and unceasing growth in healthcare budgets. They have had little or no success, and Britain's government now plans to raise taxes to pay for more health care. Labour, the party in power, will have calculated that the risk of trying to bottle up demand is greater than the—substantial—risk of raising taxes. But while increased resources will be widely welcomed, the cost of trying to defeat death, pain, and sickness is unlimited, and beyond a certain point every penny spent may make the problem worse, eroding still further the human capacity to cope with reality.

Ivan Illich did not want the wholesale dismantling of medicine. He favoured "sanitation, inoculation, and vector control, well-distributed health education, healthy architecture, and safe machinery, general competence in first aid, equally distributed access to dental and primary medical care, as well as judiciously selected complex services."[1] These should be embedded within "a truly modern culture that fostered self-care and autonomy." This is a package that many doctors would find acceptable, particularly if available to everybody everywhere.

Doctors and their organisations understandably argue for increased spending—because they are otherwise left paying a personal price, trying to cope with increasing demand with inadequate resources. Indeed this is one of the sources of worldwide unhappiness among doctors.[18–20] Although seen by many as the perpetrators of medicalisation, doctors may actually be some of its most prominent victims.[3] This is perhaps why *BMJ* readers wanted this theme issue.

Perhaps some doctors will now become the pioneers of de-medicalisation. They can hand back power to patients, encourage self care and autonomy, call for better worldwide distribution of simple effective health care, resist the categorisation of life's problem as medical, promote the de-professionalisation of primary care, and help decide which complex services should be available. This is no longer a radical agenda.

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Health: perception versus observation

Self reported morbidity has severe limitations and can be extremely misleading

Critical scrutiny of public health care and medical strategy depends, among other things, on how individual states of health and illness are assessed. One of the complications in evaluating health states arises from the fact that a person's own understanding of his or her health may not accord with the appraisal of medical experts. More generally, there is a conceptual contrast between "internal" views of health (based on the patient's own perceptions) and "external" views (based on the observations of doctors or pathologists). Although the two views can certainly be combined (a good practitioner would be interested in both), major tension often exists between evaluations based respectively on the two perspectives.

The external view has come under considerable criticism recently, particularly from anthropological perspectives, for taking a distanced and less sensitive view of illness and health.[1 2] It has also been argued that public health decisions are quite often inadequately responsive to the patient's own understanding of suffering and healing. This type of criticism sometimes has much cogency, but in assessing this debate the severe limitations of the internal perspective must also be considered. Self reported morbidity is, in fact, already widely used as a part of social statistics, and a scrutiny of these statistics brings out difficulties that can thoroughly mislead public policy on health care and medical strategy.

For sensory assessment, the priority of the internal view can hardly be disputed—for example, pain is quintessentially a matter of self perception. If you feel pain, you do have pain, and if you do not feel pain, then no external observer can sensibly reject the view that you do not have pain. But medical practice is not concerned only with the sensory dimension of ill health. One problem with relying on the patient's own view of matters that are not entirely sensory lies in the fact that the patient's internal assessment may be seriously limited by his or her social experience. To take an extreme case, a person brought up in a community with a great many diseases and few medical facilities may be inclined to take certain symptoms as "normal" when they are clinically preventable.

Consider the different states of India, which have very diverse medical conditions, mortality rates, educational achievements, and so on. The state of Kerala has

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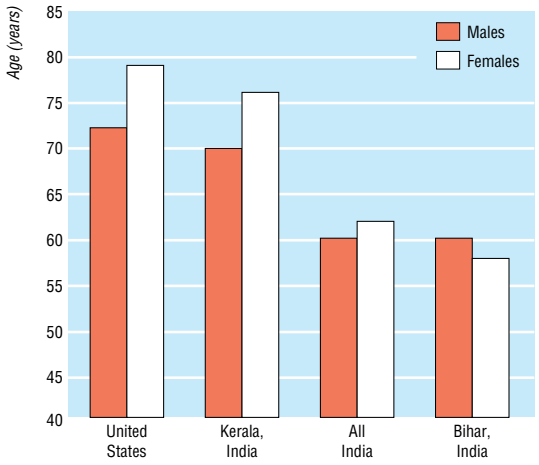

Fig 1 Life expectancy among males and females in India compared with United States, mid-1990s[7 8]

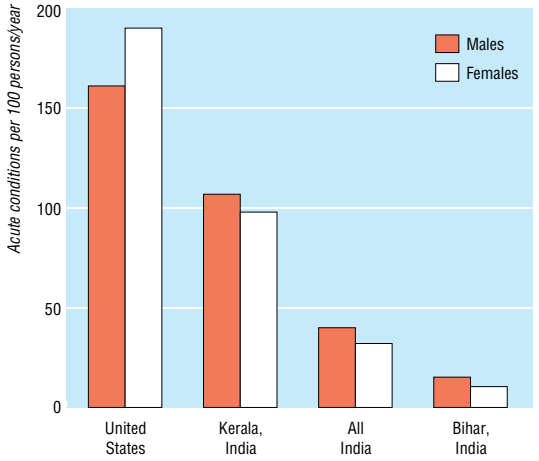

Fig 2 Incidence of reported morbidity in India, mid-1970s, compared with United States, mid-1980s[6 9]

the highest levels of literacy (nearly universal for the young) and longevity (a life expectancy of about 74 years) in India. But it also has, by a very wide margin, the highest rate of reported morbidity among all Indian states (this applies to age specific as well as total comparisons). At the other extreme, states with low longevity, with woeful medical and educational facilities, such as Bihar, have the lowest rates of reported morbidity in India. Indeed, the lowness of reported morbidity runs almost fully in the opposite direction to life expectancy, in interstate comparisons.[3–5]

We have to ask why such dissonance arises. There is much evidence that people in states that provide more education and better medical and health facilities are in a better position to diagnose and perceive their own particular illnesses than are the people in less advantaged states, where there is less awareness of treatable conditions (to be distinguished from "natural" states of being). The medically ill-served and substantially illiterate population of Bihar may have a very low perception of illness, but that is no indication that there is little illness to perceive. This interpretation is supported also by comparing the reported morbidity rates in the Indian states and in the United States. In disease by disease comparison, while Kerala has much higher reported morbidity rates than the rest of India, the United States has even higher rates for the same illnesses.[6] If we insist on relying on self reported morbidity as the measure, we would have to conclude that the United States is the least healthy in this comparison, followed by Kerala, with ill provided Bihar enjoying the highest level of health, in this charmed internal comparison.

Although the internal view is privileged with respect to some information (particularly that of a sensory nature), it can be deeply deficient in other ways. There is a strong need for scrutinising the statistics on self perception of illness in a social context by taking note of levels of education, availability of health facilities, and public information on illness and remedy.[3–5] The internal view of health deserves attention, but relying on it in assessing health care or in evaluating medical strategy can be extremely misleading.

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The medicalisation of old age

Should be encouraged

The *Oxford English Dictionary* describes medicalisation as pejorative, initially applied to the over-investigation and treatment of sexually active teenage girls. Since Ivan Illich's popularisation of the term, its use has spread to conditions such as pregnancy and childbirth, sexual orientation, mental illness, and the menopause. There is legitimate concern about the medicalisation of dying,[1] and because old people die, it is tempting to extend such concern to old age.

In the 1930s, Marjory Warren showed that old people in workhouse wards had treatable diseases and

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