

MEDICAL PRACTICES IN CONTEMPORARY SOCIETY

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Abstrak

Fenomena banyaknya kasus pasien miskin yang ditolak mendapat perawatan oleh beberapa rumah sakit merupakan refleksi dari situasi konflik yang dihadapi sistem sosial penyedia perawatan seperti rumah sakit. Rumah sakit berada dalam situasi dilematis untuk berorientasi pada keuntungan atau tetap berpijak sebagai lembaga sosial yang tidak mencari keuntungan. Desakan kapitalisme begitu kuat mempengaruhi sistem sosial penyediaan perawatan terhadap kebutuhan dasar manusia ini. Di lain pihak, terjadi kecenderungan makin menguatnya kesadaran masyarakat akan hak-hak untuk hidup secara sehat. Berbagai tantangan di lakukan masyarakat untuk menanggulangi watak penyedia perawatan yang cenderung semakin mahal dan komersial. Analisis sosiologis terhadap masalah ini menjadi penting untuk dilakukan guna mengetahui cara-cara membangun kembali rasa percaya masyarakat terhadap sistem sosial penyedia perawatan ini (*health care systems*) yang pada gilirannya dapat membangun kembali rasa percaya terhadap negara yang memang berkewajiban menyediakan sistem sosial tersebut. Artikel ini merupakan hasil penelitian kepustakaan, observasi di tempat-tempat perawatan baik modern maupun tradisional dan wawancara mendalam dengan sejumlah dokter, praktisi tradisional perawatan kesehatan, pasien dari berbagai kelas dan manajemen penyedia perawatan.

Introduction

There have been considerable changes in the concept of knowledge in today's modern societies. These changes include not only the evolution of the abstract aspect of knowledge but also its application. Parallel to these changes, there has also been a growth in our consciousness towards individual experiences within the process of social development. One example of the

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phenomena is in medical practices; where the domination of medical knowledge by the medical profession has been questioned and challenged by people outside the discipline. Among the questions arising in recent decades include: (1) ethical and financial aspects of using modern technological instruments which involve considerable amounts of money; (2) doctor-patient relationships; (3) the power of medical practitioners; and (4) the forms of treatment and the hospital systems (Krause, 1983; Navaro, 1981). One consequence of these challenges is a world-wide emergence of community health services, which have an alternative emphasis on disease prevention and the promotion of healthy living conditions. Nevertheless, the role of the modern medical system in health delivery is still dominant. This domination of the medical system can be seen in practice by the influence of such motives as the intention to gain profit, which can be observed from the emergence and predominant private hospitals and private clinics. Consequently, health services have become expensive. In essence, the commercial features of the health system are in conflict with the social nature of health services that aims to help people in maintaining healthy life.

This article will examine two conflicting aspects of medical practice, namely the emergence of commercial practice in the medical system, and the growth of social and traditional medical practice. In order to understand the phenomena, two sociological themes will be used. Firstly, the predominant tendencies of capitalism that will be analysed by Marxian theory particularly the concept of commodity. Secondly, the enhanced importance of individual experiences which will be approached by Giddens' theory on the role of abstract systems in individual experience. In order to achieve the objectives, this article will begin with a description about the conditions of the medical practices in contemporary society. These include the shift from curative practice, to both curative and preventive practices, the factors that have stimulated this change and the commercial aspects of the medical system. Observation and depth interviews with some doctors, traditional healers, management of health care system and patients from different social classes have been conducted to provide some empirical evidence.

Conditions of Medical Practices

The traditional view of health care is that hospitals are the primary place for the diagnosis and treatment of the sick. However, this view has faced a remarkable change, in both developed and developing countries. This is not only because of the increasing demand from the community for changes in medical services and equity in health status; but also as a response to change the system of medical practices. The explanations behind the changes are

firstly, there has been shift from curative health service practices to those that provide both curative and preventive ones. Secondly, there has been a dualistic conflict in the operation of the medical system between the social-oriented and the profit-oriented systems, each of which has been developing even in such a 'peripheral country' like Indonesia.

For the first issue, it is necessary to understand the development of preventive services, which later known as community health service. This community health sector's primary concern is not only with the needs of the individual but also with those of the community by providing services focusing on education/training and disease prevention. At educational level, for instance, activities including information campaign is aimed at voluntary life-style changes; physical and mental health programs such as assertiveness training; and providing information about the advantages and disadvantages of a particular medical treatment or medical examination (Baum and Cooke, 1986:26; Hart, 1989:417). In terms of preventive activities, the aim is to prevent health problems before they occur; to pick up health problems at earlier stage; and to mediate health problems in order to retard the progress of the existing disease. These three levels of prevention have been labelled as primary, secondary and tertiary prevention (HIC, 1985:5). The community health sector also implements curative programs such as early diagnosis of disease, the management of health, illness and rehabilitation.

In developed countries, community health service practitioners work in multi-disciplinary professionals teams that include medical practitioners, physiotherapists, occupational therapists, speech pathologists and social workers. In this system, there is a requirement of each professional to have some knowledge of other disciplines. For example, there is a requirement for the doctor, to acknowledge and understand non-medical issues such as interpersonal relationships, patients living conditions and their work environment in order to help them in a significant way (Anderson, 1979:101-103).

In the Australian case, the growing interest in community health services has existed since 1960, during which time people in the community were making demands on a health system. Responding to this pressure, the Royal Arbert Hospital, for example, developed the Global Community Care Centre in 1969, which as a consequence also expanding the hospital health care services. This centre provides services in occupational therapy, social work, community nursing, mental health, dieted and speech therapy (Harper and Money, 1977:13-15). Almost at the same time, similar phenomena took place in Indonesia, in which the community established a non-government organisation, namely Perkumpulan Keluarga Berencana Indonesia (PKBI) in 1957. The bases for establishing this organisation were twofold. Firstly, there was a need

of reducing a family size by using birth control techniques; and secondly, there was recognition of the benefits of providing preventive health programs. This was based on evidence that these two factors, large family size--that was common in the Indonesian community in that time--and health status were interrelated.

Viewing these issues, however, it is obvious that support for community health services has come not only from the community, but also from the medical profession. It is therefore necessary to understand the reason for these demands. One of the reasons can be traced back to the beginning era of medical knowledge, where medical care was primarily directed toward people who are sick or ill. This was related to the nature of medical knowledge that was based on a theoretical understanding (germ theory) that the cause of illness derives from micro-organisms such as bacteria and viruses (Navaro, 1976:541). Consequently, the treatment was directed to the eradication of the disease causes from the patient's body. However, recognising that not all illness was germ-related, medical research increasingly put this uni-causal theory of illness into question, which then replaced by multi-causal theory. This multi-causal theory advocated the notion that a particular disease can have several causes, including the relationship between health and a person's socio-economic status as well as his/her living conditions. This theory has led to changes in the treatment and services offered to patients (Paine and Tjam, 1988:13).

An important factor in this process was the increasing influence of the World Health Organization (WHO). Set up after Second World War, WHO is now one of the main proponents in changing health services in the world. WHO has defined health as 'a state of complete physical mental and social well-being and not merely the absence of disease or infirmity' (cited from Health Issue Centre (HIC), 1988:3). This definition reflects the view that health service is not only a matter of providing treatment to sick persons, but it is also important to prevent illness by maintaining physical and mental health. The establishment of WHO and its more communitarian concern about health presented a challenge for governments to provide appropriate systems for the delivery of medical services. The response to this challenge has varied. The Australian government, for example, started to promote this message seriously in 1973 by introducing the Community Health Program throughout the nation (Anderson, 1979:99). In 1980s, two major conferences were held in Melbourne focusing on community health status; (1) the National Women's Health Conference in 1986; and (2) the Australian Community Health Association in 1988. These two conferences were aimed to address several issues that have arisen in previous community health system (CHS, 1989:1). Since community health services became part of the government agenda, most funding were acquired from the government, especially for service provided by public hospitals and the community health centres.

Meanwhile, the Indonesian government included health issues in its first five year development or the so-called PELITA I. Rapid population growth was still a major problem for Indonesia and seen as a constraint for various aspects of development, therefore, the community health programs were combined with family planning programs, for which In 1970, the government established the National Family Planning Co-ordinating Board (BKKBN) to organise such programs.

Another reason for the implementation of community health policy can be seen as the reaction towards the high cost of medical services. The use of modern technology has been one of the reasons for this high cost, as recognised by one member of WHO expert committee:

“Over the past twenty years there has been increasing dissatisfaction about the relevance and effectiveness of national health systems in the developing as well as in industrialized countries. This highly sophisticated and very costly medical technologies usually concentrated in hospital have been seriously questioned in the light of their social relevance and effectiveness of the health of people.” (Paine and Tjam, 1988:17).

It is apparent that the governments’ attitude in establishing community health care has been influenced by the increasing costs to operate modern public hospitals. To a large extent, this is due to their dependence on expensive modern technology. For private sectors, however, funding issues are primarily offset by their ability to make profit from health service delivery. However, an important question for the private sectors is the extent to which they can achieve equity of service delivery, because there is a common principle that health is a basic human entitlement to which all should have equal rights and access (Paine and Tjam, 1988:12). In effect, the private health system works on the premise that those who cannot bring profit, can not have the services. While some people understand and accept this ‘politics of health’ by arguing that a high standard of living is relevant to high standard of health care, others argue that these practices are merely ‘predatory’ practices (McKinly, 1977:461).

In Australia, the demands for community health care have also been made by physically and mentally handicapped persons who challenged institutional health services on the basis that they were not being provided with appropriate health services which would enable them to participate in community life. Therefore, there were two main reasons for the Australian government in establishing community health policy. Firstly, to respond to community demands; and secondly to reduce the cost for funding the modern hospital (Bates and Linderpelz , 1987:97).

Two Sociological Themes: Medical Practices and Medical Sociology

In discussing the changes in health care delivery, it is observed that there have been some changes in the body of medical knowledge in responding to the needs of the community, as well as individual demands for access to medical services. To understand the social dynamic and the interrelated factors which influence changes in medical practices, there is a need to use the sociological theories which are relevant to the two sociological themes mentioned above.

Contemporary medical sociology (also referred as sociology of health and illness), 'a sub-discipline' of sociology, has greatly been influenced by the perspective of Neo-Marxism and the political economy. These perspectives, view health a commodity, like other commodities in the market place (Turner, 1987:172). Attempts have been made in medical sociology to understand the condition or the trends of the development of medical systems and service delivery.

Before examining changes in the medical system, it is necessary to look at the basic idea of capitalism. The economic activities of capitalism are evident in many areas of the world. The rational capitalistic organisation, identified by the free labour market developed in Western societies, has subsequently influenced the economic systems of various countries all over the world. The main idea of capitalism is a concern with the pursuit of profit, which continues to be renewed rationally through capitalistic enterprises. Marx is the most influential theorist in this area and he provides the basis, where upon many current theorists have built their arguments.

Marx employed the term capitalism to a particular system of production. This system of production can be traced to Marx's description of the historical development of processes of production. Marx explains that in pre-capitalism era:

Labour is, in the first place, a process in which both man and Nature participate, in which man of his own accord starts, regulate, and controls the material re-actions between himself and Nature. He opposes himself to Nature as one of her own forces, setting in motion arms and legs, head and hands, the natural forces of his body, in order to appropriate Nature's productions in a form adapted to his own wants....The elementary factors of the labour-process are 1, the personal activity of man, i.e., work itself, 2, the subject of that work, and 3, its instruments (Marx, 1971:156-157).

At this stage, the basic means of production was controlled by the labourer through his work in transforming the subject of work from raw material and/or extract material to material goods by using the modes of production, the instruments directly used by the worker (Marx, 1971:159). In a later stage of development where the capitalist and advances in technology are integrally involved in the process of production, labour is no longer subordinated to the will of the labour, but rather the labourers' work becomes controlled by the owner of the capital. The development of this process is apparent in Marx's analysis about two characteristic of labour under capitalist systems:

Firstly, the labourer works under the control of the capitalist to whom is labour belongs: the capitalist taking good care that the work is done in a proper manner, and that the means of production are used with intelligence....Secondly, the product is the property of the capitalist and not that of the labourer (Marx, 1971:165).

However, even though the ownership of production has changed, the role of these factors of production (the labour, the subject of work and the instrument of work) are still crucial in the process of production, for which Marx argues, "the general character of the labour-process is evidently not changed by the fact, that the labourer works for the capitalist instead of for him" (Marx, 1971:164). It can therefore be argued that these three elements of production determine the existence of production, for which there is no production of goods without participation of the labour, the subject of work and the instrument of work.

Furthermore, the economic actions of the capitalist rest on the expectation of profit from the economic exchange of the material goods that have been produced, while the exchange value itself could be various depending on the time and place. The things that can be exchanged are things that have useful value or that could satisfy human wants and those are called commodities (Marx, 1971:1-3). The commodity value is determined by the function of the human organism (the labour power), the quantity of labour, and the social form of the labour, because according to Marx, people usually work for one another. This social character of labour has been the basis of the expansion of the concept of commodity, for which Marx asserts:

A commodity is therefore a mysterious thing, simply because in it the social character of men's labour appears to them as an objective character stamped upon the product of the labour; because the relation of the producers to the sum total of their own labour is presented to them as a social relation, existing not

between themselves, but between the products of their labour (Marx, 1977:77).

This is one of the reasons why Marx regards the products of the labour as commodities. The way of objectifying the product of human hands is called by Marx as 'fetishisms' (Marx, 1971:77). Therefore, fetishism of commodities has its origin in the social character of the labour that produced them. This nature of commodity seems to become the basis to consider various human products as commodities including services.

Accordingly, the economic value of commodities becomes evident in an economic market where producers exchange their products with one another. In this market, the exchange value of the commodities is determined by producers equating the values of human labour expended upon the products. As a consequence of the evolution of social life and scientific analysis of commodity process, the determination of magnitude of product value exchange was later established in monetary terms (Marx, 1971:78-80).

Today's capitalist system is an evolution of earlier capitalist system of the eighteenth and nineteenth century in England. As described by Marx, early capitalism was accepted as pure capitalism, where cash nexus dominated labour and capital, and in which private ownership controlled the basic means of production. The modes of exchange, the forms of commodities and the determination of their values are much more complicated. In modern capitalism there has been a growing separation between ownership and control of capital. One development has been the emergence of a special managerial class involved in organising and controlling capitalist production. Another difference between these capitalists' societies is in increasing influence of the state in regulating the system in order to protect civil rights and to guarantee the capitalists general rates of profit (Turner, 1989:176-178).

In relation to medical system, it is obvious that this system is intertwined in the capitalist mode of production. This is highlighted by the existence of private hospitals and other private clinics in delivering health to people that operate and exist on the basis of profit-making motives. However, medical system itself has a specific nature. Medical practices are not involved in the production of material goods that can be exchanged. Instead, people work by using their knowledge and skill to deliver health services for other people. In this respect, the interrelationship between scientific knowledge and capitalist system needs to be examined, a theme which is evident in the work of Max Weber.

Weber's incorporation of knowledge into a capitalist system draws on and extends Marx's notion of commodification. Marx's theory of commodity

fetishism implied that only the practical aspects of scientific knowledge can be exchanged. However, the nature of knowledge is that it does not produce material commodity, as in Marx's theory regarding the process of production. From this perspective, therefore, professional knowledge could not be regarded as productive amenable to capitalist appropriation. Weber argues that modern capitalism has been strongly influenced by the development of technical possibilities. These technical possibilities are themselves dependent to the development of modern sciences such as mathematics and natural sciences. In addition, the development of these sciences has also been stimulated by the demand of capitalism and the needs of capitalist interests. Weber endorses the domination of economic consideration in the technical utilization of scientific knowledge because he saw it as being the best way to improve people's living conditions (Weber, 1965:24). The economic value of knowledge was also stated by Weber in his speech 'Science as a Vocation', then published in 1948, in which he compared the attitudes of German academic society which considered someone's academic knowledge in terms of its value as an academic activity with American society that compensated one's academic activities with money.

However, medical services should not be regarded as being the same as other commodities that can be exchanged in economic markets. The medical system delivers services related to basic needs of human being. If those people could not have appropriate health care, they could not, in effect, maintain their life. Therefore, human values or ethics need to be taken into consideration as a factor that influences service delivery.

Conflicting Situation of Medical Practices, How do Sociologists Analyse?

The conflict between the notion of health as a commodity, and health as a basic human right has resulted in the development of a dual health system in recent decades: (1) the traditional curative based hospital system involved in the capitalist system; and (2) the growing tendency for delivering community (preventive) health care, which by its very nature is related to the social aspect of medical system. This conflict has not been examined by such classical theorists as Marx and Weber. However, Marx and Engels have considered health status of labourers in terms of its relation to the capitalist production. They pointed out that the living conditions of labourers and their family may influence them which in turn may affect the amount of production (cited in Gerhardt, 1989:xiii). This view, indeed, is apparent in Engels' description of the higher incidence of sickness in working class communities in the nineteenth

century England by referring to their living conditions in terms of poor housing and bad quality of food consumption:

That the dwellings of the workers in the worst portion of the cities, together with the other conditions of life of this class, engender numerous disease, is attested in all sides....Typhus, that universally diffused affliction, is attributed by the official report on the sanitary conditions directly to the bad state of the dwellings in the matters of ventilation, drainage, and cleanliness...another category of diseases arises directly from the food rather than the dwelling of the workers. The food of the labourer, indigestible enough in itself, is utterly unfit for young children, and he has neither means nor time to get his children more suitable food (cited in Gerhardt, 1989:xiv)

Even though Marx and Engels do not consider health in terms of individual needs, they have established the importance of good living conditions to people's health status, thereby identifying one of the bases for development of community health care.

The dualism of medical systems, between the nature of capitalism and the non-business character, and the social nature, of medical professions has been examined by Parsons (1951), and Navaro (1983). Parsons examined this dualism from a functionalist approach. In contrast to Weber who tolerated the ethical consideration, Parsons places great emphasis on this ethical aspect for the function of medical system by stressing the idea that health represents one basis condition for participation in an equal opportunity society, because it influences people's readiness to survive in a capitalist competitive society (Parsons, 1951:434-436). Consequently, Parsons argues:

With regard to the pattern variable, self vs collectivity-orientation, the physician's role clearly belong to what, in our occupational systems, is the 'minority' group, strongly insisting on collectivity-orientation. The 'ideology' of the profession lays great emphasis on the obligation of the physician to put the 'welfare' of the patient' above his personal interests, regards 'commercialism' as the most serious and insidious evil with which it has to content. The line, therefore, is drawn primarily vis-à-vis 'business'. The 'profit motive' is supposed to be drastically excluded from the medical world (Parsons, 1951:435).

Nevertheless, Parsons acknowledges that medical practices are subjected to the capitalist system, particularly since the emergence of expensive modern medical technology which has encouraged medical practices to take place in

the context of an organisation. The reason is that the cost for technical facilities is beyond the reach of individual practitioners (Parson, 1951:436).

Meanwhile, Navaro's argument about dualism in medical system is more complicated than Parson's. Navaro bases his argument on the capitalist social relations of production, whereby through the social division of labour, the medical profession occupies a dual function position:

One, necessary under any mode of production, is to contribute to the care and cure of the (historically and socially determined) health and disease of the collectivity. The other is the control function over the working class and popular masses (Navaro, 1983:185).

These two functions do not work separately. Rather, the existence of the control function is dependent to the existence of the delivery or service functions. This dual function of medical profession is not dependent on the will of the individual; rather it is an outcome of the position of the medical professionals within social division of labour. Furthermore, Navaro argues that:

In this dual function, the global function of capital (or the bourgeois control function) is the one that shapes the needed function..., it must reproduce the dominant/dominated relationship (which exists at the level of production) at the political and ideological levels as well. In this respect, medicine is capitalist because, as a consequence of its position within the social division of labour, it reproduced the dominant/dominated class relations in which the capitalist class is dominant. In other words, it is the position the medical profession occupies within the social structure that makes medicine capitalist or bourgeois (Navaro, 1983:186).

In this respect, it is not medical professionals who dominated medical enterprise, but the bourgeoisie. Navaro rather regards the medical profession as 'the administrator of medicine'. From this view, it is apparent that the social aspects of medical practices, to contribute care and cure to the people, have been manipulated by the capitalist (the bourgeoisie) in order to satisfy capitalist demands.

However, unlike in the economic system, the practice of capitalism in the medical system has its limitation. This limitation mainly emerges from the nature of the medical system itself. As stated before that the medical system delivery services are required to satisfy basic needs of human beings. Thus, as

the development of the medical system incorporates stronger capitalist practices, contradiction will emerge, stimulating considerable challenges from the community.

The development of community health care has been one means of addressing these challenges. The ethics of the medical profession itself also provides certain limitations on medical professionals that can result in professional sanctions if there is a failure to follow the rule of the ethics. Another challenge comes from government policy that has posited the dominant influence not only in medical system but also in other social systems. Even though some analysts, such as McKinley, have argued that some groups have influenced government policy for their own interests, there have been innovations such as Medicare policies, community health care establishments and the deregulation of prescribed medicine that have brought advantages to the general population.

So far, this article has examined the influence of the capitalist system in medical practice. However, people's reaction towards the medical system cannot be analysed fully from this capitalist perspective. To understand the mechanisms and interrelated aspects which influence this reaction, there is a need of using Giddens' theory of the abstract systems and people's attitudes towards the systems.

Giddens recognises today's world as the world 'beyond modernity' in which systematic knowledge about social organisation can not be achieved, for the reasons that the events in contemporary societies can not be fully comprehended, and in considerable part, are out of human's control (Giddens, 1990:2). This view can be seen as a criticism to the evolutionary perspective that regards human history as a continuing process. Giddens, however, proposes the 'discontinuist' interpretation of modern social development by arguing that 'modern social institutions are in some respects a unique-distinct form of all types of traditional orders'. Therefore, it is necessary to have a preliminary understanding of modernity and its consequences for people in present world. The discontinuity of modernity can be identified by the 'dramatic and comprehensive' changes which are significant not only for their pace, but also in their range and nature. The extent of these changes has been such considerable that people have had little opportunity, or ability, to recognise and interpret them (Giddens, 1990:3-6).

The involvement of the abstract systems in people's everyday life is a crucial aspect of Giddens' view about the impact of modernity. Giddens defines the abstract system as the systems which involve the symbolic tokens (such as money and media political legitimacy), and the experts systems. The

nature of the modern world, according to him, 'is bound up with the mechanism of trust in abstract systems' (1990:22-30).

The pragmatic form of those systems provides a great deal of security in people's daily life, in which no one can be completely free from the involvement of the abstract systems in modern institutions. For examples, someone can get cash from the bank without having to know how the economic system functions. Driving a car is another example. One does not have to understand the technical system of that car, only practical knowledge about driving and traffic rules are needed. In essence, the abstract systems provide the basis for a wide range of activities in which people are effective. In this respect, Giddens tries to show the domination of these systems through the creation and implementation of expert knowledge, which has resulted in a kind of dependency of people towards those systems. In other words, in developing a level of dependence, the expert systems have compelled members of society to accept and adapt to their creations. This has led to a situation where people have a sense of trust in the systems, without much knowledge about how such systems operate.

Furthermore, the representative of the abstract systems are also significant in Giddens theory, especially those who are in the position of direct encounter with people who use the systems, besides the modes of operations of the system itself. Giddens provides accounts of the crucial position of these professionals in terms of building and maintaining the level of trust among ordinary people towards the systems. For example, the relationship between doctors and patients will affect the 'trustworthiness' of the medical systems (Giddens, 1990:83-84).

However, the abstract systems themselves are not easily accessible, or observable by an outsider who is ignorant about the knowledge-base behind the system. In this respect, Giddens emphasises the essence of professionalism, which to some extent request the professionals to control the threshold between 'back stage' and 'front stage' performance in order to reduce the impact of 'imperfect skills and human's fallibility' (Giddens, 1990:86). Unlike McKinley (1977:460), who regards such professionals as medical practitioners, in a pessimistic view, Giddens examines the role of professionals in a broader social context, in which the professionals is not only important to the system, but also to the 'ignorant' people who can not opt out of their involvement in the abstract systems. In this sense, the professional can stimulate feelings of security in the 'ignorant' that is important for dealing with every day activities.

Nevertheless, the effectiveness of a professional's performance, as well as the modes of the systems have their limitations such as the impact of human

fallibility, which in turn, have some consequences. Giddens' account of these consequences implies that the problem is in the closeness of the abstract system to the lay people who can only encounter with the system in pragmatic ways.

The impact of the erosion of trust toward the systems varies from claims of incompetence, sometimes to be settled in the court, to a more serious impact such as the collapse of the system (Lewis and Weigert, 1985: 978-979). Giddens, however, examines the consequences of the lack of trust at an individual level. He asserts that people's reaction towards an untrustworthy system can result in cautious and sceptical attitudes towards the system and its representatives. The reflection of these attitudes could be varied from a kind of cynicism to more demonstrative actions such as disengagement with the system altogether (Giddens, 1990:91).

One interesting phenomenon which has been taking place in Indonesia since the mid 1980s, and which can be regarded as a demonstrative reaction towards the medical system, is the growth of traditional healers who apply spiritual medication and use of natural medicine to cure the sick. The costs of the service are not usually set by the healer, rather it depends on the patients willingness to pay for the service. There is a common belief that if a traditional healer sets up a standard of costs for the services, as modern medical practitioners do, then he/she is not a competent healer. Some traditional healers also provide accommodation for the patients who come from distant places. Interestingly, the patients are not only from lower socio-economics status, but also from middle and high socio-economic status, even medical practitioners who are usually ones that have failed to regain health from modern medicine techniques.

Back to Giddens theories, so far he has not examined how the interconnection between the abstract systems can also work in determining the trustworthiness of a particular system. For example, the deregulation of the economic market by the state can influence people's attitude towards a fragile economic systems, which in turn impact on the health system through budget outlays, affects on personal income, and the competitive features of the health system. Government obviously has a significant role in influencing or stimulating various changes in the body of social organisation. It has been claimed that the involvement of the state has brought some advantages and disadvantages towards both the social systems as well as the civil citizen (Offe, 1985:818). Under modern capitalism, the state has had an increasing role in regulating the capitalist system. It has been argued that governments' regulation can be seen as protecting the existing system. As suggested by a sociologist, there is 'a fusion between the political and the non-political sphere of social life, in which government is regarded as losing some of its authority in order to conform to non-political demands' (Offe, 1985:817). The

example of this non-political sphere that has become more apparent in recent decades is the new social movements. The demands of this new social movement have oriented to welfare and individual rights as the human's nature. Further, Offe states that:

Dominant issues of new social movements consist in the concern with a (physical) territory, space of action, or 'life-world', such as the body, health and sexual identity; the neighbourhood, city and the physical environment; the cultural, ethnic, national and linguistic heritage and identity; the physical conditions of life, and survival for humankind in general (Offe, 1985:829).

Several demands of the new social movements have been accommodated by the government. The establishment of community health care and women health centre; the regulation of the doctors to give the patient a low cost prescription medicine for certain level of illness in Indonesia (generic medicine), public provision of insurance schemes (such as ASKES and recently ASKESKIN) are important examples of government recognition of individual demands in enhanced health status. In other words, the interconnection between the abstract systems can work in determining the trustworthiness of a particular system.

Conclusions

This article has discussed the relevance of two sociological themes, the predominant of capitalism in current social systems, and the enhanced consciousness of individual experiences in social orders, in examining the changes in medical system. In understanding of today's medical system, it seems that one can not apply only a particular paradigm because the nature of today's societies where the systems involve is very complicated. Many interconnected aspects are involved in influencing the ways in which the medical system is changing.

In the context of the medical system, this article has examined the influence of capitalism that has certain limitations, mainly due to the nature of medical practice itself that delivers services for human's basic needs namely health. The evidence of this limitation can be observed from people's efforts to find other alternatives (alternative medication) to get access to appropriate health services. The increasing demand for traditional medication conducted by traditional healers in Indonesian society is empirical evidence of this social

phenomenon. The community healthcare sector is another consequence of these efforts.

Giddens' argument is also relevant to that social phenomenon, to the extent that there is a level of scepticism in people's attitude towards the medical system. This can be observed from the continuing questions raised over issues such as the high cost of medical service, the expensiveness of medicines, the unequal access to health services and the ways that medical professionals provide treatment to patients. Consequently, people try to find their own ways to overcome this problem by seeking information about healthy life-styles and disease prevention techniques, besides finding an alternative way to have appropriate services as mentioned before.

In relation to the role of the government, the case of government regulation and supervision on health care system as well as establishing community health care can be interpreted as a way to re-build people's trust in modern medical system. At the same time, it can be seen as the government duty to give the citizens, one of their basic rights, which has previously been manipulated by the influence of capitalism in the medical system. In this context, an issue of formulation and implementation of a health policy for enhanced standard of health services for all citizens (such as Undang-Undang Pelayanan Kesehatan) is one of major policy concerns confronting the Indonesian government.

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