The Crisis of Medicine or the Crisis of Antimedicine?
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I would like to open this lecture by drawing attention to a question which is beginning to be widely discussed: should we speak of a crisis of medicine or a crisis of antimedicine? In this context I shall refer to Ivan Illich's book *Medical Nemesis: the Expropriation of Health*,[1] which, given the major impact it has had and will continue to have in the coming months, focuses world public opinion on the problem of the current functioning of the institutions of medical knowledge and power.

But to analyse this phenomenon, I shall begin from at an earlier period, the years between 1940 and 1945, or more exactly the year 1942, when the famous Beveridge Plan was elaborated. This plan served as a model for the organisation of health after the Second World War in England and in many other countries. The date of this Plan has a symbolic value. In 1942 — at the height of the World War in which 40,000,000 people lost their lives — it was not the right to life that was adopted as a principle, but a different and more substantial and complex right: the right to health. At a time when the War was causing large-scale destruction, society assumed the explicit task of ensuring its members not only life, but also a healthy life.

Apart from its symbolic value, this date is very important for several reasons:

1. The Beveridge Plan signals that the State was taking charge of health. It might be argued that this was not new, since from the eighteenth century onwards it has been one of the functions of the State, not a fundamental one but still one of vital importance, to guarantee the physical health of its citizens. Nonetheless, until middle of the twentieth century, for the State guaranteeing health meant essentially the preservation of national physical strength, the work force and its capacity of production, and military force. Until then, the goals of State medicine had been, principally, if not racial, then at least nationalist. With the Beveridge plan, health was transformed into an object of State concern, not for the benefit of the State, but for the benefit of individuals. Man's right to maintain his body in good health became an object of State action. As a consequence, the terms of the problem were reversed: the concept of the healthy individual in the service of the State was replaced by that of the State in the service of the healthy individual.
2. It is not only a question of a reversal of rights, but also of what might be called a morality of the body. In the nineteenth century an abundant literature on health, on the obligation of individuals to secure their health and that of their family, etc. made its appearance in every country in the world. The concept of cleanliness, of hygiene, occupied a central place in all these moral exhortations concerning health. Numerous publications insisted on cleanliness as an indispensable prerequisite for good health. Health would allow people to work so that children could survive and ensure social labour and production in their turn. Cleanliness ensured good health for the individual and those surrounding him. In the second half of the twentieth century another concept arose. It was no longer a question of an obligation to practise cleanliness and hygiene in order to enjoy good health, but of the right to be sick as one wishes and as is necessary. The right to stop work began to take shape and became more important than the former obligation to practise cleanliness that had characterised the moral relation of individuals with their bodies.
3. With the Beveridge Plan health entered the field of macroeconomics. The costs involved in health, from the loss of work days, to the necessity of covering those risks stopped being phenomena that could be resolved through the use of pension funds or with mostly private insurance. From then on, health — or the absence of health — the totality of conditions which allowed the health of individuals to be insured, became an expense, which due to its size became one of the major items of the State budget, regardless of what system of financing was used. Health began to enter the calculations of the macro-economy. Through the avenue of health, illnesses and the need to ensure the necessities of health led to a certain economic redistribution. From the beginning of the present century one of the functions of budgetary policy in the many countries has been ensuring a certain equalisation of income, if not of property, through the tax system. This redistribution did not, however, depend on taxes, but on the system of regulation and economic coverage of health and illnesses. In ensuring for all the same opportunities for receiving treatment, there was

[1] Ivan Illich, *Medical Nemesis: the Expropriation of Health*, London, Calder and Boyars, 1975.

an attempt to correct inequalities in income. Health, illness, and the body began to have their social locations and, at the same time, were converted into a means of individual socialisation.

4. Health became the object of an intense political struggle. At the end of the Second World War and with the triumphant election of the Labour party in England in 1945, there was no political party or political campaign, in any developed country, that did not address the problem of health and the way in which the State would ensure and finance this type of expenditure. The British elections of 1945, as well as those relating to the pension plans in France in 1947, which saw the victory of the representatives of the *Confédération générale du travail* [General Confederation of Workers], mark the importance of the political struggle over health.

Taking the Beveridge Plan as a point of symbolic reference, one can observe over the ten years from 1940-1950 the formulation of a new series of rights, a new morality, a new economics, a new politics of the body. Historians have accustomed us to drawing a careful and meticulous relation between what people say and what they think, the historical development of their representations and theories and the history of the human spirit. Nevertheless, it is curious to note that they have always ignored that fundamental chapter that is the history of the human body. In my opinion, the years 1940-1950 should be chosen as dates of reference marking the birth of this new system of rights, this new morality, this new politics and this new economy of the body in the modern Western world. Since then, the body of the individual has become one of the chief objectives of State intervention, one of the major objects of which the State must take charge.

In a humorous vein, we might make an historical comparison. When the Roman Empire was crystallised in Constantine's era, the State, for the first time in the history of the Mediterranean world, took on the task of caring for souls. The Christian State not only had to fulfil the traditional functions of the Empire, but also had to allow souls to attain salvation, even if it had to force them to. Thus, the soul became one of the objects of State intervention. All the great theocracies, from Constantine to the mixed theocracies of eighteenth century Europe, were political regimes in which the salvation of the soul was one of the principal objectives.

One could say that the present situation has actually been developing since the eighteenth century not a theocracy, but a 'somatocracy'. We live in a regime that sees the care of the body, corporal health, the relation between illness and health, etc. as appropriate areas of State intervention. It is precisely the birth of this somatocracy, in crisis since its origins, that I am proposing to analyse.

At the moment medicine assumed its modern functions, by means of a characteristic process of nationalisation, medical technology was experiencing one of its rare but extremely significant advances. The discovery of antibiotics and with them the possibility of effectively fighting for the first time against infectious diseases, was in fact contemporary with the birth of the major systems of social security. It was a dazzling technological advance, at the very moment a great political, economic, social, and legal mutation of medicine was taking place.

The crisis became apparent from this moment on, with the simultaneous manifestation of two phenomena: on the one hand, technological progress signalling an essential advance in the fight against disease; on the other hand, the new economic and political functioning of medicine. These two phenomena did not lead to the improvement of health that had been hoped for, but rather to a curious stagnation in the benefits that could have arisen from medicine and public health. This is one of the earlier aspects of the crisis I am trying to analyse. I will be referring to some of its effects to show that that the recent development of medicine, including its nationalisation and socialisation — of which the Beveridge Plan gives a general vision — is of earlier origin.

Actually, one must not think that medicine up until now has remained an individual or contractual type of activity that takes place between patient and doctor, and which has only recently taken social tasks on board. On the contrary, I shall try to demonstrate that medicine has been a social activity since the eighteenth century. In a certain sense, 'social medicine 'does not exist because all medicine is already social. Medicine has always been a social practice. What does not exist is non-social medicine, clinical individualising medicine, medicine of the singular relation. All this is a myth that defended and justified a certain form of social practice of medicine: private professional practice. Thus, if in reality medicine is social, at least since its great rise in the eighteenth century, the present crisis is not really new, and its historical roots must be sought in the social practice of medicine.

As a consequence, I shall not be posing the problem in the terms used by Illich and his disciples: medicine or antimedicine, should we save medicine or not? The problem is not whether to have individual

or social medicine, but whether to question the model of the development of medicine beginning in the eighteenth century, that is, from when what we might describe as the 'take off 'of medicine occurred. This 'take off 'of health in the developed world was accompanied by a technical and epistemological removal of important obstacles in medicine and in a series of social practices. And it is precisely these specific forms of 'take off 'that have produced the current crisis. The problem can be posed in the following terms: (1) what was that model of development? (2) to what extent can it be corrected? (3) to what extent can it be used today in societies or populations that have not experienced the European and American model of economic and political development? To sum up, what is this model of development? Can it be corrected and applied in other places? I would now like to expose some hidden aspects of this current crisis.

Scientificity and Efficacy of Medicine

In the first place, I would like to refer to the separation or distortion that exists between the scientificity of medicine and the positive nature of its effects, or between the scientificity and the efficacy of medicine. It was not necessary to wait for Illich or the disciples of anti-medicine to know that one of the capabilities of medicine is killing. Medicine kills, it has always killed, and it has always been aware of this. What is important, is that until recent times the negative effects of medicine remained inscribed within the register of medical ignorance. Medicine killed through the doctor's ignorance or because medicine itself was ignorant. It was not a true science, but rather a rhapsody of ill-founded, poorly established and unverified sets of knowledge. The harmfulness of medicine was judged in proportion to its non-scientificity.

But what emerged at the beginning of the twentieth century, was the fact that medicine could be dangerous, not through its ignorance and falseness, but through its knowledge, precisely because it was a science. Illich and those who are inspired by him uncovered a series of data around this theme, but I am not sure how well elaborated they are. One must set aside different spectacular results designed for the consumption of journalists. I shall not dwell therefore on the considerable decrease in mortality during a doctors strike in Israel; nor shall I mention well-recorded facts whose statistical elaboration does not allow the definition or discovery of what is being dealt with. This is the case in relation to the investigation by the National Institutes of Health (USA) according to which in 1970, 1,500,000 persons were hospitalised due to the consumption of medications. These statistics are upsetting but do not afford convincing proof, as they do not indicate the manner in which these medications were administered, or who consumed them, etc. Neither shall I analyse the famous investigation of Robert Talley, who demonstrated that in 1967, 3,000 North Americans died in hospitals from the side effects of medications. All that taken as a whole does not have great significance nor is it based on a valid analysis.[2] There are other factors that need to be known. For example, one needs to know the how these medications were administered, if the problems were a result of an error by the doctor, the hospital staff or the patient himself, etc. Nor shall I dwell on the statistics concerning surgical operations, particularly in relation to certain studies of hysterectomies in California that indicate that out of 5,500 cases, 14% of the operations failed, 25% of the patients died young, and that in only 40% of the cases was the operation necessary. All these facts, made notorious by Illich, relate to the ability or ignorance of the doctors, without casting doubt on medicine itself in its scientificity.

On the other hand what appears to me to be much more interesting and which poses the real problem is what one might call positive iatrogenicity, rather than iatrogenicity[3]: the harmful effects of medication due not to errors of diagnosis or the accidental ingestion of those substances, but to the action of medical practice itself, in so far as it has a rational basis. At present, the instruments that doctors and medicine in general have at their disposal cause certain effects, precisely because of their efficacy. Some of these effects are purely harmful and others are unable to be controlled, which leads the human species into a perilous area of history, into a field of probabilities and risks, the magnitude of which cannot be precisely measured.

It is known, for example, that anti-infectious treatment, the highly successful struggle carried out against infectious agents, led to a general decrease of the threshold of the organism's sensitivity to hostile agents. This means that to the extent that the organism can defend itself better, it protects itself, naturally,

[2] Letters in relation to this study can be found in Robert B. Talley, Marc F. Laventurier, and C. Joseph Stetler, 'Letters: Drug Induced Illness.'*Journal of the American Medical Association* 229, no. 8 (1974) pp. 1043-44.

[3] Caused by a doctor, from *iatros*, physician.

but on the other hand, it is more fragile and more exposed if one restricts contact with the stimuli which provoke defences.

More generally, one can say that through the very effect of medications — positive and therapeutic effects — there occurs a disturbance, even destruction, of the ecosystem, not only at the individual level, but also at the level of the human species itself. Bacterial and viral protection, which represent both a risk and a protection for the organism, with which it has functioned until then, undergoes a change as a result of the therapeutic intervention, thus becoming exposed to attacks against which the organism had previously been protected.

Nobody knows where the genetic manipulation of the genetic potential of living cells in bacteria or in viruses will lead. It has become technically possible to develop agents that attack the human body against which there are no means of defence. One could forge an absolute biological weapon against man and the human species without the means of defence against this absolute weapon being developed at the same time. This has led American laboratories to call for the prohibition of some genetic manipulations that are at present technically possible.

We thus enter a new dimension of what we might call medical risk. Medical risk, that is the inextricable link between the positive and negative effects of medicine, is not new: it dates from the moment when the positive effects of medicine were accompanied by various negative and harmful consequences. With regards to this there are numerous examples that signpost the history of modern medicine dating from the eighteenth century. In that century, for the first time, medicine acquired sufficient power to allow certain patients to become healthy enough to leave a hospital. Until the middle of the eighteenth century people generally did not survive a stay in a hospital. People entered this institution to die. The medical technique of the eighteenth century did not allow the hospitalised individual to leave the institution alive. The hospital was a cloister where one went to breathe one's last; it was a true 'mortuary'.

Another example of a significant medical advance accompanied by a great increase in mortality was the discovery of anaesthetics and the technique of general anaesthesia in the years from 1844 to 1847. As soon as a person could be put to sleep surgical operations could be performed, and the surgeons of the time devoted themselves to this work with great enthusiasm. But at the time they did not have access to sterilised instruments. Sterile surgical technique was not introduced into medical practice until 1870. After the Franco-Prussian war and the relative success of German doctors, it became a current practice in many countries.

As soon as individuals could be anaesthetised, the pain barrier — the natural protection of the organism — disappeared and one could proceed with any operation whatsoever. In the absence of sterile surgical technique, there was no doubt that every operation was not only risky, but led to almost certain death. For example, during the war of 1870, a famous French surgeon, Guérin, performed amputations on several wounded men, but only succeeded in saving one; the others died. This is a typical example of the way medicine has always functioned, on the basis of its own failures and the risks it has taken. There has been no major medical advance that has not paid the price in various negative consequences.

This characteristic phenomenon of the history of modern medicine has acquired a new dimension today in so far as that, until the most recent decades, medical risk concerned only the individual under care. At most, one could adversely affect the individual's direct descendants, that is, the power of a possible negative action limited itself to a family or its descendants. Nowadays, with the techniques at the disposal of medicine, the possibility for modifying the genetic cell structure not only affects the individual or his descendants but the entire human race. Every aspect of life now becomes the subject of medical intervention. We do no know yet whether man is capable of fabricating a living being which will make it possible to modify the entire history of life and the future of life.

A new dimension of medical possibilities arises that I shall call bio- history. The doctor and the biologist are no longer working at the level of the individual and his descendants, but are beginning to work at the level of life itself and its fundamental events. This is a very important element in bio-history.

It has been known since Darwin that life evolved, that the evolution of living species is determined, to a certain degree, by accidents which might be of a historical nature. Darwin knew, for example, that enclosure in England, a purely economic and legal practice, had modified the English fauna and flora. The general laws of life, therefore, were then linked to that historical occurrence. In our days something new is in the process of being discovered; the history of man and life are profoundly intertwined. The history of man does not simply continue life, nor is simply content to reproduce it, but to a certain extent renews it, and can exercise a certain number of fundamental effects on its processes. This is one of the great risks of

contemporary medicine and one of the reasons for the uneasiness communicated from doctors to patients, from technicians to the general population, with regards to the effects of medical action.

A series of phenomena, like the radical and bucolic rejection of medicine in favour of a non-technical reconciliation with nature, themes of millenarianism and the fear of an apocalyptic end of the species, represent the vague echo in public awareness of this technical uneasiness that biologists and doctors are beginning to feel with regards to the effects of their own practice and their own knowledge. Not knowing stops being dangerous when the danger feared is knowledge itself. Knowledge is dangerous, not only because of its immediate consequences for individuals or groups of individuals, but also at the level of history itself. This is one of the fundamental characteristics of the present crisis.

Undefined Medicalisation

The second characteristic is what I am going to call the phenomenon of undefined 'medicalisation'. It is often argued that in the twentieth century medicine began to function outside its traditional field as defined by the wishes of the patient, his pain, his symptoms, his malaise. This area defined medical treatment and circumscribed its field of activity, which was determined by a domain of objects called illnesses and which gave medical status to the patient's demands. It was thus that the domain specific to medicine was defined.

There is no doubt that if this is its specific domain, contemporary medicine has gone considerably beyond it for several reasons. In the first place, medicine responds to another theme which is not defined by the wishes of the patient, wishes which now exist only in limited cases. More frequently, medicine is imposed on the individual, ill or not, as an act of authority. One can cite several examples in this instance. Today, nobody is employed without a report from a doctor who has the authority to examine the individual. There is a systematic and compulsory policy of 'screening', of tracking down disease in the population, a process which does not answer any patient demand. In some countries, a person accused of having committed a crime, that is, an infringement considered as sufficiently serious to be judged by the courts, must submit to compulsory examination by a psychiatric expert. In France, it is compulsory for every individual coming under the purview of the legal system, even if it is a correctional court. These are examples of a type of a familiar medical intervention that does not derive from the patient's wishes.

In the second place, the objects that make up the area of medical treatment are not just restricted to diseases. I offer two examples. Since the beginning of the twentieth century, sexuality, sexual behaviour, sexual deviations or anomalies have been linked to medical treatment, without a doctor's saying, unless he is naive, that a sexual anomaly is a disease. The systematic treatment by medical therapists of homosexuals in Eastern European countries is characteristic of the 'medicalisation 'of something that is not a disease, either from the point of view of the person under treatment or the doctor.

More generally, it might be argued that health has been transformed into an object of medical treatment. Everything that ensures the health of the individual; whether it be the purification of water, housing conditions or urban life styles, is today a field for medical intervention that is no longer linked exclusively to diseases. Actually, the authoritarian intervention of medicine in an ever widening field of individual or collective existence is an absolutely characteristic fact. Today medicine is endowed with an authoritarian power with normalising functions that go beyond the existence of diseases and the wishes of the patient.

If the jurists of the seventeenth and eighteenth centuries are considered to have invented a social system that had to be governed by a system of codified laws, it might be argued that in the twentieth century doctors are in the process of inventing a society, not of law, but of the norm. What governs society are not legal codes but the perpetual distinction between normal and abnormal, a perpetual enterprise of restoring the system of normality. This is one of the characteristics of contemporary medicine, although it may easily be demonstrated that it is a question of an old phenomenon, linked to the medical 'take off'. Since the eighteenth century, medicine has continually involved itself in what is not its business, that is, in matters other than patients and diseases. It was precisely in this manner that epistemological obstacles were able to be removed at the end of the eighteenth century.

Until sometime between 1720 to 1750, the activities of doctors focused on the demands of patients and their diseases. Thus has it been since the Middle Ages, with arguably non-existent scientific and therapeutic results. Eighteenth century medicine freed itself from the scientific and therapeutic stagnation in which it had been mired beginning in the medieval period. From this moment on, medicine began to

consider fields other than ill people and became interested in aspects other than diseases, changing from being essentially clinical to being social.

The four major processes which characterise medicine in the eighteenth century, are as follows:

1. Appearance of a medical authority, which is not restricted to the authority of knowledge, or of the erudite person who knows how to refer to the right authors. Medical authority is a social authority that can make decisions concerning a town, a district, an institution, or a regulation. It is the manifestation of what the Germans called *Staatsmedizin*, medicine of the State.
2. Appearance of a medical field of intervention distinct from diseases: air, water, construction, terrains, sewerage, etc. In the eighteenth century all this became the object of medicine.
3. Introduction of an site of collective medicalisation: namely, the hospital. Before the eighteenth century, the hospital was not an institution of medicalisation, but of aid to the poor awaiting death.
4. Introduction of mechanisms of medical administration: recording of data, collection and comparison of statistics, etc.

With a base in the hospital and in all these social controls, medicine was able to gain momentum, and clinical medicine acquired totally new dimensions. To the extent that medicine became a social practice instead of an individual one, opportunities were opened up for anatomical pathology, for hospital medicine and the advances symbolised by the names of Bichat, Laënnec, Bayle, et al. As a consequence, medicine dedicated itself to areas other than diseases, areas not governed by the wishes of the sick person. This is an old phenomenon that forms one of the fundamental characteristics of modern medicine. But what more particularly characterises the present phase in this general tendency is that in recent decades, medicine in acting beyond its traditional boundaries of ill people and diseases is taking over other areas. If in the eighteenth century, medicine had in fact gone beyond its classic limits there were still things that remained outside medicine and did not seem to be 'medicalisable'. There were fields outside medicine and one could conceive of the existence of a bodily practice, a hygiene, a sexual morality etc., that was not controlled or codified by medicine. The French Revolution, for example, conceived of a series of projects concerning a morality of the body, a hygiene of the body, that were not in any way under the control of doctors. A kind of happy political order was imagined, in which the management of the human body, hygiene, diet and the control of sexuality corresponded to a collective and spontaneous consciousness. This ideal of a non-medical regulation of the body and of human conduct can be found throughout the nineteenth century in the work of Raspail for example.[4]

What is diabolical about the present situation is that whenever we want to refer to a realm outside medicine we find that it has already been medicalised. And when one wishes to object to medicine's deficiencies, its drawbacks and its harmful effects, this is done in the name of a more complete, more refined and widespread medical knowledge.

I should like to mention an example in this regard: Illich and his followers point out that therapeutic medicine, which responds to a symptomatology and blocks the apparent symptoms of diseases, is bad medicine. They propose in its stead a demedicalised art of health made up of hygiene, diet, lifestyle, work and housing conditions etc. But what is hygiene at present except a series of rules set in place and codified by biological and medical knowledge, when it is not medical authority itself that has elaborated it? Anti-medicine can only oppose medicine with facts or projects that have been already set up by a certain type of medicine.

I am going to cite another example taken from the field of psychiatry. It might be argued that the first form of antipsychiatry was psychoanalysis. At the end of the nineteenth psychoanalysis was aimed at the demedicalisation of various phenomena that the major psychiatric symptomatology of that same century had classified as illnesses. This antipsychiatry is a psychoanalysis, not only of hysteria and neurosis, which Freud tried to take away from psychiatrists, but also of the daily conduct which now forms the object of psychoanalytic activity. Even if psychoanalysis is now opposed by antipsychiatry and antipsychoanalysis, it is still a matter of a type of activity and discourse based on a medical perspective and knowledge. One cannot get away from medicalisation, and every effort towards this end ends up referring to medical knowledge.

Finally, I would like to take an example from the field of criminality and criminal psychiatry. The question posed by the penal codes of the nineteenth century consisted in determining whether an individual

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[4] François Vincent Raspail, *Histoire naturelle de la santé et de la maladie, suivie du formulaire pour une nouvelle méthode de traitement hygiénique et curatif*, Paris: A. Levavasseur, 2 Volumes, 1843.

was mentally ill or delinquent. According to the French Code of 1810, one could not be both delinquent and insane. If you were mad, you were not delinquent, and the act committed was a symptom, not a crime, and as a result you could not be sentenced.

Today an individual considered as delinquent has to submit to examination as though he were mad before being sentenced. In a certain way, at the end of the day, he is always condemned as insane. In France at least, a psychiatric expert is not summoned to give an opinion as to whether the individual was responsible for the crime. The examination is limited to finding out whether the individual is dangerous or not.

What does this concept of dangerous mean? One of two things: either the psychiatrist responds that the person under treatment is not dangerous, that is, that he is not ill and is not manifesting any pathology, and that since he is not dangerous there is no reason to sentence him. (His non-pathologisation allows sentence not to be passed). Or else the doctor says that the subject is dangerous because he had a frustrated childhood, because his superego is weak, because he has no notion of reality, that he has a paranoid constitution, etc. In this case the individual has been 'pathologised 'and may be imprisoned, but he will be imprisoned because he has been identified as ill. So then, the old dichotomy in the Civil Code, which defined the subject as being either delinquent or mad, is eliminated. As a result there remain two possibilities, being slightly sick and really delinquent, or being somewhat delinquent but really sick. The delinquent is unable to escape his pathology. Recently in France, an ex-inmate wrote a book to make people understand that he stole not because his mother weaned him too soon or because his superego was weak or that he suffered from paranoia, but because he was born to steal and be a thief.[5]

Pathology has become a general form of social regulation. There is no longer anything outside medicine. Fichte spoke of the 'closed commercial State 'to describe the situation of Prussia in 1810.[6] One might argue in relation to modern society that we live in the 'open medical States 'in which medicalisation is without limits. Certain popular resistances to medicalisation are due precisely to this perpetual and constant predomination.

The Political Economy of Medicine

Finally I should like to speak of another characteristic of modern medicine, namely, what might be called the political economy of medicine. Here again, it is not a question of a recent phenomenon, since beginning in the eighteenth century medicine and health have been presented as an economic problem. Medicine developed at the end of the eighteenth century in response to economic conditions. One must not forget that the first major epidemic studied in France in the eighteenth century and which led to a national data gathering was not really an epidemic but an epizootic. It was the catastrophic loss of life of herds of cattle in the south of France that contributed to the origin of the Royal Society of Medicine. The Academy of Medicine in France was born from an epizootic, not from an epidemic, which demonstrates that economic problems were what motivated the beginning of the organisation of this medicine.

It might also be argued that the great neurology of Duchenne de Boulogne, Charcot, et al., was born in the wake of the railroad accidents and work accidents that occurred around 1860, at the same time that the problems of insurance, work incapacity and the civil responsibility of employers and transporters, etc. were being posed. The economic question is certainly present in the history of medicine.

But what turns out to be peculiar to the present situation is that medicine is linked to major economic problems in a different way from the traditional links. Previously, medicine was expected to provide society with strong individuals who were capable of working, of ensuring the constancy, improvement and reproduction of the work force. Medicine was called on as an instrument for the maintenance and reproduction of the work force essential to the functioning of modern society.

At present, medicine connects with the economy by another route. Not simply in so far as it is capable of reproducing the work force, but also in that it can directly produce wealth in that health is a need for some and a luxury for others. Health becomes a consumer object, which can be produced by pharmaceutical

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[5] Foucault is probably referring to Serge Livrozet, *De la prison à la révolte*. Paris: Mercure de France, 1973. Foucault's preface to this book also appears in *Dits et écrits*. Paris: Gallimard, 1994, vol II, pp. 394-416.

[6] Johann Gottlieb Fichte, *Der geschlossne Handelsstaat*, Tübingen: Coota, 1800. There is no complete translation into English, but for selections, see Hans Reiss (ed.), *The Political Thought of the German Romantics, 1793-1815*, Oxford: Basil Blackwell, 1955, pp. 86-102.

laboratories, doctors, etc., and consumed by both potential and actual patients. As such, it has acquired economic and market value.

Thus the human body has been brought twice over into the market: first by people selling their capacity to work, and second, through the intermediary of health. Consequently, the human body once again enters an economic market as soon as it is susceptible to diseases and health, to well being or to malaise, to joy or to pain, and to the extent that it is the object of sensations, desires, etc. As soon as the human body enters the market, through health consumption, various phenomena appear which lead to dysfunctions in the contemporary system of health and medicine.

Contrary to what one might expect, the introduction of the human body and of health into the system of consumption and the market did not correlatively and proportionally raise the standard of health. The introduction of health into an economic system that could be calculated and measured showed that the standard of health did not have the same social effects as the standard of living. The standard of living is defined by the consumer index. If the growth of consumption leads to an increase in the standard of living, in contrast, the growth of medical consumption does not proportionally improve the level of health. Health economists have made various studies demonstrating this. For example, Charles Levinson, in a 1964 study of the production of health, showed that an increase of 1% in the consumption of medical services led to a decrease in the level of mortality by 0.1%. This deviation might be considered as normal but only occurs as a purely fictitious model. When medical consumption is placed in a real setting, it can be observed that environmental variables, in particular food consumption, education and family income, are factors that have more influence than medical consumption on the rate of mortality. Thus, an increased income may exercise a negative effect on mortality that is twice as effective as the consumption of medication. That is, if incomes increase only in the same proportion as the consumption of medical services, the benefits of the increase in medical consumption will be cancelled out by the small increase in income. Likewise, education is two and one-half times more important for the standard of living than medical consumption. It follows that, in order to live longer, a higher level of education is preferable to the consumption of medicine.

If medical consumption is placed in the context of other variables that have an effect on the rate of mortality, it will be observed that this factor is the weakest of all. Statistics in 1970 indicate that, despite a constant increase in medical consumption, the rate of mortality, which is one of the most important indicators of health, did not decrease, and remains greater for men than for women. Consequently, the level of medical consumption and the level of health have no direct relation, which reveals the economic paradox of an increase in consumption that is not accompanied by any positive effect on health, morbidity and mortality.

Another paradox of the introduction of health into the political economy is that the social changes that were expected to occur via the systems of social security did not occur as expected. In reality, the inequality of consumption of medical services remains just as significant as before. The rich continue to make use of medical services more than the poor. This is the case today in France. The result is that the weakest consumers, who are also the poorest, fund the over consumption of the rich. In addition, scientific research and the great proportion of the most valuable and expensive hospital equipment are financed by social security payments, whereas the private sectors are the most profitable because they use relatively less complicated technical equipment. What in France is called the hospital hotel business, that is, a brief hospitalisation for minor procedures, such as a minor operation, is supported in this way by the collective and social financing of diseases.

Thus, we can see that the equalisation of medical consumption that was expected from social security was watered down in favour of a system that tends more and more to reinforce the major inequalities in relation to illness and death that characterised nineteenth century society. Today, the right to equal health for all is caught in a mechanism which transforms it into an inequality.

Doctors are confronted with the following problem: who profits from the social financing of medicine, the profits derived from health? Apparently doctors, but this is not in fact the case. The remuneration that doctors receive, however elevated it might be in certain countries, represents only a minor proportion of the economic benefits derived from illness and health. Those who make the biggest profits from health are the major pharmaceutical companies. In fact, the pharmaceutical industry is supported by the collective financing of health and illness through social security payments from funds paid by people required to insure their health. If health consumers — that is, those who are covered by social security — are not yet fully aware of this situation, doctors are perfectly well aware of it. These professionals are more and

more aware that they are being turned into almost mechanised intermediaries between the pharmaceutical industry and client demand, that is, into simple distributors of medicine and medication.

We are living a situation in which certain phenomena have led to a crisis. These phenomena have not fundamentally changed since the eighteenth century, a period that marked the appearance of a political economy of health with processes of generalised medicalisation and mechanisms of bio-history. The current so-called crisis in medicine is only a series of exacerbated supplementary phenomena that modify some aspects of the tendency, but did not create it.

The present situation must not be considered in terms of medicine or antimedicine, or whether or not medicine should be paid for, or whether we should return to a type of natural hygiene or paramedical bucolicism. These alternatives do not make sense. On the other hand what does make sense — and it is in this context that certain historical studies may turn out to be useful — is to try to understand the health and medical 'take off 'in Western societies since the eighteenth century. It is important to know which model was used and how it can be changed. Finally, societies that were not exposed to this model of medical development must be examined. These societies, because of their colonial or semi-colonial status, had only a remote or secondary relation to those medical structures and are now asking for medicalisation. They have a right to do so because infectious diseases affect millions of people, and it would not be valid to use an argument, in the name of an antimedical bucolicism, that if these countries do not suffer from these infections they will later experience degenerative illnesses as in Europe. It must be determined whether the eighteenth- and nineteenth-century European model of medical development should be reproduced as is, or modified and to what extent it can be effectively applied to these societies without the negative consequences we already know.

Therefore, I believe that an examination of the history of medicine has a certain utility. It is a matter of acquiring a better knowledge, not so much of the present crisis in medicine, which is a false concept, but of the model for the historical development of medicine since the eighteenth century with a view to seeing how it is possible to change it.

This is the same problem that prompted modern economists to engage in the study of the European economic 'take off 'in the seventeenth and eighteenth centuries with a view to seeing how this model of development could be adapted to non-industrialised societies. One needs to adopt the same modesty and pride as the economists in order to argue that medicine should not be rejected or adopted as such; that medicine forms part of an historical system. It is not a pure science, but is part of an economic system and of a system of power. It is necessary to determine what the links are between medicine, economics, power and society in order to see to what extent the model might be rectified or applied.