

Art, Author, and Activism: *A Luxury Called Health as a Medical Memoir*

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Abstract

In contemporary times, healthcare has increasingly morphed into a business enterprise, which has been marked by commercialisation, corporatisation, and over-medicalisation. Alongside this transformation, the public health system also has inadequacies that severely affect the health of the nation. Both pique profound socio-ethical questions regarding the renunciation of medicine's foundational values, inequitable access to healthcare, resource scarcity, mounting healthcare expenses, and the increase in health crisis-driven poverty. Kavery Nambisan's medical memoir *A Luxury Called Health: A Doctor's Journey Through the Art, the Science and the Trickery of Medicine* (2021) is one such instance of questioning the agency of profit-driven healthcare and offers an unabashed representation of the country's public health system. Using theoretical frameworks such as Johan Galtung's "structural violence" concept and Arnold Relman's "medical-industrial complex" theory, this paper explores how Nambisan's work functions as a call for social justice amidst the profit-driven healthcare model. The paper is structured in three parts: (i) Why Write, which examines the author's use of literature to challenge the commercial forces shaping healthcare; (ii) Public Health and its Absence, which critiques the underfunding and failures of the healthcare system; and (iii) Health for Sale, which deconstructs the commodification of health as a product.

Keywords: Doctor-writer; Medical memoir; Medico-industrial complex; Public health; Structural violence.

Introduction

Healthcare has always been a charitable and service institution. The men of medicine of yesterday did not bother about the bills, contrasting to-

day's doctoring, where one "has to merchandise his service" to that of a "grocer" (Sigerist 674). Physicians-as-priests, monks, and shamans and hospitals as temples, ashrams, shelters, and dharamsalas have become things of the past. Moving forward, healthcare also attained a business model like the other quintessential needs of society – such as food, housing, and education. Medicine has better drugs and technology and offers higher life expectancy in the present. However, it comes with a cost: the cost. In exploring the "entangled, intimate, and respectable histories" between medicine-marxism, Horton (2017) quoted economist Rogoff (2005) caution: "The next great battle between socialism and capitalism will be waged over human health and life expectancy." Many such accounts from the opponents/supporters of healthcare as a business venture have skyrocketed globally.

These dialogues concern the pernicious effects of such commercialisation: anathema to core values and ethics, the threat to the patient-centric approach, practitioners as agents with pecuniary benefits, patients as an ongoing concern, and the question of overuse. Needless to say, the healthcare landscape in India, by and large, is facing challenges in various dimensions. Despite state-led initiatives, the country's public health appears inadequate. More than in any other country, the healthcare-led economic crisis in India – a mixed economy nation – is significant, leaving the rich over-medicalised, the middle class pauperised, and the poor simply abandoned (Anita 2009). In line with this assertion, Kavery Nambisan's medical memoir *A Luxury Called Health: A Doctor's Journey Through the Art, the Science and the Trickery of Medicine* (hereafter *Luxury*, 2021) – the selected text – commands attention for taking the "doctoring business" to task with its highs and lows.

Kavery Nambisan comes into the sparse tribe of Indian doctor-writers such as Gieve Patel, Kalpana Swaminathan, Ishrat Syed, Jahnvi Baura, and Hansda Sowvendra Shekhar, who holds pen alongside a scalpel. This Karnataka-based surgeon storyteller living between "two worlds" of medicine and literature is known for her truly Indian-flavoured and fully rich true-to-life characters. The selected text, her only non-fiction, *A Luxury Called Health: A Doctor's Journey Through the Art, the Science and the Trickery of Medicine* (2021), differs from the rest of Nambisan's oeuvre, for the book is at once personal and public. Nambisan's *Luxury* reads like a social history of medicine in India from antiquity to the current by censuring the commercialisation, privatisation, and corporatisation of medicine in the capitalist society. The "Prologue" glimpses the transition of the fifteen-year-old dressed in the blue and white pinafore to "an intern, surgeon, a

wife, a mother, a writer" (17).

The chapters that follow chronicle Nambisan's family history, early life, medical school days, internship episodes, going west, and doctoring reality. Of her journey being told, oft-closed ills of the profession being exposed, frustration being expressed, and her self-being examined, Nambisan's "Afterword" almost as a confession reads: "Your healer, your deliverer-from-suffering, your armed force, your pipe-cleaning angel and *safaii karmachari* is but one trying to do what needs doing. You have just seen the sincerity and the deception, the valour and the cowardice beneath the white coat" (Nambisan 304) and leaves the rest to the readers for their verdict. Per the reviewer, *Luxury* should not just be "read" but "discussed" (Ahanthem). Having said that, the article seeks to discuss the text in its social, economic, and medical context using the Marxist lens in general. Since India is becoming the capital of the world in lifestyle and non-communicable diseases, and the medical bills are inflating, this analysis tends to unpack the luxury called healthcare in the country through the white coat of Nambisan, which is fierce, irate, and disillusioned with the ills of the profession.

Why Write: Art, Author, and Activism

A columnist, Choudhury (2008), wrote an article on Kavery Nambisan, in which she contrasts her way of approaching rural subjects with Aravind Adiga's. While Adiga's is sharp and biting, she finds Nambisan's works filled with "quiet activism". Though the columnist termed "Quiet Activism" for Nambisan's dealing with rural life, the same could be used for her preoccupation with questioning social injustice through the mode of writing. As a surgeon and storyteller, Nambisan emerges as a singular countertrend, bothered by inequality, injustice, inaccessibility, and disparity persisting in a society where the vulnerable are further marginalised. Given these circumstances, her primary outlet is writing. Her social activism through writing is evident not only in *Luxury* but permeates throughout her entire oeuvre.

Nambisan's writing spree began with *The Truth (Almost) About Bharat* (1991), which records the exploitation of mess workers by the university administration, which the medical students oppose through petitions and protests. In her second novel, *Mango-Coloured Fish* (1998), she diverges from the central narrative to represent a dichotomy between the maidservants and their well-to-do employers. Her later work *On Wings of Butterflies* (2002) boldly dedicates "To chauvinists, male and female: you

keep out of this” and critiques patriarchy for hardening the life of women in all the ways possible; the novel depicts the formation of women-led liberation front WOW (Women or Women) with the magna carta charting: a child’s name should be after mother and father, equal rights over property, rehauling armed forces, and equal seats for men and women in state administration. Like *Luxury, The Hills of Angheri* (2005), semi-autobiographical narrative is about the medical profession, its ills, and the need for enhanced rural healthcare. The character Nalli, to that of the author Nambisan, probes the core values of medicine and its absence. In *The Hills of Angheri*, the protagonist, Nalli, critiques the bureaucracy, overuse of healthcare and lack of resources. The book reflects on a conversation with the character Nalli and a hospital chief:

I was rapidly falling out with the chief. He accused me of not being interested in the hospital. He had invested two crores in the CT scanner and had to recover the cost in a couple of years. How could he, if the doctors did not oblige and do more scans? All injuries to the head – even the most minor – must have a CT scan. It was the duty of the doctor to convince the patient, he said. (Nambisan 384)

Much like her preceding works, her subsequent novel, *The Story that Must Not Be Told* (2010), navigates the furnished life of apartment dwellers on one side and famished slum dwellers on the other, pondering how the haves can help have-nots. Thus, she questions social injustice for all the right reasons by writing sociologically sound and true-to-life fiction. The subsequent novel, *The Story that Must Not Be Told* (2010), also navigates the furnished life of apartment dwellers on the one side and famished slum dwellers on the other. However, in the select text, *Luxury* – her only non-fiction – Nambisan is more assertive in her voice and compromises truth for nothing, the truth that is stranger than fiction, for health, a service in the past is now a sales product, marketed, sold, and delivered, and the same is laid bare.

Harvard economist Kenneth Rogoff once asked about modern healthcare: “Who plays God - the bureaucrats, the doctors, or the forces of the market?”. Nambisan’s *Luxury*, in a similar fashion, provocatively questions who plays the role - the state, the system, or the society? In one of the interviews, Nambisan puts the same intention as follows:

Interviewer: What do you get as a reader when a writer of fiction, and also a surgeon who has worked closely in both the public as

well as private health sector, picks up her pen to write on the state of the health system in the country?

Nambisan: The answer is easy: you get a book that lays bare the fact that the health of the citizens of a nation is an investment, that the health system is a part of nation building and effective governance and that it is time to learn from mistakes that have been made and continue to be made. (Ahantham)

Why write *A Luxury Called Health*? Nambisan might also write for the same reasons that other doctors write, such as “therapy, exploration, sharing, atonement, sharing, joy, honour, atonement, and notoriety” (Miksaneek), yet in the various instances of her medical memoir, *Luxury* makes her intention: Self-examination (Nambisan 1). As a medical memoir at a personal level, the author-self undertakes “self-examination” of the life and time of the surgeon-self; in a larger picture, *Luxury* transcends the personal narrative and concerns with the public where the author-surgeon-self extends the “self-examination” to the nation’s doctoring profession.

In her “Introduction” to *Luxury*, Nambisan piqued herself by explaining why she was writing this book. She further advances her venture by adding how writing, which is like “performance on display”, is a “risky business”, and so is doctoring - the very subject of this book. She is trying to open windows to some of the moments of this doctoring business. She humbly confesses to the readers, both field-specific and general audience: “I speak of what I know. I applaud and criticise so that we may understand better – a little better – what our real duties are”. Thus, this self-examination of the doctoring of self/beyond does have a “confessional quality” (Miksaneek) of the highs and lows of the white coat for the audience’s perusal.

Thus, from the above-discussed details, *Luxury*, much like Nambisan’s preceding work, is sociologically sound. The same can be said about the literariness of the work. As much as the book is social, it is also about personal growth falling into the “medical memoir” category, “medical autobiography”, or bildungsroman, tracing the growth of a naive school-girl obsessed with copies of A. J. Cronin novels, and her grandfather’s copies of foundational medical textbooks such as *Gray’s Anatomy* and *The Home Doctor*, through becoming an established surgeon in the country and abroad to almost taking the historicist approach to the country’s social history of medicine. Donald Pollock, the cultural anthropologist who analysed the autobiographies of US physicians, stated that these are literary

and social acts, and so is *Luxury*. Laying the Indian healthcare system bare, questioning the bureaucracy, demanding equitable healthcare and calling for better healthcare both in rural and urban spaces, *Luxury* is a one-of-a-kind and current necessity.

Public Health and its Absence: Funding, Fairing, and Failing

Public health is one of the fundamental duties of good governance. In the pre-colonial era, medical services were rendered by dhais, midwives, Hakheems, Vaidyas, and quacks, both from medical and non-medical backgrounds (Negandhi et al.). With the advent of the British reign in India, there was a drastic shift in the paradigm of health becoming the state's subject. Measures were taken by the colonisers to improve public health, which was purely in the military's interest (to improve soldiers' health) and did not span beyond the health and mortality of British citizens in India. The British governance harboured strict policing in hygiene, sanitary, waste management, and disposals and commissioned committees to oversee. Despite resistance and challenges by the natives on various grounds, these interventions laid the stone for the country's public health. Since then, public health in India has come a long way with pioneering innovations, diverse pharmaceutical industries, technology-driven diagnosis, research parks, funded clinical trials, and a centre for medical tourism. Yet there is another side to it that Nambisan takes to the witness stand: rural health.

Nambisan, as a surgeon, predominantly worked in the extremely rural parts of the country, namely in Bihar, Uttar Pradesh, Karnataka, and Tamil Nadu, from where she gained first-hand knowledge of public health in rural India. While many surgeons prefer urban practice and tend to avoid rural settings, Nambisan stands out as a countertrend. When asked in an interview why she chose rural over urban practice, she responded:

I'm a rural person and I love the challenges of rural surgery. It demands a very different type of skills and imagination to tackle cases which a general surgeon in the city can send to a specialist. One has to keep in touch with learning always. And there is wonderful interaction with the community. I also believe that I am needed there, while in a city there are any number of surgeons who can do what I do. (D'Souza)

One of the challenges in rural health is disparity and accessibility. Though the country has a sub-health and primary health centre, as the recent

“self-assessment” undertaken by the Indian government itself verdict: “the vast majority of the country’s public health facilities are falling short of essential standards mandated by the government” (as qtd. In *The Economic Times*, 2024).

The rural populace is often recommended to the urban space for enhanced treatment, which is alien, unwelcoming, and bewildering for the “villagers and small-town folk” (Nambisan 10). The ostentatious nature of the cityscape, the entanglement of modern medicine and bills beyond the annual income add to the precarity of the ill. Of this structurally induced precarity, *Luxury* describes: “Families of patients with serious illnesses sleep outside the hospital gates, on pavements or in hastily constructed shacks to while away anxious weeks or months—cooking, washing, sleeping in the open, waiting to go back to their homes and to work” (Nambisan 10). The absence of resources for the vast majority of the country’s rural populace compared to its urban counterpart exemplifies Norwegian Sociologist Galtung’s conceptualisation of “Structural Violence” or “indirect violence”, contrasting “direct violence”. The first characteristic of structural violence, which is also interchangeable with “social justice”, is the absence of subject/actor that commits the violence or, in other words, lacks a “subject-object relation” (171) in the structure, yet the violence committed is actual. In line with this conceptualisation, healthcare disparity for the rural populace rather than its urban population fits into this paradigm of violence induced by the structure, even though the subject that commits it is unclear.

Nambisan also contends that there is a lack of medical resources for the soil tillers, further enfeebling the vulnerable. She depicts the conundrum of the country’s 70 per cent of the population in rural and semi-urban spaces, whereas 80 per cent of hospital facilities are in the cities. This lack of resources is also instances one of the characteristics features of Galtung’s structural violence, which is the uneven distribution of resources: “Resources are unevenly distributed, as when income distributions are heavily skewed, literacy/education unevenly distributed, *medical services* existent in some districts and for some groups only, and so on” (171).

Galtung incidentally and evidentially pointed out the shortage of medical services in some spaces and for some groups, thereby structurally creating indirect violence. Of the same lack of resources to “some groups” or in “some district” Nambisan is concerned with. Firstly, the onus is on the state. The hospitals are insufficiently staffed and equipped; even if equipped and staffed, the state does not ensure its functioning, and if ade-

quately equipped, it is inadequately staffed. Through government funds, the system fails. Secondly, the physicians. Some physicians in rural posting strive to get a better spot or languish. She also adds that they miss the action and flourish in private practice. Furthermore, some readily agree with rampant corruption and unethical acts because they got the spot through bribery.

However, Nambisan does not generalise and hastens to affirm that physicians are committed to rendering their service with the utmost ethicality: "This is not always the case. A significant number of doctors have worked within the government system with great dedication and created centres of excellence in India" (Nambisan 37). In this system and its fairing and failing, there is not just individual "subject-verb-object" but a structure. The stakeholders for her are not just the state but also the society that does not question the system, and the citizen who is concerned is only with him/herself. To put his case in point, Galtung illustrates the distinction between personal and structural violence. He opines if one husband beats his spouse, then it is an instance of personal violence. However, if a million husbands beat their spouses in ignorance, the name is structural violence. The case of inadequate healthcare, not just in a rural space where Nambisan faced it during her tenure as an intern and as a surgeon but in rural spaces, is nothing less than structural violence.

The prominent theme in the writings of physician writers in the West, especially in the United States, is over-medicalisation, over-technologisation, and overuse. Per contra, the writings of Indian doctor-writers almost dirge over the lack of a medical system for the majority of the populace, the malfunctioning and malpractice culture in whatever exists. For instance, Hansda Sowvendra Shekhar, a doctor-writer who works in a rural hospital, outlined the system's flaws in his *My Father's Garden*. So does Noshir H. Anita, in his *The Autobiography of a Doctor*, meditates on the importance of community health and established the Foundation for Research in Community Health (FRCH) and the Foundation for Medical Research (FMR) and suggests a blueprint by training the women volunteers to ensure the health of their environment. The government has taken significant initiatives for its citizens' public health through various schemes and assistance, which need to be acknowledged.

Having said that, these narratives from the doctor-narrators cannot be overlooked, for they make the public sphere aware of the public health, keeping the audience informed. It is the narratives of the doctors that brought the interdisciplinary field of inquiry, medical humanities abroad.

Getting back to *Luxury*, as a reviewer puts it, is a truthful and fearless account of the medical profession in the country, and it undoubtedly makes “a compelling case for equity and a strong public health system”. The former Union Minister Jairam Ramesh has also recognised how the book commands attention and calls it didactic for it educates to do and don’t to make healthcare “more effective and equitable” (as qtd. in Nambisan).

Health for Sale: Profit, Privatisation, and the Public Health

Leo Tolstoy’s *Brother Karamazov* depicts an upsetting scene which can be read in the light of medicine and Marxism where the son is critically ill on his deathbed; the

abled-bodied daughter and the neurotic mother on the one side and the other side is the destitute father who is holding the thread. An annoyed and schadenfreude doctor walks in, fully knowing the financial status of the destitute father with a sinister motive recommending that the son be taken to Syracuse, the daughter to the Caucasus and the mother to Paris for treatment. Poor father, pointing to the bare walls symbolically telling the family’s sufferings and financial status, mourned, “Doctor! Doctor! Don’t you see?” for which he grins and replies: “Ah, that is not my business”. Onlooker of this episode, Illyusha’s friend deliberately addressed this doctor as a “Leech” (as qtd. in Nambisan 1), a worm that sucks blood from its host. Shamefaced and speechless, Leech left the room. With this intertext in the “Introduction”, Kavery Nambisan sees health from all angles, including the sufferer’s financial status, and sets the tone for what is to come.

Health, like food, education, and housing, attained the luxury model. Opponents of commodified healthcare argue that the out-of-pocket expenditure adds to the economic crisis of the poor and middle class (Thakur and Faizan; Mondal et al.; Sriram et al.). *Luxury* reprimands this privatisation of health and sees this rapid private-run healthcare as the corollary of government nonintervention. Nambisan’s past doctoring experience was in medical hospitals run by the government, missionaries, and monasteries. Due to circumstances, she landed in a “five-storeyed private hospital with six hundred beds and all the major specialities”, which she sees as a distinct change in her doctoring career. Working with nuns and swamis for whom serving the sick is next to godliness, “the boss,” (130) who overprescribes, overuses, and overcharges, distressed her. The Marxist lens has discoursed how physicians are no less than agents in commodified healthcare, and Nambisan also explicates such practice. During her tenure in the

abovementioned private firm, the corporation also attempted to lure her into complying with the business with better incentives, as she admitted more patients and contributed to bringing turnover to the firm. Failing this, she was often summoned to the boss chamber and questioned about not admitting patients to the ICU, having a lower frequency of conducted diagnostic tests, and not being fair enough regarding monetary accumulation to the firm.

Overuse, over-prescription, or over-medicalisation are byproducts of profit-driven medicine. *Luxury* has several instances of such trickery of corporate medicine. For example, this sinister figure, “the boss,” boasts one of his tricks for performing surgery on a patient. The patient, a Dubai-based engineer, had encountered a fracture weeks ago and sought medical assistance in a possible attempt to start walking without the crutches. The boss ordered an MRI, and surgery was planned. The ignorant patient thanked him effusively and said, ‘The two doctors who treated me never suggested this,’ he said. ‘I’m happy I came to you’ (Nambisan 131).

On the subject of private-public dichotomy, she blames the system for letting the private and corporate healthcare sector surpass the government-funded system, leading to the social welfare model being “outdated”, elucidating the “medical industrial complex”. The medical-industrial complex (hereafter MIC) coined by Arnold S. Relman in *The New England Journal of Medicine* seemingly serves as a metonym for today’s profit-driven healthcare services. The significant development of modern-day healthcare as Relman assets is the “unheralded” growth of the “new industry” that renders profit-based healthcare. This expression – medical-industrial complex – originated from the 1961 farewell speech of U.S. President Dwight D. Eisenhower. By addressing his countrymen, Eisenhower traced the growth of the armaments industry for the country’s defence where the net income of the US corporations in totality is spent. Though such a defence establishment is quintessential, he is critical of the rise of power in the war-based industrial complex. Thus, he hastens to warn of the combination of government and industry in producing/supplying armaments:

Yet we must not fail to comprehend its grave implications. Our toil, resources and livelihood are all involved; so is the very structure of our society. In the councils of government, we must guard against the acquisition of unwarranted influence, whether sought or unsought, by the military-industrial complex. The potential for the disastrous rise of misplaced power exists and will persist. (Ei-

senhower)

It is from this military-industrial complex that Relman conceptualised the phrase ‘medical-industrial complex’. Of this mic, per Relman:

The past decade has seen the rise of another kind of private “industrial complex” with an equally great potential for influence on public policy – this time in health care.

What I will call the “new medical-industrial complex” is a large and growing network of private corporations engaged in the business of supplying health-care services to patients for a profit – services heretofore provided by nonprofit institutions or individual practitioners (Relman).

In the wake of this profit-driven medicine, “genuine care” has become a thing of the past. Thus, the *Luxury* warning against the rhizomatic increase of health for sale emerges as more potent than the farewell speech of President Eisenhower and his concern about the military-industrial complex. Henry E. Sigerist, in analysing the medical profession through the ages – from Primitive medicine to modern medicine – concluded a similar assertion that if at all one lesson derived from the history of medicine, it is that the position of a physician in society is directly proportional to the society that is served and adds: “We can oppose the development, we can retard it” (676). *Luxury* also states that society does not resist the “unsatisfactory” state-funded healthcare for the populace, which is coded to “purchase” with money and concerned with only one’s own health. The system is the “part of the whole”; thus, it’s also in our hands to comply or resist. She coaxes the gentle readers: “Only, I must remind the reader that the system is part of a whole: the country. We the citizens make it or break it” (Nambisan 303).

Conclusion

By writing, Carlin ascertains that doctors have been “impacting society in profound ways” throughout history (Carlin 3). Assuredly, Kavery Nambisan and her *A Luxury Called Health* belong to this milieu as the author and art advocate for equity and accessibility in healthcare while exposing the unethical practices prevailing in the system. The study aimed to investigate how healthcare has also become a business venture that runs for profit; the more profit, the better. By attempting a brief view of the works of Nambisan in general and its social undertones, the paper situates her

as a social advocate alongside a medical practitioner and writer striving hard to fight the dominant dichotomies and binaries inherent in Indian societies, such as haves and have-nots; rural and urban; service and sale; and, welfare model and business model. Through examining the “self-examination” (Nambisan 1) of the author’s “white coat” and all the white coats, the paper located *Luxury* in its personal, medical, social, and literary context making its depths.

Furthermore, by employing concepts such as “structural violence” and “medical industrial complex”, the luxury in *A Luxury Called Medicine* is probed. The text’s unabashed representation of the socio-ethical issues associated with the medical profession exposes the complexities of the healthcare business, and its aim to inform and engage a better-informed audience makes Nambisan, as a reviewer, aptly puts “Indian Robin Cook” – an American doctor-writers known for his medical thrillers (Choudhury). Since the milieu of doctor-writers is still in the marginal space in India, bringing these narratives to the mainstream in the era where illness is life’s quotidian is significant. One such instance of recognition is in this paper.

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