal of "Health for All" as the country was facing a severe economic crisis and the underlying slogan was changed to "Health for the Underprivileged." The ninth five-year plan reviewed the 1983 NHP and recommended the need for another NHP. Therefore, a new and the second NHP was introduced in 2002.

The NHP 2002 focuses on the requirement for increased funding and organizational restructuring of the national public health facilities to ensure equitable access. It focused on diseases like TB, malaria, blindness and HIV AIDS. The marginalized population like women, children, tribals and senior citizens were the target. The idea is to meet minimum health needs of the people. The policy has been widely criticized for not adhering to the concept of "Health for all" and not involving the states in drafting the document. It also received flak for not substantively talking about population control, as it is still a burning issue.

The five-year plans after the 2002 NHP have tried to implement the recommendations that had been made by it. Epidemics were more or less controlled, and so were diseases like malaria, polio,and leprosy. There has also been a reduction in crude birth rate, crude death rate,and infant mortality rate. The NHP 2002 encouraged further decentralization and professionalism in the health sector. But with time, the need for a new NHP was felt,and this is why the NHP 2017 came out. We will be discussing the NHP 2017 in detail in the next section.



CHECK YOUR PROGRESS (A)

Q.1. Who introduced modern medicine and health system in India?

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Q.2. When was the second NHP announced?

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13.4 INTRODUCING THE NATIONAL HEALTH POLICY OF 2017

The government of India has released three national policies till today – the first in 1983, the second in 2002 and the latest in 2017 on 15th March. The focus of the 1983 policy was on the provision of primary healthcare to all by 2000, whereas the 2002 policy focussed on the requirement for increased funding and restructuring of organizational public health facilities for ensuring equitable access to them.

The 1983 NHP was critical of the curative model of healthcare and stressed the need for a preventive, promotive and rehabilitative approach to primary healthcare. It recommended decentralization in the health system, community based participation and expansion of a private curative health system to support the public facilities. Both the 1983 and 2002 NHPs were not very effective and did not meet the goals that they had set out to reach. In this unit, we will be assessing the 2017 National Health Policy and debates that it has raised.

The two former health policies have guided the Indian health sector,but the need for a new policy was felt as health priorities are changing. Some of the reasons why a new National Health policy was needed are –

- Increase in non-communicable diseases like diabetes and cardiovascular diseases. The focus of the previous two NHPs was on communicable diseases.
- A growing healthcare private industry
- Expenditure on health care costs which leads to further impoverishment of the poor
- Mental health issues on the rise

The main aim of the National Health Policy 2017 is to inform, clarify, strengthen and prioritize the government's role in shaping health systems in all its aspects – investment, organization, prevention of diseases, promotion of good health, access to technologies, developing human resources, building a human base, strengthening regulation and health assurance. The goal of the policy is the attainment of the maximum

possible level of health and well-being for all age groups, through a preventive and promotive healthcare orientation. Thus, the policy believes in providing universal quality healthcare and also acknowledges the importance of Sustainable Development Goals (SDGs). The emphasis is on providing primary healthcare.

The policy also proposes to provide free medicines, free diagnostics, and free emergency and necessary healthcare services in all public hospitals to provide access to everyone and financial protection to the poor. Some of the best healthcare systems are those of the UK, Canada, and the Scandinavian countries, countries in which the state leads the system. The US, which has a market-based healthcare system, therefore, has an expensive healthcare system and is unaffordable for many citizens. The NHP intends to build the ordinary person's belief in the public healthcare system to make it patient-centric, affordable and efficient. A health policy is an expression of what the health care system should be so that it can meet the health needs of the people.

Some of the fundamental principles of the policy are –

- Professionalism, integrity,and ethics
- Equity
- Affordability
- Universality
- Patient-centered
- Accountability
- Pluralism
- Decentralization

Some of the critical targets of the National Health Policy are –

- The policy suggests raising public health expenditure to 2.5% from 1.5% of the Gross Domestic Product (GDP) in a time-bound manner. This target is anticipated to be met by 2025.
- It intends to increase life expectancy at birth from 67.5 to 70 by 2025.
- It proposes to reduce Total Fertility Rate (TFR) to 2.1 at the national level.

- It plans to lower infant mortality rate to 28 by 2019.
- The policy aims to achieve the global HIV 2020 target.
- Eliminate leprosy by 2018 and tuberculosis by 2025.
- To reduce premature death from diabetes, cancer, cardiovascular diseases,and chronic respiratory illnesses by 25% by 2025.
- Increase utilization of public health resources by 50% by 2025.
- Access to safe water, hygiene,and sanitation to all by 2020 (under the Swachh Bharat Mission).
- Enhance the share of individual states on health to more than 8% of their budget by 2020.



ACTIVITY 1

1. How many National Health Policies are there in India?



CHECK YOUR PROGRESS (B)

Q.1. How does the NHP 2017 differ from the other two National Health Policies?

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Q.2. What are some of the critical targets of the NHP 2017?

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13.5 DEBATES ON THE NATIONAL HEALTH POLICY 2017

- **Public vs. private :** One of the most heated debates that have resurfaced from the National Health Policy 2017 is the argument on

the role of the public and the private sectors in providing healthcare. The public system is heavily criticized as it is unable to provide quality healthcare. People who have financial resources have the choice to seek help in the private healthcare sector, but for most people, they do not have that option. However, there are also many incidents of blatant profit-making, wrong treatment and bad practice in the private sector. The question, therefore, that arises, is should the public sector be strengthened or should the private sector be encouraged? Should the focus be on improving the public healthcare system or of enhancing and supporting the private healthcare system?

One answer is that the public healthcare system can only be improved if the middle-class people start accessing it regularly. Or else, any programme that just the poor and the marginalized uses is at the risk of being poor in quality. While private sector healthcare can supplement and complement the public system, it cannot be the leading service provider. Technical and financial support under the National Health Mission (NHM) is provided to the states and union territories (UTs) for strengthening their public healthcare systems for the provision of universal, accessible and affordable health care. The private sector mostly provides curative healthcare services, and the state sector gives preventive and promotive health facilities.

- **Unavailability of life-saving drugs :** In 2016-2017, many diseases have remerged, like diphtheria. Several new epidemics also broke out like Nipah virus. There are also several occurrences of diseases like snake bite, rabid animal bite,and scorpion bite, especially in rural areas. In most cases, the hospitals, be it public or private ones, are not prepared to deal with such outbreaks and emergencies. There are shortage and unpreparedness of hospital staff and unavailability of life-saving medicines. This highlights the need for providing life-saving drugs, which is the principal responsibility of the state.
- **Universal Health Coverage (UHC) :** The third debate that the NHP has raised is about universal health coverage. It suggests that

universal health should be given for both communicable and non-communicable diseases (NCDs). It recommends the building of health and wellness centres, and support from community health centres and district hospitals.

It proposes an 'assurance based approach' instead of a 'right based approach.' However, just building health centres and hospitals for NCDs is not enough. Treatment of NCDs like diabetes and hypertension needs a community-based approach and patients also require counselling. These diseases need lifestyle modification and discipline which need support from both the family and the community apart from medical treatment.

To provide UHC, the public sector will provide free primary care, which will be complemented by strategic buying of secondary care hospitalization and tertiary care services from both public and non-government areas to fill the existing gaps.

The concept of UHC is not new. The Health Survey and Development Committee Report or the Bhore Committee Report had prepared a detailed plan of a National Health Service for the country in 1946 before independence which had proposed universal health coverage to the entire population free of charge. But the recommendations of the Bhore Committee was not implemented properly,and the standard of health remains very low.

- **Assurance based approach to health :** The National Health Policy 2017 proposes an assurance based approach to health instead of a rights-based approach. It advocates an assurance based approach with assured funding to create an environment for raising healthcare as a right in the future.This has raised many arguments from critics, who have criticized the government's decision to not look at health as a fundamental right. This is seen as contradictory to the government's admittance that healthcare expenditure is a significant cause of poverty.
- **Focus on male sterilisation :** The NHP calls for a better focus on male sterilization to stabilize population. The government aims to increase the proportion of male sterilisation from less than 5% to at

least 30% and much higher. The male sterilisation rate is meager – 0.3% - according to National Family Health Survey (2015-16) compared to the female sterilisation rate which is 36%. Therefore, the hour requires to promote male sterilisation to stabilize the population.

- **Keeping in mind the global context :** Many of the critical targets of the NHP have been criticized for being backward and not keeping in mind the global and the South Asian settings. For instance, one of the policy goals is to increase life expectancy at birth to 70 by 2025. But this ultimate objective is seen as low, as Sri Lanka and Bangladesh, India's neighbouring countries have already achieved it. Another example is that the policy targets are reducing child mortality rates for the age group 0-5 to 23 deaths per 1000 live births and neonatal mortality rates to 16 deaths per 1000 live births by 2025. However, Sri Lanka is already doing better than these set target rates – 9.8 for infant mortality rate in the age group 0-5 and 5.4 for neonatal mortality. The targets of the NHP, therefore, are seen as backward.



CHECK YOUR PROGRESS (C)

Q.1. What kind of approach does the NHP 2017 follow?

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Q.2. How does the NHP talk about population control?

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13.6 LET US SUM UP

- Till 1982, India had no formal health policy and health was part of the five-year planning process. Every five-year plan had specific

programs and schemes that were designed to take care of the health sector.

- In the 1950s and 1960s, the primary function of the health sector was to manage epidemics as there were frequent outbreaks. There were mass campaigns to eradicate various diseases like malaria, smallpox, tuberculosis, leprosy, cholera, polio, etc. This was an extension of the colonial policy that believed in removing the germ to get rid of a particular disease.
- The first two five-year plans had a common structural framework. Urban areas got over three-fourths of medical care resources and the rural regions received 'special attention' under the Community Development Programme (CDP).
- There was a shortage of medical personnel and facilities in rural areas. Many villages did not even have proper hospitals and villagers had to travel miles to access primary healthcare.
- India was one of the first countries to implement a state-sponsored family planning programme in 1951. The country was facing a growing birth rate and a declining death rate,and therefore, family planning was seen as a necessary planned objective for the state.
- The third five-year plan (1961) looked into the problems that Primary Health Centres (PHCs) were facing. It directed attention to delay in construction of PHCs, lack of health personnel, lack of life-saving drugs, vaccines, etc.
- The fourth plan (1969) continued from the third one, with the focus on infectious diseases and the PHCs. The PHCs were given a special allocation in the fourth plan just like in the third one.
- The fifth plan marked a significant change from the previous plans in the sense that the government admitted that the health sector had not achieved the desired results that it had hoped for in the rural areas. Therefore in the fifth plan, the government decided to focus on health in rural areas.
- The sixth five-year plan was greatly influenced by the Alma Ata declaration of Health for All by 2020,and thus the plan suggested a

community-based health system. It prioritised rural areas and training of health workers in PHCs.

- The seventh five-year plan focussed on the regional imbalance by building specialties and super-specialties, especially in rural areas. Population control was also another goal. Along with communicable diseases, the plan also directed attention towards other diseases like AIDS, cancer and heart diseases.
- The eighth five-year plan was a departure from India's goal of "Health for All" as the country was facing a severe economic crisis and the underlying slogan was changed to "Health for the Underprivileged."
- The ninth five-year plan reviewed the 1983 National Health Policy (NHP) and recommended the need for another NHP. Therefore, a new and the second NHP was introduced in 2002.
- One of the most heated debates that have resurfaced from the National Health Policy 2017 is the argument on the role of the public and the private sectors in providing healthcare.
- The public system is heavily criticized as it is unable to provide quality healthcare. On the other hand, there are also many incidents of blatant profit-making, wrong treatment and bad practice in the private sector.
- The NHP suggests that universal health should be given for both communicable and non-communicable diseases (NCDs). It recommends the building of health and wellness centres, and support from community health centres and district hospitals. It proposes an 'assurance based approach' instead of a 'right based approach.'
- Many of the critical targets of the NHP have been criticized for being backward and not keeping in mind the global and the South Asian settings.



13.7 FURTHER READING

1) Duggal, Ravi. 2001. Evolution of Health Policy in India.CEHAT.

2) National Health Policy 2017. 2017. Ministry of Health and Family Welfare. Government of India.



13.8 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No A :

1. The British
2. 2002

Ans to Q No B :

1. The NHP 2017 focuses on non-communicable diseases and private sector.
2. Universal Health Coverage, increasing life expectancy and reducing premature death from non-communicable diseases.

Ans to Q No C :

1. Assurance based approach
2. Male sterilisation



13.9 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: What were the needs of National Health Policy?

Q 2: What was the focus of the five year plans before the NHP of 1983?

B) Long Questions (Answer each question within 300-500 words)

Q 1: How has health been percieved in the Five Year Plans in India?

Q 2: Discuss the National Health Policy of 2017.

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UNIT 14 : GLOBAL SURVEY OF HEALTH

UNIT STRUCTURE

14.1 Learning Objectives

14.2 Introduction

14.3 Health and Society

14.4 Relationship between health and socio-economic factors

14.5 High income and Low-income countries and the health scenario

14.6 Let Us Sum up

14.7 Further Reading

14.8 Answers to Check Your Progress

14.9 Model Questions

14.1 LEARNING OBJECTIVES

After going through this unit, you will be able to:

- understand the relation between Health and Society
- understand Socio-Economic dynamics affecting Health
- compare Health in different economies

14.2 INTRODUCTION

This unit will introduce you to the concepts of Health, Society and how they are inter-related with each other in the larger context of the well-being of a person. This unit will enable you to understand how socio-economic factors affect the well being of a person as a member of the society. It will also help you to understand how to view health as a social phenomenon and make you ready to engage with political values associated with it and the process of policy making to address the issues pertaining to health.



LET US KNOW

Health is as much a social phenomenon as it is an individual phenomenon. According to World Health Organization (WHO), "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." This definition means that a person to be healthy, it ought to have proper functioning body, as well as his relationships with his fellow peers and societal members at large should be amiable. This definition also entails that the person is also at peace within itself and not at unease leading to strenuous effects on the mind and causing stress, anxiety, or depression in the individual that leads to a negative and desensitized image of the person in their self.

Health means:

- Physical Well-being
- Mental Well-being
- Social Well-being
- Not merely absence of Disease

14.3 HEALTH AND SOCIETY

Society can be, loosely, viewed as of people inhabiting a geographical terrain sharing various spheres of life with each other as individuals and groups. Therefore, the wellbeing of the individual also depends upon, to a greater extent, the society in which the person lives. The social values attributed to health, the economic expenses on healthcare and health facilities, political will towards the well-being of the individual are some determinants.

To understand this, let us consider the case of vaccination. Vaccination strengthens our body's immunity against the diseases against which our body is vaccinated. Vaccination has helped humanity to eradicate diseases like cowpox, small pox, Whooping Cough, Measles, etc. Now

vaccination as process requires both society as an agent to engage as well as the state as an actor to facilitate the process through policy making and fund allocation, awareness campaigns and programs to impart education on such issues. Another good example are the state-run programs regarding sex education and Sexually Transmitted Diseases through various modes of advertisements and media communications. This shows how health is an intricate aspect requiring various societal aspects to play in.

Health historically has had an important part in the well-being of the individual. From the ancient Greeks to Leonardo da Vinci to Michel Foucault to recent Genome Projects, how society views health as a subject has changed over the period of time. In the modern era, various thinkers have attempted to study health, not merely from a medical perspective but also from the sociological perspective and political economy of the health.

According to the WHO, for an individual to be completely healthy, the individual ought to be socially, mentally and physically well.

Let us look at each of the three points in the above mentioned definition :

- **Physical Health :** There are various old sayings adhering to the importance of the health. One such saying says “jo jaage so pave, jo sove so khove” i.e. one who awakes gains, one who sleeps loses. Health has been regarded as wealth, virtues in various cultures across the worlds. The physical health enables a person to contribute to the physical labor towards the well-being of self and the society at large.
- **Mental Health :** The recent times have seen increase in the individuals exhibiting symptoms, of deteriorated mental health, like Stress, Anxiety, Depression, and these escalating to severe implications. The increasing crisis of job mentality, consumerist behavior, hyper-individualism leads to the individual feeling disembedded in the larger society resulting in a feeling of alienation.

- **Social Health :** This one deals with the ability of an individual to fulfill social obligations and duties towards kith and kin, and the society at large. This can be affected by improper physical health and mental health. This exhibits that the society is becoming stagnant, and the growth and progress is slow.

  Hence, we now know that the health in itself is a very serious concern for the society as it can determine the course of the evolution of the society both spiritually as well as socio-politically.

14.4 RELATIONSHIP BETWEEN HEALTH AND SOCIO- ECONOMIC FACTORS

The individual as a part of the society bears the brunt of socio-economic factors upon the well-being of the individual. This can be seen in the fact that some people have a better chance of living a long and healthy life and some have poor chances. This is a manifestation of the social advantages enjoyed by some and disadvantages borne by others. When health becomes an object at the intersection of the individual and the socio-economic environment the individual exists, it excites the imagination of a sociologist. Health then becomes a larger structural phenomenon having a bearing upon the individual as well.

- **Health Inequalities and Health Inequities :** According to Hillary Graham, Health inequalities can be understood with respect to three meanings :
  - Health Differences between individuals
  - Health Differences between Population groups
  - Health Differences between groups occupying unequal positions in society.

  However, one thing to understand according to Braverman is 'Health disparities/inequalities do not refer to all differences in health. A health disparity/inequality is a particular type of difference in health. It is a difference in which disadvantaged social groups – such as the poor, racial/ethnic minorities, women, or other groups who have

persistently experienced social disadvantage or discrimination – systematically experience worse health or greater health risks than more advantaged social groups.'

- **Socio-Economic Determinants :** Humans are members of society which has evolved over time. In this course of time, the society evolved structures and hierarchies that have resulted in disadvantages to some people and advantages to others. In the US, the racism is one such structural phenomenon, gender hierarchy is one such, in several countries. Indian society is affected by caste hierarchy, and the larger class structure.

  Individuals are slotted in such structures which prescribes roles and obligations with respect to that position and in fulfilling these structural roles people end up reproducing the structure. The people who benefit from the structure accumulate resources and the people disadvantaged by the structure are left without the resources and are struck by a resource scarcity. This resource scarcity creates problems in the disadvantaged people to have access to chances of living a longer and healthier life.

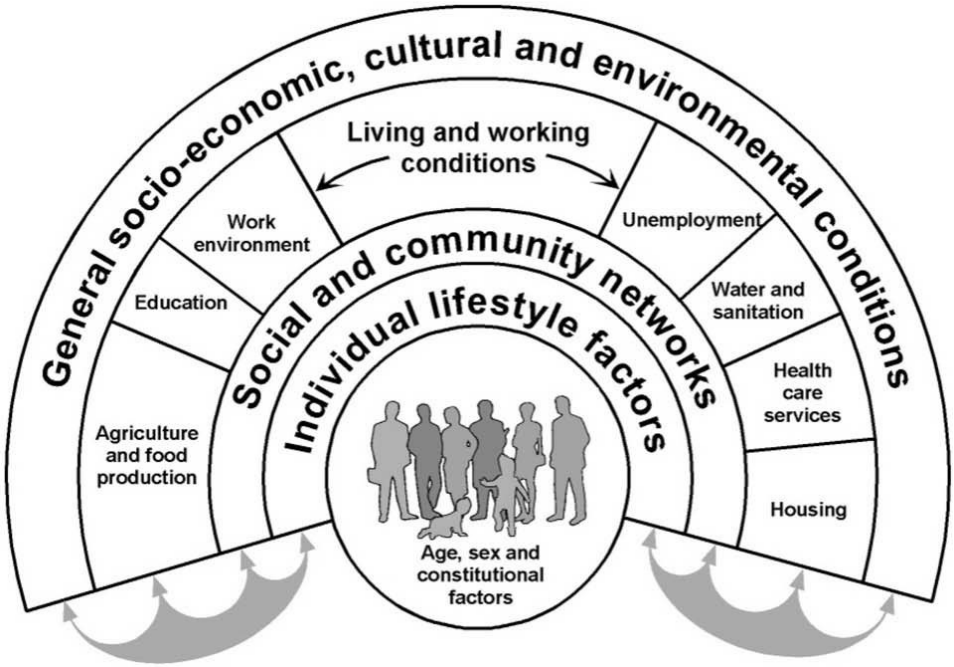


Figure 1 The main determinants of health

Private healthcare is one such aspect of health care that disadvantaged people cannot gain access due to lack of resources in their hands.

To people who are disadvantaged, the public health institutions under the supervision of the state are the options to go since they can not afford the private health care. To aid such citizens, the state allocates funds, programs, campaigns, health care schemes.

Let us understand the following instance. In China, in 2002, a person called Yong Lu was diagnosed by a form of leukemia and was advised to use the drug “Gleevec” produced by a Swiss Pharmaceutical Company. The cost of the drug being very high, it was unaffordable for many patients. To make it available to a network of patients Yong Lu started importing Indian variant of the same drug at a much cheaper price and made it available to the patients at cheap prices bearing most of the cost from the profits he would earn from his business. However, he was arrested on charges of forgery and a lawsuit was filed against him by the Swiss company against which a plea was filed on behalf of the public to regulate the price of the Anti-cancer drug “Gleevec” which was being produced by the Swiss pharmaceuticals. The case was delivered in the favor of the public and the state reformulated its policy on drugs research and pricing. It is one of the land mark cases in the history of medicine in China where state was compelled to change its views on the policies and issues of drug allocation.

The case above is an example of how health requires attention not only from the society itself but, it requires larger socio-economic factors. Inn the age of globalization, and neo-liberal world, bigger institutions are involved in the funding and awareness programs like World Bank, IMF, etc. to safeguard the rights of the citizen. It is the obligation of the state to keep a check on the regulation of the prices of drugs that are available for the masses. This might require the state to enforce laws and regulations.

14.5 HIGH INCOME AND LOW-INCOME COUNTRIES AND THE HEALTH SCENARIO

Having discussed the impact of socio-economic factors on the health of an individual, let us see how the situation varies with respect to the economy of the country. For this exercise we will engage with the comparative analysis of high income and low-income countries. Before we go into comparative analysis, we will try to understand what does the term mean.

The evidence at the disposal of medical sociology argues that people's health is closely linked in determination by their social circumstances. The evidence base is heavily tilted towards richer countries in which only a minority of the world's population live. In part, this is because these countries have more comprehensive data collection systems. For example, England and Wales have National Registration for births and deaths since 1837.

The lack of evidence on health inequalities in poorer countries cannot be wholly explained by the limitations of their national data collection systems. It is also due to the targeting of research funding at the world's richest and healthiest populations. It has been estimated that, of the total volume of global health research funded by the public and private sector, less than 10 per cent is devoted to improving the health of 90 per cent of the world's population. This has been termed the '90/10' gap (Commission on Health Research for Development,1990).

According to the World Bank, a high-income country is one that had Gross National Income Per Capita of $12,056 in 2017.

The Low-Income Country is one that had Gross National Income per Capita of $995 or less in year 2017

But what is Gross National Income?

According to Todaro and Smith, it comprises of the total domestic and foreign output claimed by residents of a country, consisting of gross domestic product (GDP), plus factor incomes earned by foreign residents, minus income earned in the domestic economy by nonresidents.

Now we move to understanding the correlation between health and income. Below is a table depicting how the life expectancy at birth and Under-5 mortality varies with income group of the country.

Table 1 Life expectancy at birth and under-5 mortality in low-income, middle-income and high-income countries, 2001

Life expectancy at birth	Under-5 mortality	(deaths per 1000)
Low income	59	121
High income	78	7

Source: *adapted from World Bank, 2003, table 2.20*

As we see from the above table the difference between the life expectancy is 19 years between the two groups while the child mortality gap shoots up in low income group by addition of 114 children dying before their 5th birthday.

According to the study of Colin Mathers and Dejan Loncar, in sub-Saharan Africa, the region of the world with the lowest life expectancy, it is estimated that 18 per cent of the average life span is spent living with disabilities; in countries where life expectancy is high, like Japan, the proportion is around 8 per cent. But how does income relate to health? This is answered by the research published in 1975 arguing how the income disparity affects health in various countries through Preston Curve as shown below.

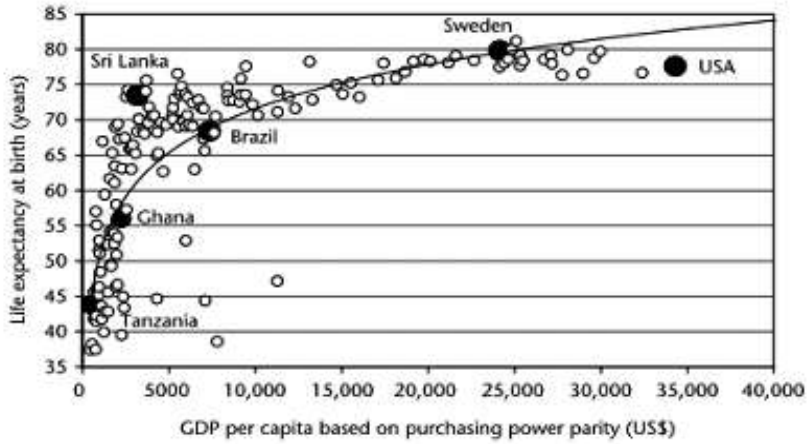


Figure 2 Gross domestic product per person in US dollars (adjusted for purchasing power parity) and life expectancy in 159 countries, 2001

Source: World Bank, 2003

The curve attempts to understand how income parity affects the health in the corresponding income group. When GDP is low, increases are strongly associated with improvements in life expectancy: at this point in the income distribution, the line linking income and health is almost vertical. Among richer countries, the curve flattens out, with higher incomes bringing diminishing health benefits. As this suggests, the marginal health gains of extra income are far greater at the lower end of the income range. It is a conclusion which lends support to the view that 'redistribution of income towards the poor will improve their average health by more than the loss of health among the rich.' (Deaton, 2003:115)

However, does this link between health and income explains exceptions? For example, according to World Bank (2003), a country where levels of health do not match its levels of wealth is the USA. In the early 2000s, the world's richest country had a lower life expectancy (77.0 years) than countries with much lower GDP, like Sweden (79.7 years) and Japan (80.7 years), and an infant mortality rate which was more than twice as high as these countries. This anomaly is explained by the receded regulation of the state in the labor market and Welfare Provision. This also features in how much proportion of GDP is allocated towards the health care provisions. The US allocates lesser GDP to healthcare as compared to other high-income group countries. Another exception in

contrast to the case of the US is Sri Lanka, Sri Lanka's GDP is half that of Brazil, but it has a higher life expectancy (73.1 years compared to 68.1 years in Brazil). Sri Lanka also has a lower infant mortality rate (17 vs 31 per 1000) and a lower rate of under-5 mortality (15 vs 35 per 1000) (UNDP, 2003; World Bank, 2003).

In the case of Sri Lanka, the issue has been resolved by allocation of a good proportion of the national wealth towards poverty alleviation, emanating from their equity-oriented policies.

In Indian context, Kerala state has been deemed as a sub-national example by Amartya Sen in his works. According to Thakkappan (2001), the modus operandi of the Kerala state has been along the similar lines regarding the equity-oriented approach by providing a land redistribution system allowing the allocation of land to the poorest as well as food distribution at a subsidized price along with public funded service expansion to women education and healthcare.

As the examples of the USA, Sri Lanka and Kerala suggest, the relationship between national wealth and population health is not a direct and simple one. Rather, the relationship appears to be mediated by government policies.

Since the 1970s, globalization has become 'shorthand for global capitalism' (Birdsall, 2006: 22), with trade liberalization and financial deregulation enabling companies based in high-income countries to extend their reach into the economies, and the populations, of poorer countries. Global financial institutions, like the World Bank, International Monetary Fund and World Trade Organization, have played an important role by negotiating what are called 'structural adjustment programmes' with poorer countries, often as a condition of financial aid and debt rescheduling (CSDH, 2005; Labonte and Schrecker, 2006; Sáinz, 2006). Actively promoted through the1980s and 1990s, the programmes required that domestic markets were opened up to foreign investment and public expenditure was cut, with private companies taking over what were formerly publicly provided services.

In India, the structural adjustment programmes have been seen to

have more far-reaching effects, with resources directed away from primary health care towards private hospitals and a sharp rise in the costs of health care, particularly for poorer groups (Qadeer, 2000; Thankappen, 2001). Analyses suggest that the programmes have impacted negatively on Kerala, making it hard for the Indian state to sustain the principle of universal access to health care and threatening the survival of its redistributive model of welfare (Kutty, 2001; Thankappen,2001). As this suggests, politics and policies matter for people's health.

Taking the case further we see the table below for our further analysis.

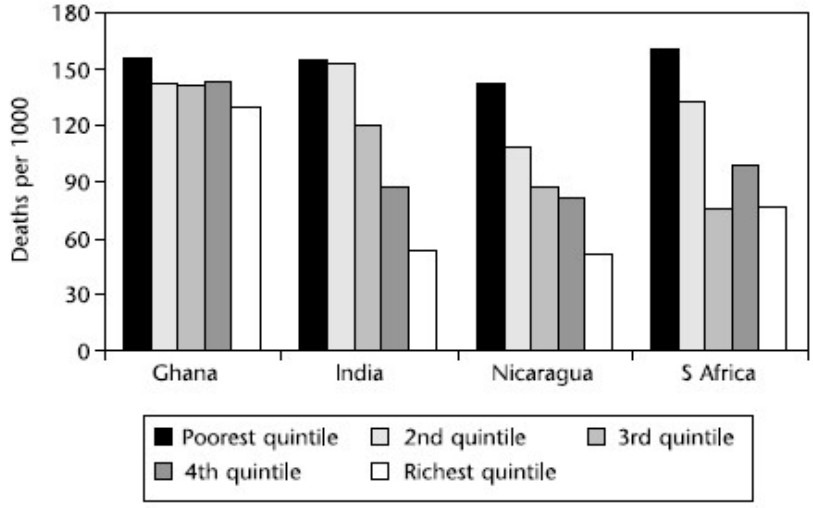


Figure 3 Under-5 Mortality

In the figure above, we have a middle-income country, South Africa (per capita GDP of $3500 in 2003), and three low income countries: Ghana, one of the poorest countries in the world ($350), India ($550) and Nicaragua ($750) (UNDP, 2005). The steepness of the socio-economic gradient varies, with death rates falling much more rapidly with rising household income in India, Nicaragua and South Africa than in Ghana. But in all four countries, death rates are at their highest in the poorest households. In rich societies, overall standards of health are much, much higher. But high overall standards mask the unequal distribution of health between more and less advantaged groups.



CHECK YOUR PROGRESS-(A)

Q.1. Which of these is included in WHO's definition of Health?

a). Being privileged b).Being rich

c). Political Power d). Mental Health

Q.2. Write two important factors that affect the health of an individual.

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14.6 LET US SUM UP

- According to World Health Organization (WHO), "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."
- A health disparity/inequality is a particular type of difference in health. It is a difference in which disadvantaged social groups – such as the poor, racial/ethnic minorities, women, or other groups who have persistently experienced social disadvantage or discrimination – systematically experience worse health or greater health risks than more advantaged social groups.
- The lack of evidence on health inequalities in poorer countries cannot be wholly explained by the limitations of their national data collection systems. It is also due to the targeting of research funding at the world's richest and healthiest populations.
- Global financial institutions, like the World Bank, International Monetary Fund and World Trade Organization, have played an important role by negotiating what are called 'structural adjustment programmes' with poorer countries, often as a condition of financial aid and debt rescheduling.
- In India, the structural adjustment programmes have been seen to have more far-reaching effects, with resources directed away from primary health care towards private hospitals and a sharp rise in the costs of health care, particularly for poorer groups.



ACTIVITY 1

Try finding out initiatives of Indian government regarding mental health

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_____

_____



CHECK YOUR PROGRESS - (B)

Q.1. Which country has a high income per capita?

a). Brazil b). the US

c). India d). Bangladesh

Q.2. The Criteria for a country to be High Income is:

a). Rich Natural Resources b). $12,056 income per capita

c). wealthy politicians d). Poor people

Q.3. World Bank Defines High-Income and Low-Income Countries. True/ False

Q.4. For better health of the population, policy needs to be

a). profit oriented b). equity oriented

c). capitalist oriented d). none of the above



ACTIVITY 2

Find about the health care initiatives in your locality

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_____



CHECK YOUR PROGRESS - (C)

Q.1. Why does the US have higher mortality rate?

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Q.2. Why does Sri Lanka have higher life expectancy?

.....

Q.3. The state referred to as the sub-national example is

a) Manipur b) Meghalaya c) Gujrat d) Kerala

Q.4. Write two important works mentioned in the chapter above done in Kerala for better health.

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14.7 FURTHER READING

1) *The Sociology of Health and Illness* (Routledge Student Readers) by Michael Bury

2) *Key Concepts in Medical Sociology* (Sage key concepts series) by Jonathan Gabe and Lee Monaghan

3) *The New Medical Sociology : Social Forms of Health and Illness*, by Bryan S. Turner

4) Unequal Lives : *Health and Socio-Economic Inequalities*, by Hillary Graham



14.8 ANSWERS TO CHECK YOUR PROGRESS

A

Ans to Q No 1. Mental Health

Ans to Q No 2. Social and Economic factors

B.

Ans to Q No 1. the US

Ans to Q No 2. $12,056 per Capita

Ans to Q No 3. True

Ans to Q No 4. Equity Oriented

C.

Ans to Q No 1. The US has higher mortality rate because of lack of Institutions, and minimal allocation of GDP for health care.

Ans to Q No 2. Sri Lanka has a higher life expectancy because of their equity-oriented policies and allocation of more portion of GDP for health and mass welfare.

Ans to Q No 3. Kerala

Ans to Q No 4. Land redistribution to the poor and availability of food at subsidized rates for the masses



14.9 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: What is the definition of Health as given by World Health Organization (WHO)?

Q 2: What factors affect the health of an individual apart from the environmental factors?

B) Long Questions (Answer each question within 300-500 words)

Q 1: What is the role that policy plays in providing masses the access to health care?

Q 2: What do you think could be reasons why low-income countries fare poorly in healthcare?

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