Health Politics: Taking up the challenge

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I have always been interested in the politics of health, beginning with my university studies when I explored the medicalization of the female body as gynaecology and obstetrics were established. I traced the growing power of the medical profession at the turn of the 20th century in Australia that, from my secondary reading, mirrored similar processes in other parts of the western world. I looked at how the medical profession in the 1870s to the 1910s built a new knowledge and set of practices based on the scientific gaze (in the Foucauldian sense).¹ In the process, they redefined what had been seen as the natural processes of child birth as a medical event and developed a series of practices to treat newly observed diseases of the female sexual organs. My interest was two-fold: one to understand how the female body became a particular subject of the medical gaze, and two, I wanted to understand how the status of medical practitioners shifted from little better than quacks to becoming one of the most influential and respected professions in the modern world.

To a great extent, I would argue nothing much has changed in most medical practices in the western world, some 100 years later. Doctors continue to be among the most well paid and respected professions and are highly organized to keep it that way. Their continued power comes from highly specialized and stratified knowledge that demands rigorous training in the scientific method and which focuses on disease rather than the patient, who is cured through access to specialized knowledge, drugs and allopathic treatment. There is a whole edifice of powerful wealthy institutions, from universities, public and teaching hospitals, to specialized clinics and journals to pharmaceutical drug companies and related marketing and insurance companies that promote globally the importance of medical science and the medical profession.

Whereas undoubtedly scientific medicine has saved millions of lives and continues to do so, the scientific medical regime's power/knowledge nexus securely links the medical profession to other powerful groups. The elitist and narrow medical model of health underlies most health practices, whether in the private or public sector. To this extent, I would query Derek Yach and Mahesh Maskey's references to Virchow's belief that politics is medicine writ large. I would underline that the dominant politics of medicine is one of power and embedded in a politics of wealth that is not the heroic and selfless politics of Virchow.

However, somewhat to my surprise, questioning medical power and knowledge and the institutions that support them was not the line that most of the authors took up when asked to write on the politics of health. It seems that when we move to health and development issues, in particular when we look at the structures that enable the delivery of public health to the very poor in 'developing countries', there is another agenda. Here, we find the doctor's role and medical knowledge are unquestioned, and the scientific approach not queried.

Indigenous medicines and practices of holistic approaches to health are also rarely part of these debates; in fact in this journal issue, again somewhat to my surprise, the issue of other forms of medical knowledge has been rarely discussed.²

What is questioned is the complex political institutional structures in which modern medical knowledge and cures are delivered, or not, defined by a whole range of actors and institutions, which in the affluent countries rarely impact on the medical establishment.

Within the politics of aid there are a whole range of advisers who determine many decisions in the 'developing' countries – bilateral and multi-lateral agencies – as well as private funds and partnership such as the Global Fund for Health. They give large amounts of resources delivered in complex processes of negotiations that are imposed in ways that are impossible for national governments to ignore. In doing so donors determine whole national health agendas. Ministers of Health bow to that pressure, and very few doctors challenge the decision, trained as they are to see the practice of medicine and provision of health as a technical biomedical concern rather than a political issue. Most doctors in the 'developing countries' move to train in 'developed' countries, or institutes funded by those countries, learning scientific methods and gaining in the process status and the required distance from patients. And somewhat ironically when the treatment is provided, although available in the rich countries for free or relatively affordable, user fees can be charged in the poor countries, leaving whole sections of the population unable to access medical treatment. And not surprisingly, the very rich pay

for exclusive treatment or fly themselves and their families to clinics elsewhere.

Even if in health and development it seems that there is very little questioning of medical science or the medical establishment as a whole, there is certainly a discussion of the politics of health within the development terrain. All of the authors write in the belief that the ten points of the Declaration of Alma Ata (1978) (which we reproduce in full as the Last Word) are the starting points for public health that would be equitable and just. The vision of the Alma Ata is revolutionary still, some 26 years later. Essentially because it takes up poverty as a central health issue, and therefore the issue of power and the need to change economic, social and political systems to achieve 'health for all'.

Sadly, those revolutions have not happened, indeed in many ways the chance for good health has decreased for the poor and also, one would add a little snidely also the rich, though for different reasons. The articles in the journal show clearly why. It is not because of lack of knowledge – even the most damning scourge of the developing world, particularly in Africa, HIV/AIDS can be stemmed and controlled. It is because of wrong health practices, lack of equitable distribution of resources and the drive for economic growth – making money for the wealthy – riding on the backs of the poor. It sounds like rhetoric, but these articles show the many missed opportunities because the agreements of the Alma Ata were ignored. Socrates Litsios shows primary health care did not in the end take the lead and as a result the poor have not benefited from the new health discoveries. Human rights, health and well-being are spoken about but not put into practice, according to Joanna Cseste. Lenore Manderson argues that the growing number of disabled are still not part of protected global legislation. Lesley Doyal and Manisha Desai show that poor women, though resisting and organizing and subject of many UN accords and gender programmes are dying in even greater numbers of maternal mortality and preventable diseases.

At a macro level, other authors show how governance structures continue to serve a certain view of health not designed to benefit the poor –

aggravated by today's form of economic globalization as argued by Kelley Lee. Henry Waxman reveals that this is not ignorance but deliberate policy by the USA. The public-private partnerships are equally placed under scrutiny by Judith Richter who underlines that there are alternatives and by Kent Buse and Andrew Harmer who expose the power games being played, which are not, despite claims, focused on people's health.

Kelley Lee, Kent Buse and Suzanne Fustukian in 'Health Policy in a Globalising World (2003) (see Bookshelf) ask us to look at the positive and negative side of globalization. On the one hand, we can be almost cynical like Tim Lang and Michael Heasman who warn in their article on diet and nutrition that there are no longer so many differences between South and North when it comes to food and nutrition – globalizing food habits towards easy lifestyle, fat-saturated and sweet food is leading to problems everywhere. Or as Susan Raymond and colleagues point out, cardiovascular disease is a rising trend in developing countries. SARS, HIV/AIDS and environmentally related ill health due to congestion and pollution are all products of our global world.

Moreover on the positive side of globalization, there is the networking using new information technologies, the increasing awareness of human rights around the world, and the challenge to modernity that has led to another set of responses. A further set of articles show how it is possible to challenge the practices that are not benefiting public health. Amalia Waxman gives a detailed and revealing account of the fight of WHO against the sugar industry. Jeff Collin describes the main events in the very successful campaign against tobacco and Peter Illig lists the way to reform environmental legislation in particular to secure children's health – but in the end for all of us. Two articles by senior UN officials, Eugene Villar and Sadig Rasheed show how within the UN there is a strong attempt to push for a much more focused health agenda based on rights and an end to poverty and gender discrimination.

It is in the last section, which relates some of the political battles at regional and national level, that we see just how hard it is to change convention, whether you are a doctor, senior politician, or an

NGO advocate. Mwajuma Saidy Masiaganah of East African focal point for the Peoples Health Assembly (see this issue of *Window on the World*) shows how desperately the Tanzanian health system needs to take up a primary health-care approach, but how hard it is to do so given the structural adjustments and other donor pressures. Farida Akhter, while examining family planning, echoes the same concern – the numbers of people count more than the well-being of the people. John Bowis, former Minister of Health in the UK shows that even at his level of influence he is not able to lobby to end the stigma that surrounds the growing numbers of people suffering poor mental health and prevents adequate treatment.

Maresh Maskey's article stands out as the only contribution that speaks about doctors in action against a political regime that not only denies people's human rights to medical treatment but also to democracy and justice. He describes (and the photographs show) how these doctors working for people's justice take on a conservative monarchy using their leverage and power as doctors to fight not only for medical treatment for the community but also for political change to ensure peace.

As Yach succinctly describes it 'politics and health have always been intertwined' and 'advocates for health are destined to struggle for change in settings where other interests take precedent.' As almost all articles show, even when those in power claim to have poverty and health at the heart of their activities, there are other agendas that are really driving their decisions.

The message of the journal issue is that it is important to question how we deliver health, not only the sociopolitical and economic conditions but also the methods and practices. Within the apparatus of aid, is it possible to deliver health that is culturally appropriate, given the institutional inequalities and knowledge differences? What is the role of doctors? I see all too few playing the admirable role of Physicians for Social Responsibility and others featured in the journal (see *Window on the World*). It will take many more to make the changes necessary for the medical profession to move from an establishment primarily catering for the rich to a profession caring for all. What is

the role of WHO? All those assemblies and meetings around agreements feature a great deal of wrangling and power battles outside and within the institution as different approaches to policy are hotly debated. These lengthy negotiations can take resources and focus away from WHO's stated goals. What are the global public-private partnerships about – the power plays described by Richter, Buse and Harmer, that is, funding institutions as well as health solutions? Given all the different actors described in the articles in this journal – doctors, politicians, researchers, lobby groups, NGOs, development workers, private sector, food, drug companies, health is a highly complex political business on many levels.

Yet despite all the activities and hopes, there continues to be a stark increase of ill health closely related to increase of poverty and the gap between the rich and poor. As the articles so clearly show preventive health measures are not only technical, they are also political to provide the

governance, resources, retraining, education and institutions required. The question is how do we respond effectively to the injustice and inequity that create poverty and ill health? Following the spirit of the Alma Ata remains a good start, and there are multiple suggestions in these articles as how to take it further. More research combined with action is needed that takes into account the political nature of health policy. I would add that we should not be afraid also to challenge the dominance of medical science and the whole edifice of the powerful medical profession. As in all processes of change, it is very important to be self-critical and open to learning how we also fit into the system, and from within how we need to change. All the authors have taken that challenge very seriously. The challenge now is how to convince other actors within the health arena and arenas outside the health establishment to find the political will to make those changes, and collectively to bring about health for all.

Notes

- 1 The French philosopher Michel Foucault in his writings on modern knowledge uses the term 'medical gaze' to describe the form of medical practice based on the empirical scientific enquiry – the 'opening up' of the body to medical classification. My thesis focused on how the medical gaze reclassified the medical understanding of child birth and disease in what became the specializations of obstetrics and gynaecology and in doing so constructed a way of understanding women's health and disease, even being, based around the female sexual organs as the defining point of difference to men.
- 2 A gap I regret, as those I asked working in indigenous health were unable to write; for those interested, earlier *Development* issues did feature articles on Indigenous rights and health by USA, Australian and New Zealand indigenous writers (see *Development* 43.3, 44.3, 46.2).