BA Sociology (Hons)   DSE-I

SOCIOLOGY OF HEALTH

Sociology of Health

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1.0. Objectives of the Unit:

The main objective of this unit is to inform the readers about the basic idea on Health Sociology. After the completion of studying this unit the students will gain some fundamental knowledge on the following topics:

❖ Meaning, aim, objectives and scope of Health Sociology.

❖ Major theoretical approaches to health sociology.

❖ The concept of health and illness and different social determinates of health and illness.

❖ Major contributions of health sociology.

❖ Social Medicine- Its Evolution and development.

1.1 Sociology of Health: an introduction

Over the last decade the promotion of health has become a central feature of health policy at local, national and international levels, forming part of global health initiatives such as those endorsed by the World Health Organization. At the same time a concern with 'healthy living' has become a preoccupation for many people. *The Sociology of Health Promotion* responds by offering the first critical sociological account of these developments and locates them within a set of wider socio-cultural changes associated with late modernism. *The Sociology of Health* offers analyses of contemporary public health policy, lifestyle, consumption, risk and health. It also examines socio-political critiques of health promotion and reflects upon their implications for policy and practice, the impact of both morbidity on social life and social life on morbidity. Diseases and conditions once attributed mainly to genetic predispositions are increasingly being looked at under a more global microscope with factors such as family, education, religion and economic standing all playing key roles in understanding the issue at hand. The history of HIV/Aids illustrates a prime example of how sociological factors affect health. The disease is thought to have originated in Sub-Saharan Africa, where 69% of the world's HIV/Aids cases currently exist, making heritage an important component to consider. However, there are even more sociological circumstances that contribute to the plethora of HIV/Aids victims in this area of the world. Female genital mutilation, an unfortunate cultural norm in parts of Africa, is conducive to the exchange of blood during sexual intercourse. Additionally, interference by religious activists often prevents any hope for promoting safe-sex campaigns. Even major political figures in Africa have been known to cling strongly to AIDS-denialist claims. This ignorant standpoint places a society that is already intensely prone to contracting the disease in an even more uneducated position.

The positive side to discovering the influence of sociological factors on disease is that it provides us with further insight to humanity's core issues and obstacles. When not adequately paid attention to, however, knowledge can be a double-edged sword. For instance, when HIV/Aids first emerged in the US in the 1980s, it was feared but also believed to solely infect the homosexual and/or African American communities. Though these groups do often dominate statistics, HIV/Aids have actually been on the rise significantly in heterosexual females as of late. So, though the stigma and fear of HIV/Aids still exists in the US, the invention of new medicines and the spotlight on stereotypical victims sometimes make it not

as prominent a concern as it should be for others who could still be infected. As we progress as a society, it is vital that we fully acknowledge potential health risks and make a joint effort to share and spread preventative knowledge.

Health is a state of complete well-being: physical, mental, and emotional. This definition emphasizes the importance of being more than disease free, and recognizes that a healthy body depends upon a healthy environment and a stable mind. Medicine is the social institution that diagnoses, treats, and prevents disease. To accomplish these tasks, medicine depends upon most other sciences—including life and earth sciences, chemistry, physics, and engineering. Preventive medicine is a more recent approach to medicine, which emphasizes health habits that prevent disease, including eating a healthier diet, getting adequate exercise etc.

The sociology of health and illness studies the interaction between society and health. In particular, sociologists examine how social life impacts morbidity and mortality rates and how morbidity and mortality rates impact society. This discipline also looks at health and illness in relation to social institutions such as the family, work, school, and religion as well as the causes of disease and illness, reasons for seeking particular types of care, and patient compliance and noncompliance. Health, or lack of health, was once merely attributed to biological or natural conditions. Sociologists have demonstrated that the spread of diseases is heavily influenced by the socioeconomic status of individuals, ethnic traditions or beliefs, and other cultural factors. Where medical research might gather statistics on a disease, a sociological perspective of an illness would provide insight on what external factors caused the demographics that contracted the disease to become ill.

The sociology of health and illness requires a global approach of analysis because the influence of societal factors varies throughout the world. Diseases are examined and compared based on the traditional medicine, economics, religion, and culture that are specific to each region. For example, HIV/AIDS serves as a common basis of comparison among regions. While it is extremely problematic in certain areas, in others it has affected a relatively small percentage of the population. Sociological factors can help to explain why these discrepancies exist.

Moreover, there are obvious differences in patterns of health and illness across societies, over time, and within particular society types. There has historically been a long-term decline in mortality within industrialized societies, and on average, life-expectancies are considerably higher in developed, rather than developing or undeveloped, societies. Patterns of global change in health care systems make it more imperative than ever to research and comprehend the sociology of health and illness. Continuous changes in economy, therapy, technology and insurance can affect the way individual communities view and respond to the medical care available. These rapid fluctuations cause the issue of health and illness within social life to be very dynamic in definition. Advancing information is vital because as patterns evolve, the study of the sociology of health and illness constantly needs to be updated.

1.2 Aim and Scope:

1.2.1 The social basis of health, illness and medicine

1.2.1.1 Bio-chemical model versus Holistic approach

Health and illness are, surely, simply biological descriptions of the state of our bodies. When we're ill, we're ill. A more refined version of this common-sense view underlies the long-standing **biomedical model** of disease, which is based on the following assumptions:

- Disease is an organic condition: non-organic factors associated with the human mind are considered unimportant or are ignored altogether in the search for biological causes of pathological symptoms.

- Disease is a temporary organic state that can be eradicated – cured – by medical intervention.

- Disease is experienced by a sick individual, who then becomes the object of treatment.

- Disease is treated after the symptoms appear – the application of medicine is a reactive healing process.

- Disease is treated in a medical environment – a surgery or a hospital – away from the site where the symptoms first appeared.

This model has dominated medical practice because it has been seen to work. It is based on a technically powerful science that has made a massive contribution to key areas of health (for example, vaccination). The anatomical and neurophysiologic structures of the body have been mapped out, and the genetic mapping of the body is being undertaken through the Human Genome Project. The search for the fundamental – that is, genetic – basis of human pathology is on, whether the target is cancer, AIDS or Alzheimer's disease. This ever closer and more sophisticated inspection of the body –or as Foucault (1977a) would say, the medical gaze – has brought considerable power and prestige to the medical profession. It has also established a large and profitable market for major pharmaceutical companies. The biomedical model also underlies the official definition of health and disease adopted by state and international authorities. National governments and international agencies such as the World Health Organisation (WHO) proclaim their long-term health goal to be the eradication of disease. Sometimes they have been successful, as in the global elimination of smallpox. The rational application of medical science is therefore a hallmark of modernity, inasmuch as it has depended on the development over the past two centuries of a powerful, experimentally based medical analysis of the structure and function of the body and the agents that attack or weaken it. During the course of this, scientific medicine has effectively displaced folk or lay medicine. Modernity is about expertise, not tradition; about critical inspection, not folk beliefs; about control through scientific and technical regulation of the body, not customs and mistaken notions of healing.

Yet the power and status of the medical profession and the health industry in general should not deflect us from asking about the social basis of health and illness. In fact, the position of medical professionals is itself a result of the socially institutionalized power to define the experience of being 'ill' and decide what treatment is required. More reflective doctors will acknowledge that their definitions of health and illness are not always shared by their patients and therefore have to be promoted through education, socialization and expensive advertising. Symptoms that, according to the biomedical model,

should force us to go to the doctor or take a pill are not necessarily seen as signs of illness by people themselves. Among a household of smokers, for example, the morning 'smoker's cough' is unlikely to be seen as abnormal or a sign of ill-health: indeed, it is often calmed by a good pull on the first cigarette of the day. Among many Westerners, a suntan suggests health and good looks rather than leading to wrinkled skin or skin cancer. Among the Madi of Uganda, illness is often associated with failure to deal properly with interpersonal relations, so that social or moral – rather than biomedical – repair is needed (Allen, 1992).

Thus an alternative or complementary remedy for ill-health often takes a **holistic approach** to understanding the cause of illness and its remedy.

Sociologists, anthropologists and historians have described the social basis of health and illness in a wide range of studies, including ethnographies of specific communities. They have explored issues of health care, performance of '*the sick role'*, the construction of mental illness as a disease, the wider creation of medical belief systems and the relationship between these and the exercise of power and social control.

The sociology of *health and illness* is concerned with the social origins of and influences on disease, rather than with exploring its organic manifestation in individual bodies. The sociology of medicine is concerned with exploring the social, historical and cultural reasons for the rise to dominance of medicine – especially the biomedical model – in the definition and treatment of illness. These fields are closely related, since the way in which professional (or orthodox) medicine defines and manages illness reflects wider social dynamics that shape the perception and experience of disease.

1.2.1.2   The relationship between society and individual:

The relationship between individuals and the society or structure in which they live is specific and distinct. A helpful example of the way on which structure (society) influences the actions and experiences of individuals is provided by Giddens. He uses the analogy of language to illustrate the relationship that individual have with the wider social structure. None of us has invented the language that we use but without it the social activity would be impossible because it is our shared meanings that sustain society. However, as Giddens (1994) also points out, each of us is capable of using that language in a creative, distinct and individual way, and yet no one person creates language. In the same way human behavior is not determined in a mechanical way by the structure we call society. The relationship and interplay between society and individual is explained in terms of Structure and agency**.** The latter is a concept used to refer to a cluster of ideas about the potential for individuals to determine their lives, to change their environment and ultimately influence the wider structure. The concept of agency therefore, allows us to appreciate the way in which we are shaped by society and in turn shape society.

If the subject-matter of sociology is human society and behavior is explained primarily in terms of 'structure', than this logically denotes specific factors in the explanatory framework of the discipline. Sociological explanations of what determines our state of health will necessarily differ from, for example, biological explanations. Clearly disease is a biological and physical entity experienced through the medium of the body. The cause of the disease, while biological, can also be considered in terms of social and structural factors. The immediate cause of disease may be infection but the factors that lead to this may be many and varied. This we may call as the social determinates of health. The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair

and avoidable differences in health status seen within and between countries. Some of these social and environmental factors such as **age, social class, ethnicity, race and gender** fall within the scope of health sociology.

1.2.1.3   Class and health inequalities:

Class refers to a complex stratification of society based on access to and control of power, status and economic resources. It is a complex and dynamic power relationship between people. Class societies are also distinct from other societies that are also stratified. For example in feudal society distinction between people was rigid, immobile and seen to be religiously ordained. The reason why someone was a lord or a peasant was because God willed it that way and there was no way to change it. But in contemporary societies one can be more socially mobile between classes. This is because, in many ways one achieves one's own class position and it is not fixed by his birth.

There is a great deal of difference between people's life expectancy depending on the class to which they belong. If someone is from manual or working class background, generally speaking, likely die younger, age faster and encounter more long-term limiting illnesses than someone from a non-manual or middle- class, background. This lamentable state of affairs has been apparent in much of the research looking at class and health for some time now. Going back to the mid-1800s, Marx's collaborator Engels wrote about the poor health of the working class in Manchester. He claimed that the levels of disease, illness and death were a form of 'social murder' committed by bourgeoisie. More recently, landmark reports such as the Black Report published in 1980 and the Acheson Report published in 1998 both strongly indicated that which class you are in affects your health. However there are two perspectives such as *Psycho-social perspective* and *Neo-material perspective* that attempt to explain the existence of class and health inequalities. Both of the approaches are provided by Lynch et al. (2000).

- **Psycho-social perspective**

    Psycho-social perspective refers to explanation of class and health inequality that emphasize the negative emotional experiences of living in an unequal society, particularly feeling of stress and powerlessness. Wilkinson's (1996) work in the 1980s and 1990s demonstrated that in influent societies it is relative, not average, income that affects health. Wilkinson argues that the greater the inequality in a given society, the less social cohesion it has and therefore, the more insecurity and isolation experienced by the most disadvantaged groups in that society. This insecurity and isolation result in greater levels of chronic stress. In turn, this chronic stress moves down biological pathways (particularly the nervous system) in the human body causing all sorts of harm.

- **Neo-material perspective**

    Neo-material perspectives refer to explanations of class and health inequality that emphasis unequal distribution of resources such as housing, income and access to education.

Thus, there are consistent and persistent differences in class and health in contemporary society. Such differences are part of the array of inequalities to do with wealth, income and other recourses. Perhaps it is in health that the social division of class is most evidently visible, with the bodies

people affected and changed by their location in society. As discussed earlier the bodies of working-class people are more likely to age quicker, be more susceptible to illness and be much more likely to encounter limiting long-term conditions than those located higher in society.

1.2.1.4 Ethnicity, race and health

Race refers to biological differences between people based on skin colour and other physical features, though the actual differences between them genetically are extremely small. Ethnicity refers to the cultural heritage and identity of a group of people where a common cultural heritage is socially learned and constructed. Race is supposed to be based on biological or genetic traits where ethnicity is purely social phenomena. Racism refers to the supposed racial superiority of one group over another.

There has been much research on ethnicity and health over the years. What much of the research indicates is that there is a burden of ill-health among ethnic minority groups in the UK. Many people from ethnic minority groups report poor health and long-term limiting illness. This is even more notable as ethnic minority groups tend to have a younger age profile than the white majority population. Researchers in the past often favored explanations that drew attention to either genetic or cultural reasons for ill health. The implication was that there was something wrong with the biology of ethnic groups, which predisposed them to certain types of ill-health or that the culture of the ethnic group was to blame. An indicative example of this older approach can be noted in research on 'South Asians' and coronary heart disease (CHD) (Nazroo1998). Work by Gupta et.al. (1995) inferred that it was something to do with either the genetic make-up of 'South Asians' that predisposed them to CHD, something in cultural practices such as cooking with ghee, nor exercising or not making the best use of medical services. In the past few years, however the work of other researchers, such as Ahmad (2000), Nazroo (2006) and Smaje(1996), have put forward a more challenging and sophisticated explanation of the complex way in which ethnicity , society and health interact. As Higginbottom (2006:585) usefully summarizes, variations in ethnicity and health and ill-health, 'arise from the coalescence of complex factors such as migration, cultural adaptation, racism, reception by host community, socio-economic influences, and prevailing societal ideologies'. Reviewing a range of research and reports, Chahal(2004) concluded that medical and health care services can be problematic for Black and ethnic minority people, with negative experiences of medical and health services being a common problem. This is particularly evident with mental health services. Black people are over represented in mental illness statistics, more likely to be placed in secure wards and to receive different if not poorer –treatment and care than Whites. Thus, class and socio-economic differences affect the health of ethnic minority groups. Even within the same ethnic minority group there are differences in health, with those from the non-manual occupation class having better health than those in manual occupation classes. Moreover psycho-social effects of racism can have a strong impact on the health of ethnic minority groups.

1.2.1.5 Gender and health

Gender refers to social, cultural and psychological differences between men and women. It is the socially constructed differences in roles and responsibilities assigned to men and women in a given culture or location and the social structure that supports them. Gender roles and expectations are learnt. They can change over time and they vary within and between cultures.

The study of gender and health has recently undergone a period of change and transition. How being a woman or a man affects one's health are currently being developed and developed in a new and interesting way. However we cannot ignore the traditional perspective of discussing gender and health which could be easily summarized as' men die and women suffer', means when it comes to health differences between men and women, men experience higher levels of early mortality, while women live longer but experience higher levels of morbidity during their lives. The reasons for these differences were often explained by reference to paid and domestic work roles as well as the wider and often stereotypical, social roles, which men and women held.

Though traditional perspectives on gender and health produced a great deal of vital and interesting research, recently certain sociologist, such as Kandrack *et al.* (1991), Annandale and Hunt (2000) and Macintyre *et al.* (1999), have focused on a new understanding of health and gender. Much of this contemporary thinking of relation between health and gender has been prompted by two influences.

- Firstly, the society is becoming more complex regarding gender relations. Many of the old assumption about gender- for instance the man as breadwinner, going out to earn the family wage and the woman staying at home tending to domestic chores- simply no longer fit today's society. There have been many other transformations, shifts and movements in how women and men relate to the home, to work and to each other. In the midst of all this change women's and men's health is affected in new ways.
- Secondly, there is growing questioning of the theories used to conceptualize gender. So adequate understanding of how issues relating to gender affect both sexes is needed. So emphasis is now lies on understanding the lived experiences of both women and men and acknowledging that differences exist within each sex.

Annandale and Hunt (2000) have recently pointed out that research in the study of gender and health is at a crossroads with 'traditional' approaches giving way to 'new' approaches. The traditional approaches as mentioned earlier view that men and women are located in very distinct and different social roles (man in full-time paid work and women in the home). Theses social roles required them to act in certain ways, which were, generally speaking, good for men but bad for women. The new approach hold that social roles may be 'masculine' or 'feminine' in orientation (such as running a business or looking after children) but a man may carry out a feminine role (looking after children), while a woman may occupy a masculine role as (running a business). The new approaches also focus on how men and women experience those roles and how those experiences affect their health (Annandale and Hunt 2000). The more 'feminine' a role, the lower status it tends to have and this can lead to poor health. Performing feminine roles also carries much more pressure than performing male roles.

Annandale and Hunt (2000: 27-9) usefully summarize the differences between 'traditional' and 'new' approaches to gender and health:

- 'Traditional' forms of research had the tacit assumption that what was good for men was bad for women when it comes to health. 'New' research follows a more nuanced and subtle approach, and understands that similar circumstances may have similar or different consequences for the health of men and women.

- 'New' approaches are aware of the differences within men and within women. In traditional research men in particular, were treated as an undifferentiated group, where all men had similar health experiences.
- In traditional research positivist, quantitative, statistical methods were predominant. In new research the role of qualitative method is highlighted in trying to obtain an understanding of how the experiences of men and women shape their health.

Gender and morbidity

One long-held view is that women have higher morbidity rate than men. There have been a number of reasons behind this, for example:

➢ Women do experience more ill-health than men because of the demands of their social roles.
➢ Women are more disposed to seek help than men.
➢ Women are more in-tune with their bodies.
➢ Surgeries are not male friendly and put men off seeking help.
➢ It is easier for women to adopt the seek role.
➢ Women's more attachment to their relation result different kind of mental diseases including stress.

Gender and mortality

Another long-standing perception, when looking gender and health, is that women have some form of biological advantage in terms of life expectancy. In the UK, for instance a woman born in 2004 can expect to live until she is 81.1 years old, while a male born in the same year can expect to reach the age of 76.7 years (ONS 2006). Such statistics strongly suggest that women do enjoy some form of biological advantage over men. However the sizable life expectancy advantage that women experience in the UK is very much a western phenomenon. Figure depicts how overall women do have longer lives than men in most countries but this is extremely variable. On one hand, in some countries, such as Malawi, the life expectancy for both men and women is very low, while in Algeria there is a negligible difference in life expectancy for women and men. The reasons for this are multiple and diverse. For example it depends on levels of health care a country can offer, where child birth is safer, the levels of poverty and endemic illness, such as in Malawi, which faces widespread poverty and has many people infected with HIV/AIDS.

1.2.2 Mental health

Mental health as an important aspect of heath system comes directly under the scope of health sociology where it has an important role to play in trying to understand the full intricacies of mental illness, especially when it comes to the way in which society influences and frames both how we see mental health and illness and how society creates situations that can negatively impact on individual's mental health.

1.2.2.1 Mental illness

There are complexities and uncertainties that surrounded the whole processes of diagnosis and identifying mental illness. Unlike physical illness, there is often no clear-cut objective sign that someone is experiencing a mental illness. McPherson and Armstrong (2006:50) this concern well, when they say:

What is pneumonia or appendicitis or cancer can be agreed internationally with reference to the presence or absence of certain clearly defined physical characteristics. In psychiatry, however, there is no such external biological referent to act as an anchor

for diagnosis. Essentially, psychiatry classifies on the basis of a patient's patterns of symptoms which might vary according to how they are elicited and interpreted.

Because then it cannot always clearly identified what mental illness is, this makes the search for a cause all the harder. Broadly speaking, explanations for mental illness fall into one of two camps: biological explanations and social explanations. These look in very different directions and see quite different reasons for the existence of mental illness.

➢ Biological explanations:

Biological explanations focus on faulty genes or imbalance in the chemistry of the brain. There is, for instance an association between low levels of serotonin and depression. This way of thinking, of looking for biological cause, in increasingly reinforced by the proliferation of pharmaceutical interventions such as SSRIs (selective serotonin reuptake inhibitors) for treating depression which suggest that if an illness can be treated by chemicals, than it must have a biological, organic basis.

➢ Social explanations:

Social explanations fall into two general categories: *Social causation and Social constructionist.*

❖ **Social causation perspective** refers to how the various inequalities in society (mainly to do with ethnicity, gender and class) produce toxic levels of stress for some people. As a result of this stress, people may be 'tripped' into mental illness, whether it is a woman expected to bring up children on her own and keep down a job; or the experience someone from an ethnic minority group has of being racially abused by a neighbor; or the constant soul destroying grind of poverty and not being able to lead the life of that others enjoy.

❖ **Social constructionist** explains mental illness is something that does not exist as a 'fact' or something that is 'real' and has absolutely no organic basis. This sociological view is influenced by the work of Foucault, who has argued that there is no single incontestable truth that can be discovered and agreed on by everyone. Rather, society is constructed by the idea and conceptualizations of both individual people and also, more importantly, certain powerful groups. Some groups, such as psychiatrists, are able to construct a discourse that privileges a certain view point of others, which allow them to effectively rule out and rule in ways of conceptualizing, for example what constitutes mental illness. Constructing such discourses allows such groups to become dominant in society and allows them to regulate and control the activities of others.

Thus, both biological explanations and social explanations explain about mental illness. But these two are not sufficient to address the complexity of mental health and illness. Rather there is a complex interweaving of both society and biology, where both have to be understood as often working together in complex and dynamic ways. As captured by Rose (2005) in his discussion of causes of mental illness and how biology and society interact. He points out that just because a change in the chemistry of the brain takes place does not mean that the chemical change caused the illness. To illustrate this point he gives a beautiful example: if someone has a headache, he takes an aspirin. If we

were then to check the chemicals in the person's brain in order to discover the chemical basis of a headache, we would find aspirin. Thus, according to the biological explanation, we would claim that aspirin causes headache, because people who do not have headaches do not have the chemical aspirin present in their brains. Now, obviously, this not to be the case. So, Rose concluded that chemical changes do occur, but that could equally be the result of other (in this case social) factors.

Pilgrim and Rogers (1994) acknowledges and develops the social and cultural factors responsible for mental health in their studies. According to them the misery and sufferings of the world is related to the complexities of human life: that humans are simultaneously organic biological and social beings. This critical realist perspective fully acknowledges the strong and influential role of culture, but does not say that it is all down to society. It also accepts the importance of medical information and research, but crucially, questions how diagnoses are framed by the social influences on the medical professions. Finally, a critical realist perspective accepts that biological processes are at work but, like Rose (2005) attempts to place those processes in a wider context where social factors may be the cause of biological changes.

1.2.2.2 Stigma

Stigma refers to an attitude that 'discredits' or prevents someone's full acceptance in a particular situation. Social stigmas increase the stress of those with mental illness and exacerbate feeling of social exclusion and social distance.

Goffman is one of the best known sociologists to have studied and theorized how certain groups of people attract stigma. His humanistic and sympathetic work focuses on why certain attributes of an individual or group deny them full acceptance in given situations and lead them either to be excluded or to be left with a feeling of not 'fitting in'. He classifies stigma into three broad groups:

> - **Physical stigma** - mainly to do with aspects visible 'on the surface' of people, for example facial scarring, a physical impairment or an amputation.
> - **Personal/character stigma** - mainly to do with aspects 'below the surface', for example drug use, sexuality or mental health.
> - **Social stigma** - belonging to a particular group or ethnic minority. (Goffman, 1968)

The 'counting the cost' survey by Baker and Macpherson (2000) for MIND highlighted the extent of stigmatizing images and the effects they had on people with mental illness. For many respondents to the survey the social stigma was harder to deal with than the symptoms of their particular condition.

1.2.2.3 Ethnicity and mental health:

There are a number of explanations for why people from Black and other ethnic backgrounds appear to have higher rates of mental illness and a different, often coercive, relationship with services. These explanations include:

- racist and prejudiced attitude on the part of service providers and agencies of the state, such as the police;
- lack of cultural sensitivity

- more frequent exposure to stressors in the form of, for example, unemployment;
- adjusting to a new society if recently arrived;
- racism generally.

However, Pilgrim and Rogers (1993) pointed out another related concept regarding the relationship of ethnicity and health. They draw on Foucault's concept of seeing madness as a part of the 'other', that is the groups of people who are regarded as being outside the norm of society and as constituting a threat to the order of society.

1.2.2.4 Gender and mental health:

Every review of literature concerning sociology and mental health reaches the same conclusion when discussing gender – that women always display higher rates of certain mental illness than man (Foster 1995; Bebbington (1996).

In substantial review of literature relating to women and depression Bebbington (1996) and Nazoo et al. (1998) demonstrated the following points:

❖ Women did report more depressive episodes – whether distant, mild or exaggerated episodes. Whereas there is little evidence for men masking their depression by turning to alcohol or substance abuse.

❖ The chance of depression is higher in case of woman because of her role identity. For example: a woman feels a particularly close attachment to and sense of responsibility for children and because of her role identity, then the chance of depression is much greater if there is child related problem, such as difficulties at school or drug misuse.

One of the best known pieces of sociological research on women and mental health was carried out by Brown and Harris (1978). Key component of the model are:

❖ **Current vulnerability factors** – these factors relate to events that have happened in a woman's past and indicates whether or not she may be more susceptible to depression. There are four vulnerable factors:
  1. losing a mother before the age of 11;
  2. presence at home of three or more children under the age of 15years;
  3. absence of any confiding relationship, particularly with the husband;
  4. lack of full or part-time job.

❖ **Provoking agents** – there are various events that could occur in a woman's life, which could then trigger a depressive episode. The events mainly relate to loss and disappointment, e.g. death, losing a job or discovering a partner's unfaithfulness.

❖ **Symptom** – formation factors- women over 50 years of age and women with low self-esteem were at greatest risk of developing depression.

1.3 Theoretical approaches:

The sociology of health and illness is informed by five theoretical traditions:

- *Functionalism* is based on the following basic assumptions:
    1. It is an analogy between society and biological organism.
    2. It provides a 'consensual' representation of society based on agreement to sustain society as it is.
    3. It is an analogy between society and biological organism. It offers an explanation of human society as a collection of inter-related substructures, the purpose of which is to sustain the overarching structure of society.

    ➢ *Parsonsian functionalism and 'the sick role'*

In relation to the study of health and illness the functionalist perspective is usefully illuminated by Talcott Parsons' concept of the 'sick role'. Here the concept is used to analyze sickness as a social role, not merely a biological entity and physical experience. For any society to function smoothly, 'sickness' needs to be managed in such a way that the majority of people maintain their normal social roles and obligations. This perspective is based on the assumption that if too many people were to describe themselves as sick and need of being excused from their normal range of social obligations, this would be dysfunctional in the sense of disruptive for society as a whole. Since being sick means choosing to withdraw from the normal patterns of social behavior, it amounts to a form of deviance, and hence the efficient functioning of the social system depends on the sick being managed and controlled. The role of medicine is to regulate and control those who have decided they are sick so that they can return to their normal tasks and responsibilities. In short, the sick role enquires a commitment on the part of those who feel unwell to return to normality as soon as possible. Four features define the sick role:

- ⚔ Sick people are legitimately exempted from normal social responsibilities associated with work and the family.

- ⚔ Sick people cannot make themselves better – they need professional help.

- ⚔ Sick people are obliged to want to get better – being sick is only tolerated if there is a desire to return to health.

- ⚔ Sick people are therefore expected to seek professional treatment.

- *Symbolic interactionism* in contrast to functionalism is based on the following assumptions:

    1. It is based on the fundamental difference between the subject matter of sociology and that of natural sciences. While the study of the former deals with physical, inanimate objects, the subject matter of the latter consists of people whose actions are motivated by human consciousness.
    2. It explains social phenomena from the perspective of its participants.
    3. The meaning of human action must be interpreted by studying the meanings that people attach to their behavior.
    4. It is concerned with how people see and understand the social world.
    5. This approach is concerned less with the larger social system or structure than with interpreting human behavior.

The significance of this approach in relation to understanding health behavior is that: it is basically concerned with examining the interaction between the different role players in the health and illness drama. The focus is on how illness and the subjective experience of being sick are constructed through the doctor–patient exchange. The argument here is that illness is a social accomplishment among actors rather than just a matter of physiological malfunction.

- *Marxism* provides a powerful insight into the structure of society is based on the following ideas:
    1. It is the economic structure of any society that determines the social relations contained within that structure.
    2. It is the distribution of the ownership of the means of production that gives rise to specific patterns of class relations, which crucially in all societies are characterized by inequalities of power.
    3. Society is divided between those who privately own the means of production (a minority) and those are dependent on selling their labor power to make a living (the majority).
    4. The relation between these two classes bourgeoisie and proletariat is unequal, exploitation and oppressive.
    5. Marxist theory is concerned with the way in which the dominant economic structure of society determines inequality and power, as well as shaping the relations upon which the major social institutions are built.

Marxist explanation relating to the cause of ill health and relationship between the state and medical profession is based on the insight of the relationship between health and illness and capitalist social organization. The main focus is on how the definition and treatment of health and illness are influenced by the nature of economic activity in a capitalist society. Medicine is a
major social institution, and in capitalist societies, it is shaped by capitalist interests. Marxist accounts of capitalist medicine have been developed by a number of sociologists and health policy analysts, notably Navarro (1985). According to Navarro, there are four features that define medicine as capitalist, or as he puts it, that point to 'the invasion of the house of medicine by capital' (ibid., p. 31):

- Medicine has changed from an individual craft or skill to 'corporate medicine'.

- Medicine has become increasingly specialized and hierarchical.

- Medicine now has an extensive wage-labor force (including employees in the pharmaceutical industry and related industrial sectors).

- Medical practitioners have become proletarianised, that is, their professional status has gradually been undermined as a result of administrative and managerial staff taking over responsibility for health care provision.

These four processes mean that medicine has become a market commodity, to be bought
and sold like any other product. Furthermore, it has become increasingly profitable for two dominant capitalist interests: the finance sector, through private insurance provision; and the corporate sector, through the sale of drugs, medical instruments and so on. The power to direct and exploit the medical system has been seized by large corporations that enjoy monopolistic control over related market sectors. This process is characteristic of (late) capitalism as a whole: 'Monopoly capital invades, directs

and dominates either directly (via the private sector) or indirectly (via the state) all areas of economic and social life' (ibid., p. 243). The last point illustrates Marxists' claim that just because medicine is organized as a national system of health care (as in the UK), this does not mean it is free of capitalist influence. Rather, it is part of the medical– industrial–state complex, involving close relations between large firms and state agencies. The state buys drugs and other equipment from large firms, subsidies their research through university laboratories and maintains a large hospital infrastructure that requires their goods.

Marxists also claim that health problems are closely tied to unhealthy and stressful work environments. Rather than seeing health problems as the result of individual frailty or weakness, they should be seen in terms of the unequal social structure and Navarro in his analysis suggests the alliance of interest between the ruling classes and the medical profession; each, for different reasons, derives power from the continuation of these conditions of inequality. For the ruling classes, health inequalities are an indication of the difference in life chances that exist between themselves and working classes in particular. The provision of health care through a system such as the National Health Service is largely about maintaining a reasonable level of health among the working classes, sufficient to ensure that people are able to work and be returned to work following illness. Therefore, the alliance between the ruling classes and the medical profession serves the interest of both by maintaining the professional dominance of the later and by sustaining a reasonably healthy working population for the former.

- *Feminism* – Marxist theory has been criticized in particular for its almost exclusive emphasis on the economic determinants of social relationships and for the resulting primacy of social class in any analysis of inequality. *Feminist theory* from 1960s onwards sought to challenge the invisibility of gender in sociological theory. It is based on the following basic assumptions
  1. Social structure is fundamentally based on inequalities between women and men.
  2. It endorses the social equality of the sexes and opposes patriarchy and sexism.
  3. It seeks to eliminate violence against women and to give women control over their reproduction.
  4. There are three variants of feminist thinking:
     - **Liberal feminism** seeks equal opportunity for both in the existing society
     - **Socialist feminism** advocates abolishing private property as the means to social equality
     - **Radical feminism** seeks to create a gender-free society.

Feminist theory thus makes a substantial contribution to the understanding of health and illness. It provides an analysis of gender relations on the basis of the way in which female inequality has been structured and maintained in society. It explores the gendered nature of the definition of illness and treatment of patients. Its main concern is the way in which medical treatment involves male control over women's bodies and identities. Such as Oakley (1984) have argued that the women's life have been subject to far better control and regulation by the medical profession than have men's. Particular example can be seen in relation to pregnancy and childbirth.

- *Postmodernism* - Postmodernism is the final theoretical approach to the understanding of health and illness. It refers to the present historical period characterized by the globalization of the economy and culture. It shows a fragmentation of individual identity such that old certainties of class, national and gender identity. This theory is otherwise known as Foucauldianism for major contribution of Michel Foucault where he concentrates on the dominant medical discourse, which has constructed definitions of normality (health) and deviance (sickness). This discourse provides subjects in modern

societies with the vocabulary through which their medical needs and remedies are defined. The source and beneficiary of this discourse is the medical profession. Foucauldian theorists also argue that medical discourse plays an important role in the management of individual bodies (what Foucault called 'anatomopolitics') and bodies *en masse* (bio-politics), Medicine is not just about medicine as it is conventionally understood, but also about wider structures of power and control.

1.4   contribution of sociology to health:

More than a century ago, Rudolf Virchow noted that medicine is in essence a social science, and politics nothing more than medicine on a larger scale. Virchow and many others over the past two centuries saw the extent to which disease and epidemics derived from the material conditions of living and the social stratification of society. An enormous body of research and analysis has confirmed this observation in more recent years in relation to mortality as a whole and to a wide range of diseases and disabilities. Two important government reports in the 1980s, in England (the Black Report) and in the United States (Report of the Secretary's Task Force on Black and Minority Health), reviewed the impressive evidence of the effects of socioeconomic status and racial and ethnic differences on health and longevity.

1.4.1   HEALTH PROMOTION AND SOCIOLOGY

According to the World Health Organization "health promotion is the process of enabling people to increase control over the determinants of health and thus improve their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions." Since 1984 the promotion of health has become a principal feature of health policy at local, national and international levels, forming part of global health initiatives such as those sanctioned by the World Health Organization. Sociologists have tended to contribute to the development and refinement of health promotion activities rather than analyzing it as an object of inquiry. They have carried out surveys, interviews and observations of people's lifestyles to provide information for health promotion campaigns. Following are some of the major contribution of sociology regarding health promotion.

- Health promotion is the attention that it gives to the *facilitation* of healthy lives: the idea that it is not just telling people that they should change their lifestyles but also altering their social, economic and ecological environments health.

- promotion aims to work not only at the level of individuals but also at the level socio-economic structures and to encourage the creation and implementation of 'healthy public policies' such as those concerned with transport, environment, agriculture and so on.

- The promulgation of healthy lifestyles and the discourse of health promotion and the 'new public health' more generally are important and topical subjects which, although retaining some continuities with past health policy, can increasingly be viewed as representing a new paradigm of health care (Nettleton, 1995).

- An etiology and distribution of health and illness which reveal that adequate health policies must take structural and environmental factors has been analyzed and focused. The

political and ideological bases of health education and health promotion activities have also been debated.

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- The dominant strand of the sociology of health promotion is its concern to analyze the phenomena as a characteristic of the much wider set of socio-economic and cultural processes associated with late modernism.

- Sociological analyses of health promotion; develop analyses on matters in relation to health promotion which are of interest to contemporary sociology, including risk, the body, consumption, and processes of surveillance and normalization; and develop critiques of health promotion which are of interest to health and medical practitioners, including issues of gender and race in the implementation of health programmes, cultural dimensions of lifestyles and health behaviors, and the marketing and consumption of health-related activities.

1.4.2 Mental health roots

Sociologists worked on health issues throughout the century, but medical sociology as an institutionalized specialty first developed a strong educational infrastructure in the 1950s and 1960s, largely with the support of the National Institute of Mental Health (NIMH). Unlike the National Institutes of Health (NIH) at that time, NIMH saw the social and behavioral sciences as central to the development of its mission. Thus, the agency broadly invested in fellowships and training programs in sociology, psychology, and anthropology. In the 1950s and 1960s, most medical sociology was focused on mental health issues and contributed many of the concepts and much of the research that helped transform mental health services in the United States from a hospital to a community endeavor. It was NIMH that supported studies in psychiatric epidemiology, stress and coping, public attitudes and stigma, labeling processes, the course of disability, and the study of hospitals. In those years, the emphasis was on mental health broadly conceived, and NIMH contributed importantly to the development of social and behavioral research, including the development of methodologies and analytic techniques. Under pressure during the Reagan years, NIMH very much narrowed its training and research support to focus more specifically on the mentally ill population, in contrast to broader mental health concerns. By the 1980s, however, many of the NIH institutes recognized the importance of social and behavioral research for their missions and helped compensate for NIMH's more narrow emphasis. The National Institute on Aging, with its broad agenda of studying developmental change across the life cycle, did much to promote improved methodology and high-quality data and to support substantive research across a wide range of issues affecting health, function, and well-being. Similarly, the National Institute of Child Health and Human Development supported much sociological effort in the area of population research. While the heart, cancer, and other institutes were more narrowly focused, they increasingly supported epidemiological and behavioral research relevant to their categorical missions. The heart institute was particularly instrumental in developing the field of behavioral medicine.

1.4.3 Some Contributions of Medical Sociology

Medical sociological endeavors tend to follow two streams:

- *sociology in medicine and*
- *Sociology of medicine.*

In the sociology in medicine, sociologists work as applied investigators or technicians, seeking to answer questions of interest to their sponsors, whether government agencies, foundations, hospitals, or medical schools. Depending on the ingenuity of the researcher, such work can make broader contributions than the particular task may suggest, but the emphasis is on information and application. This role is familiar, encompassing those who design and execute health surveys and who study such varied topics as access to care, use of services, satisfaction, risk factors in disease, health status determinants, and many more.

Sociology of medicine, in contrast, focuses on testing sociological hypotheses, using medicine as an arena for studying basic issues in social stratification, power and influence, social organization, socialization, and the broad context of social values. Work within this tradition explores such themes as how physicians control the work of other health occupations; how lower social status and gender affect health interactions; and how political and economic interests influence the structure of care, reimbursement, and the uses of technology. At the organizational level, such studies commonly contrast rhetoric with reality, seeking to identify the motivations, incentives, and group interests that result in departures from public declarations and stated goals.8 Medical sociology has little theory of its own, depending on its parent discipline for its broader perspectives. Thus, the major points of emphasis that define sociology in general help focus the way generic questions about health and medicine are formulated.

1.4.4   Medical education:

Medical sociology, for example, has had long involvement in the study of medical education, dating from the 1950s. Educators sought assistance from sociologists in improving curricula and in understanding better how to structure education to deal with the stresses of training, reduce unethical behavior, improve selection processes, and induce more thoughtful inquiring behavior on the part of physicians in training–in short, how to transform students into better medical professionals. Many sociologists sharing these goals with medical educators did excellent studies on such issues as coping with uncertainty, specialty selection, factors affecting professional socialization, and the like Other studies, however, examined medical education in terms of its values and contradictions. They focused on the incompatibility between educational rhetoric and the behavior of the faculty; they described the economic and prestige incentives that deterred faculty from their professed goals and values; and they viewed some of the less commendable behavior of medical students as adaptive to many of the contradictory challenges and incentives to which they were exposed. They questioned whether the ethical problem was simply a matter of more careful selection to avoid a few "bad apples" as physicians often saw the issue, the lack of a course in ethics, or the result of fundamental problems concerning the incentives and rewards within medicine. In short, they saw the problem not as one of simple remedies. In addition, critics of medical education were less impressed by the claims and status of the profession.

1.4.5 Medical sociology and physicians

Work in medical sociology, more closely tied to disciplinary interests, finds less acceptance among physicians and administrators because it looks at issues of health and medicine from the outside, commonly operating on premises that reject basic assumptions of the medical profession. Thus, in response to one study that described the deceptions used by house officers under pressure from their medical chief to gain autopsy permissions, one prominent physician lamented the preoccupation with "learning in its most ghoulish aspects" and warned that it just opened "new veins of muck for those who make it their business to rake the medical profession." An eminent physician, stung by a highly critical study of his service, lamented, "The authors' combination of smugness and naivete is hard to bear by someone who has been dealing with the realities." This is just one of many instances in which sociology from the outside was hard to take by those being studied.

Robert Petersdorf and Alvin Feinstein, in commenting on the field, note that such work "has been a troublesome domain for many clinicians, who believe their distinctive concerns for individual people are lost in collectivist beliefs about society, and whose generally conservative political views have clashed with the strongly liberal, often radical positions of many sociologists."It seems clear that these commentators–and probably most of their colleagues–prefer a sociology that is adjunct to medical activity and accepting of its basic premises. Such a sociology would simply be a servant to medicine, not fulfilling its larger responsibility to understand medicine as a social, political, and legal endeavor; to challenge its curative and technological imperatives; to examine equity of care in relation to class, race, gender, age, character of illness, and geographic area; and to study the appropriate goals and objectives for health care in the context of an aging society with an illness trajectory dominated by chronic disease.

Although the critical perspective accounts for only a part of sociological effort, it is an indispensable component. This is not to argue that such analyses are not occasionally overstated or that their failure to show understanding for the constraints under which health professionals and policymakers work sometimes undermines receptivity of the audience. Perhaps most grating to the practitioner is a tendency to view necessary restructuring less in terms of small adjustments and more in terms of major changes that, if not politically repugnant, may seem far-fetched or impractical. Yet such work and the perspectives underlying it have been enriching and over time have been accepted as part of conventional wisdom.

Sociologists have for decades studied organized forms of group practice, including health maintenance organizations (HMOs), making efforts to understand how alternative organization and payment arrangements affect access to and use of care and its costs. Researchers have inquired how patients' social class, race, gender, and geography affect the quality of communication with health professionals and access to specialized care and how interaction and communication processes relate to adherence with medical advice, patient satisfaction, and issues of equity. Seemingly esoteric concerns of sociology have now become commonplace, such as the rights of patients in human experimentation, choices in pregnancy and childbirth, the right to be informed about the nature of one's treatment, protection against the uses of medicine for social control purposes, the excessive use of medical technology, the importance of primary care, the role of social behavior in disease and disability, and the potential of prevention. *Disability as an example.* Because the scope of sociology is so broad, it is more useful to convey how sociologists think than to attempt to summarize the range of their concerns. The area of disability and rehabilitation offers one important example. From the early work of Talcott Parsons, it was clear that sickness and disability were, in part, social role definitions evolving from a system of expectations and social relationships. Expectations are seen as powerful influences in society, conditioning not only what is permitted but also the human possibilities of adaptation. Social norms and social arrangements commonly result in the unnecessary exclusion of persons with disabilities from many social settings and often indirectly undermine their subsequent motivations and efforts. Sociologists have often noted that the social definition of a chronic disease or impairment and the

processes of adaptation that relate to it shape future opportunities and constraints. In such instances as myocardial infarction, spinal injury, loss of hearing or sight, and other chronic disease and impairment, persons with comparable conditions adapt in varying ways to varying degrees. Whether the condition becomes the core of the person's identity and totally incapacitates function or whether it is more peripheral depends not only on personality and motivation but also on social arrangements and public attitudes. Whether a person with impairment becomes disabled thus depends in large part on how rehabilitation efforts are organized and the extent to which physical access, attitudes, and social reactions make jobs, recreation, and other forms of social participation feasible. Such thinking is the basis of the Americans with Disabilities Act, supported by a strong bipartisan coalition and pending action in Congress. These views are only now becoming commonplace. Yet their foundation and philosophy have been developing for decades by studies that established the deleterious ways in which people with disabilities were socially defined and dealt with.

1.4.6   SOME OF OTHER MAJOR CONTRIBUTIONS OF TH E SOCIOLOGY OF HEALTH AND ILLNESS:

- On the social psychological level, Mechanic has extended the early work on the sick role to consider illness behavior and what constitutes trust. Parsons (1951) made a major contribution in identifying the components of the sick role in terms of what was expected of the patient. Over the years, others criticized and expanded this model to include expectations of those with chronic illnesses and disabilities.

- Mechanic (1962) made contributions in considering what it meant to be ill and how one experienced and expressed illness. This work led him to reconsider the doctor–patient relationship and, on a more macro level, what illness meant in society. This stream of research has laid conceptual building blocks and theoretical foundations that make discussions of trust and social justice more sophisticated. As Mechanic (1989) points out, trust is the social glue that makes diagnosis and treatment possible on the individual level and social policy possible on the community and societal levels.

- On the organizational level, studies of national health care services, multiple hospital systems, assisted care facilities, hospices, support groups for those with HIV/AIDS and the environment within which these organizations operate have led to important findings about how the organization of health care directly impacts the cost, access and quality of care. This work is now expanding to important sets of cross-national studies that are examining the essentials of effective health care systems, how different organizational models may produce similar results and how the mix of populations served interact with the organizational structures of the delivery system to yield variable results. In other words, the organization of health care needs to be tailored to the needs of the population and local culture and environment. That is why there is persistent interest in comparative health care system.

- Inequality in health has also been a dominant theme of the sociology of health and illness which has evolved from a consideration of differences in behavior and material circumstances to a complex consideration of how health behaviors and material and social resources interact to produce differences in health outcomes both on the individual and community levels. Researchers in this area have illustrated the importance of social capital in dealing with health issues.

- Social capital refers to the social resources and networks available to individuals that help them define and cope with health problems. Consistent findings show that larger amounts of social capital are predictive of less disability, more support and a higher quality of life.

- Research on social equity has also highlighted the need to do multi-level analysis; to consider individuals in their environments and as members of a community and nation. Each layer of relationships is likely to explain some of the health outcomes and considering individuals in context permits a more fine-grained analysis of health and disease realities.

- Health-related quality of life research has directed attention beyond issues of mortality and morbidity to how people are living (Levine, 1987, 1995). This concept is applicable across the lifespan and groups of individuals.

- Investigations into quality of life have led to important distinctions between objective and subjective indicators of well-being. Albrechtand Devlieger (1999) discovered, for example, that there was a disability paradox raised by the apparent discrepancies between the quality of life of disabled people as perceived by the general public and those living with the disability. About 50 per cent of the people with serious and persistent disabilities in the study reported that they had a good or very good quality of life even though outside observers might deem otherwise. This type of result suggests that clinical and policy decision-makers need multiple sources of data to understand the desires, wants and experiences of vulnerable and disable people. As a consequence, quality of life is being incorporated into most judgments of treatment outcomes. Much progress is being made in this area.

- The work on health-related quality of life has also drawn renewed attention to the concepts of normalcy and deviancy (Phelan et al., 2000).

- The women's movement and interest in international health have illustrated how white male norms established at one point in history in postindustrial countries do not serve as useful reference points for the behavior of all people

- .Most research has been traditionally done on men by men and for men. Yet, recent research clearly demonstrates that women's health experiences and issues are different from those of men, requiring considerable changes in the conceptualization and delivery of health care for women and children. In fact, one of the major factors in improving the health of a nation is to educate women and make health resources available to them, for women are usually the people who care for children, older parents and disabled people.

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1.5 The Future of Medical Sociology

The Health Insurance Experiment and many of the studies that followed point to the extent to which the course of disease and the behavior of patients and health professionals are governed by noneconomic factors. The uncontrollable costs of medical care will continue to occupy a central place on the health policy agenda.

Inequities have increased in access to care and in quality of service, and significant

proportions of our population are under- or uninsured. Encouragement of competitiveness has basically demolished our system of community rating, making it difficult for those who most need health insurance to obtain it. Tax subsidies for insurance give substantial entitlements to the most affluent, encouraging over insurance and overuse among those who need care the least. We lack a viable strategy for organizing or paying for long-term care, despite the growing size of the elderly population and the old-old subgroup. Care for chronic illness–particularly for the stigmatized chronically mentally ill, alcohol and chemical abusers, and people with AIDS– is fragmented and in disarray. In the face of galloping medical technology, we lack standards of care and waste enormous resources through unnecessary and inappropriate procedures. Administrative costs are extraordinarily high. And, we have yet to effectively engage the tough ethical issues that biomedical advances make inevitable. Examination of the future health care agenda makes it abundantly clear that if we didn't have sociology of health we would now have to invent one. The influences affecting health and the provision of services are largely social, and the way we address problems of illness and care reflects our values and the arrangement of powerful interests within our social system. In a recent volume issued by The Henry J. Kaiser Family Foundation, *Pathways to Health: The Role of Social Factors,* substantial documentation is again presented, illustrating the pervasive influence of socioeconomic factors on disease processes, health status, longevity, and access to medical care. The integrity of our health care system requires that we address questions relating to such broad influences as well as to the more technical immediate ones and that we critically examine our goals and initiatives in the light of the best scientific knowledge of the determinants of health and welfare. There is little doubt that the powerful interests in our health care system, and our political processes of decision making, create serious obstacles to fundamental change. Nevertheless, a clear view of our goals, and the structures necessary to implement them, is an essential basis for constructive advancement.

1.6   Definition of Health & Illness:

🔸 HEALTH

Health is the basic human right of all the human beings. Health contributes to a person's basic capability to function. Denial of health is not only denial of 'good life-chance', but also denial of fairness and justice (Sen 2006). The Universal Declaration of Human Rights stated in Article 25: 'Everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family….'(United Nations 1948). The Preamble to the World Health Organization (WHO) constitution affirms that it is one of the fundamental rights of every human being to enjoy the highest attainable standards of health. Article 21 of the Constitution of India also identifies health as an integral aspect of human life (Desai 2007). Further, Article 47 (Part IV: directive principles of state policy) says: The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavor to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health. However, the spirit of the constitution hardly gets reflected in the health policies and programmes in India. Definitions and conceptualization of health may vary systemically among various social groups and it is likely that different accounts of health are drawn according to social circumstances.

Following are some simple points to understand health:

➢ Heath is a metaphor for well-being. To be healthy means to be of sound mind and body; to be integrated; to be whole. Over time and across societies, influential theorists have emphasized that health consists of balance, of being centered. The concept of health can be applied to human parts, as when we say, 'Your mother has a healthy heart' or 'Your father has a healthy psyche'. More generally, health refers to a holistic notion of individual well-being.

➢ One's perspective on health is oriented by cultural values (Gilman, 1995). For example, contemporary Western medicine evaluates the health of a body organ or individual through a series of technological laboratory tests used to determine if indicators of structure, such as readings of radiographs, and function, such as kidney filtration rates, fall within a 'normal' range for this individual in these circumstances.

➢ The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being, and does not consist only of the absence of disease or infirmity". This definition underscores the major theme of this chapter:

- Health is not just a matter personal choice, nor it is only a biological issue; patterns of wellbeing and illness are rooted in the organization of society.
- This definition also confirmed health as a social issue and this is borne out by evidence which demonstrates that standards of health have varied over time and also from one society, culture and country to another. For example, what is considered as good health in a low-income country such as Sri Lanka is very different to what is considered good health in the high-income UK. and insuring a safe environment.

➢ The biomedical approach which dominated the medical thought till the end of nineteenth century and based on the 'germ theory of disease' views health as an 'absence of diseases'. This approach almost ignores the role of environmental, psychological and other socio-cultural factors in defining health. The ecological approach views health as a dynamic equilibrium between man and his environment. For them, disease is maladjustment of the human organism to environment. The psychological approach states that health is not only related to the body but also to the mind and especially to the attitude of the individual. The socio-cultural approach considers health as a product of the social and community structure. A functional definition of health implies the ability of a person to participate in normal social roles.

➢ A **sociological understanding of health** considers structural and social factors, rather than simply biological explanations of health and disease. It describes the complex relationship between structural factors and personal choice in relation to health inequalities.

1.6.1 HEALTH: A GLOBAL SURVEY:

As mentioned in the above points health is closely linked with social life. Research shows that human well-being has improved over the long course of history as societies have developed economically. For the same reason there is striking differences in the health of rich and poor societies today.

1.6.1.1 Health in history:

Health passed through two phases:

- ❖ Our ancestors could do little to improve health with only simple technology. Hunters and gathers faced frequent food shortage, which sometimes forced mothers to abandon their children. Those lucky enough to survive infancy were still vulnerable to injury and illness, so half died by the age of twenty and few lived to the age of forty(Nolan & Lenski, 1999; Scupin, 2000).

- ❖ As societies developed agriculture, food became more plentiful. At social inequality also increased, so that the elites enjoyed better health than the peasants and slaves, who lived in crowed, unsanitary shelters and often went hungry. In the growing cities of medieval Europe, human waste and other refuse piled up in the streets, spreading infectious disease and plagues that periodically wiped out entire towns (Mumford, 1961).

1.6.1.2 Health in low-income countries:

Severe poverty in much of the world cuts life expectancy far below the seventy or more years typical of rich societies. People of most part of Africa have a life expectancy of barely fifty, and in poorest countries of the world, most people die before reaching their teen.

The World Health Organization reports that 1 billion people around the world- one in six- suffer from serious illness due to poverty. Bad health results just not for eating only one kind of food but, more commonly, from simply having too little to eat. Poor sanitation and malnutrition kill people of all ages, especially children.

In impoverished countries, safe drinking water is as hard to come by as balanced diet, and bad water carries a number of infectious diseases, including influenza, pneumonia, and tuberculosis, which are wide spread killers in poor societies today. To make matter worse, medical personnel are few and far between so the world's poorest people – many of whom live in central Africa- never see a physician. In poor nations with minimal medical care, it is no wonder that 10 percent of children die within the year of their birth.

In much of the world, illness and poverty form a vicious circle: Poverty breeds disease which in turn undermines people's ability to work. Moreover when medical technology does control infectious disease, the population of poor nations rises. Without resources to ensure the wellbeing of people they have now, poor societies can ill-afford population increases. Thus, programs that lower death rates in poor countries will succeed only if they are coupled with programs that reduce birth rates as well.

1.6.1.3 Health in high-income countries:

Industrialization dramatically changed patterns of human health. By 1800s, as the Industrial Revolution took hold, factory jobs took people from all over the countryside. Cities quickly became overcrowded, a conditions creating serious sanitation problems. Moreover, factories fouled the air with smoke, which few saw as threat to health until well into the twentieth century. Accidents in work place were common.

But industrialization gradually improved health by providing better nutrition and safer housing for most people. After 1850, medical advances began to control infectious diseases.

1.6.2 Current inequalities in health

It's a fact of modern times that the wealthy in all societies, have much better physical, mental and social health than the poor. This starts at birth with the poorest members of society having the highest infant mortality rates and continues throughout life as the wealthy enjoy better access to healthcare thus having a better chance of recovering from serious illnesses and major trauma. The present world average life expectancy is 67.8 years. In most developed societies it is 78 years plus, however in the lowest income countries health is undermined by lack of food and poor sanitation and the average life expectancy is below 50 years. Approximately half the children born in these countries do not make it into adulthood.

1.6.3 Sociological Perspective on Health

Sociology assumes that a functioning society depends upon healthy people and upon controlling illness. Although many believe that science alone determines illness, the sociological view points out that society determines sickness as well. For example, the culture defines diseases as legitimate if they have a clear "scientific" or laboratory diagnosis, such as cancer or heart disease. In the past, society considered conditions such as chemical dependency, whether drug- or alcohol-based, as character weaknesses, and denied those who suffered from addiction the sick role. Today, drug rehabilitation programs and the broader culture generally recognize addictions as a disease, even though the term "disease" is medically contested. In today's culture, addicts may take on the sick role as long as they seek help and make progress toward getting out of the sick role.

In the past, society first dismissed or judged various ailments, only to later recognize the ailments as legitimate. People now recognize premenstrual syndrome (PMS)—once considered female hypochondria—as a legitimate, treatable hormonal condition. Acquired Immunodeficiency Syndrome, or AIDS, first emerged in the early 1980s in the male homosexual community. Because of the disease's early association with a lifestyle many people considered immoral, society granted those who acquired the disease little to no sympathy and denied them the sick role. People punished these victims for violating the norms and values of the society, rather than recognizing them as legitimately ill. As society became more knowledgeable about the disease, and as the disease affected a broader portion of the population, attitudes toward AIDS and those afflicted changed as well.

Today some conditions still struggle for recognition as legitimate ailments. One controversial condition is **chronic fatigue syndrome**. Called the "yuppie flu," chronic fatigue syndrome generally affects

middle-class women, though men have also been diagnosed with it. Flu-like symptoms, including low-grade fever, sore throat, extreme fatigue, and emotional malaise, characterize the condition, which is often accompanied by depression. These symptoms may last for years and often result in disability. Sufferers experience difficulty in getting their condition recognized, not only by family and friends, but by insurance companies as well. Because of social hesitancy to accept chronic fatigue syndrome as legitimate, sufferers who are unable to work are often denied disability. Advocates have responded by renaming the disorder **chronic fatigue immune-deficiency syndrome**. This renaming associates the disorder with more scientific, readily recognized diseases. More families, physicians, and employers are now taking the disease seriously, so chronic fatigue sufferers are gaining support.

People with mental illnesses equally struggle for recognition and understanding. Although treatment conditions and understanding of mental illness have drastically improved, critics and mental health providers argue that considerable work remains. Prior to the 1960s, most mentally ill patients were locked away in places referred to as "insane asylums," in which patients were often sedated for easy control. Because of new drugs that reduce or eliminate many symptoms and changed attitudes toward mental illness brought about by the work of sociologists and psychologists, many asylums closed and thousands of patients were released to community group homes, halfway houses, or independent living. This movement toward community care produced mixed results, with most mental health professionals concluding that the majority of deinstitutionalized patients adapt well with appropriate community placement and follow-up. Critics point to an increase in homelessness coinciding with deinstitutionalization. They claim many homeless are mentally ill patients who need institutionalization or at least better mental health care.

Communities now face a number of issues due to deinstitutionalization because many localities object to group homes and halfway houses being located in their communities. Many wrongly believe that the mentally ill are more likely to commit crimes. Because of this misperception, as well as others, recovered mentally ill people, as well as those diagnosed and in treatment, are still stigmatized and discriminated against. In addition, turf wars can exist among mental-health professionals and over the use of drugs to control problematic behaviors. Psychiatrists and other medical doctors can prescribe drugs, while nonmedical professionals cannot. Insurance companies limit the kind of professional mentally ill patients may see and the length and cost of treatment. All these issues make it more difficult for mentally ill patients to get and remain in treatment.

Some mental illnesses, such as paranoid schizophrenia, require drug treatment for normal functioning. Patients in the community sometimes neglect to take their medication when they start feeling better, opting out of continued treatment and resulting in a relapse. Patients who stop taking their medications are the ones most likely to become homeless or to pose a danger to themselves or others. These are not the majority of patients being treated for a mental illness, however. People with conditions such as depression, panic, bipolar disorder (formerly known as manic depression), and a host of other debilitating conditions can respond well to other therapies in addition to medication. With treatment, they are no different from any other member of society. With increased awareness of mental and

emotional disorders, finding cost-effective ways to meet society's need to appropriately care for these patients and benefit from their many talents will become more critical.

1.6.4 The determinants of health

The determinants of health are a range of personal, social, economic and environmental factors which affect the health of individuals and communities. The context of people's lives affects their health and people are not often able to directly control many of these factors such as; where they live, the condition of their physical environment, their genetics, their education and occupation and their social and interpersonal relationships. Therefore, health promotion directs action at both those determinates of health outside a person's direct control such as environmental hazards and those within their control which include individual health behaviors such as smoking, diet and personal fitness.

1.6.5 Policies to improve health

In 1984 the World Health Organization advocated legislation, fiscal measures, organizational change, community development and spontaneous local activities against health hazards as methods of health promotion. One of the major targets of their health promotion programme was 'Equity in Health', meaning that everyone should have an equal opportunity to reach their full health potential. It does not mean eliminating all health differences but rather reducing those deemed avoidable or unfair.

Health promotion is often focused on changing behavioral risk factors and appears as 'health education' and 'social marketing.' Social marketing is the systematic application of marketing to achieve particular behavioral objectives for social good. It is used to promote 'merit goods' and discourage the consumption of 'demerit goods'. Examples of social marketing include campaigns to promote the wearing of seatbelts and to discourage smoking and to inform people of the relationship between sunbathing and skin cancer.

The promotion of a healthy lifestyle has also become a major media issue that goes far beyond guidelines concerning diet, fitness and awareness of health issues. Nowadays it promotes a culture of youthfulness, beauty and wellbeing via a multitude of treatments, procedures, pills, supplements, diets, exercise regimes, exercise equipment and alternative medicine plus an inordinate amount of health and fitness associated products. This type of promotion is commercial marketing aimed at those who are able and willing to pay for the goods and services.

Healthy living and a healthy lifestyle however does not need to be expensive. Education and the promotion of the fundamentals of good health should be a global initiative undertaken by all governments along with specific strategies to provide poorer communities with the basic requirements to enable them to adopt healthier lifestyles.

ILLNESS

> By contrast, to health illness refers to imbalance. Something is out of sync. This can be understood in terms of judgments about what constitutes the normal and abnormal (Lock, 2000). These judgments are made in terms of biomedical tests, individual perceptions of 'I

don't feel well' and the social construction of the abnormal. Like the analysis of health, an examination of illness can take place on the level of the diseased organ, the individual, the community or the nation. While discussions of pathology dominate the medical literature, social scientists point out that illness is culturally constructed and closely associated with the dominant social, political and moral order (Turner, 2000). Their argument is that regardless of the organic basis of disease, the cultural context and interpretation of illness has profound implications for an individual's sense of well-being and perceived attribution of responsibility. When we say, 'He is sick', we employ a rich metaphor which means much more than the person has been judged to have an organic pathology determined by biomedical tests. We mean that the person is out of balance judged from our perspective.

➢ Theories of illness have been based on imbalances in the body, in the person or in social relationships. The great healing systems of India, China and Europe, for example, are based on the analysis of and interventions in such imbalances. Ayurvedic medicine is based on the Hindu belief that the body contains three elementary substances representative of the three divine universal forces they call spirit, phelem and bile. These forces are comparable to the Greek 'humours' of blood, yellow bile, black bile and phlegm grounded in the four elements of fire, earth, air and water. In traditional Chinese medicine, there is a dualistic cosmic theory of the yang (the male force) and the yin (thefemale force). The body is made up of five elements: wood, fire, earth, metal and water. In these systems, specific illnesses were attributed to an inordinate amount of one force, element or humour. For instance in the Greek system, colds in the winter were due to phlegm and diarrhea in the summer to bile. In these three theoretical systems, illness depended on preservation of balance between these forces and it was the task of the healer to bring these forces into equilibrium.

➢ In a review of ethnographic data from 139 societies intended to sample the world's cultures, Murdock (1980) argues that an understanding of illness and by implication of health, across cultures can be based on theories of natural and supernatural causation. According to Murdock (1980: 9), theories of natural causation consist of 'any theory, scientific or popular, which accounts for the impairment of health as a physiological consequence of some experience of the victim in a manner that would appear reasonable to modern medical science'. Natural causation explanatory frameworks include theories of infection, stress, organic deterioration, accidents and overt human aggression. The germ theory of illness, for example, which drives Western scientific medicine, would fall under a natural causation model emphasizing infection.

➢ The theories of the supernatural causation of illness rest on assumptions that scientific Western medicine does not recognize as valid. According to Murdock's (1980: 17–27) analysis, there are three general types of theories of supernatural causation:
- *Theories of mystical causation*
- *Theories of animistic causation*
- *Theories of magical causation*.

Theories of mystical causation are 'any theory which accounts for the impairment of health as the automatic consequence of some act or experience of the victim mediated by some putative impersonal causal relationship rather than by the intervention of a human or supernatural being' (Murdock, 1980: 17). Some examples are the notion of 'fate' among the Romans and the breaking of food or sex taboos among the Thonga. *Theories of animistic causation* are 'any theory which ascribes the impairment of health to the behavior of some personalized supernatural entity – a soul, ghost, spirit or god' (Murdock,

1980: 19). An example is the concept of soul loss among the Tenino Indians of Oregon State in the United States. *Theories of magical causation* are 'any theory which ascribes illness to the covert action of an envious, affronted, or malicious being who employs magical means to injure his victims' (Murdock, 1980: 21). An example is the concept of the 'evil eye' invoked in Mediterranean cultures to explain illness and death. Each of these theories deals with the issues of:

> ❖ Agency: Who or what is causing the illness
> ❖ Social role: What is the role expected of the patient and of the healer?
> ❖ Symbols of knowledge, power and healing: What is the knowledge base of the healer? What symbols distinguish the healer from others in the community? and, What does purging by sweating or colonic therapy mean?
> ❖ Structure, process and outcome: Where should one seek help when ill? How does the healing take place? And, How should the healers be treated if they succeed or fail in their endeavors? (Ackerknecht, 1971; Porter, 1999).

Some studies on illness:

> ➤ Murdock (1980: 88–95) found that nearly 80 per cent of his sample had a notion of mystical retribution expressed through a sense of sin; the belief that acts in violation of some taboo or moral injunction would be followed by punishment of the individual or group which is the cause of their illness.

> ➤ Malinowski (1944, 1948) made a major contribution to our understanding of theories of illness and help seeking by analyzing how individuals seek help for illness or seek to restore balance when things are out of sorts. In his examination of the workings of magic, science and religion, Malinowski concluded that individuals seek help for maladies according to their cultural and societal frames. What they have learned and experienced gives meaning to and a sense of control over their illnesses. Malinowski and others also discovered that people can use multiple frames of reference in understanding disease and seeking help. For instance, among the Wakomba of Kenya, individuals would often seek help from their medicine man if they were 'sick'. But if that did not work, they might visit a health clinic to try Western scientific medicine delivered through a colored pill or injection by a doctor in a white coat. If the intervention of the medicine man and the doctor did not work, they might turn to their indigenous belief system or to the Christ of the missionaries. Often these approaches for help and interventions are commingled, with no one healer knowing that the others are being simultaneously invoked.

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Subjective illness:

> ➤ While health is defined either as an ideal state or absence of disease, illness is the subjective experience of feeling unwell.

> ➤ Defined by Radley, "Illness can be taken to mean the experiences of disease, including the feeling relating to changes in bodily states, and the consequences having to bear that ailment; illness therefore, relates to a way of being for the individual concerned".

➤ Illness therefore is what the individual senses that is 'wrong' with him or her, and may lead to making an appointment to see a doctor. Disease is what the individual has wrong with her or him on the return from that appointment.

➤ According to Cecil Helman (2007), a wide variety of subjective evidence is involved in the process of defining oneself as ill. These perceived alterations can be in physiognomy (for example, loss of weight), bodily emissions (for example, urinating frequently, or diarrhea), the working of specific organs (for example, heart beating fast, or headaches) or the emotions (for example, depression or anxiety).

➤ Helman (2007) describes the social context of illness. According to him, one cannot really understand how people react to illness, death, or misfortunes without an understanding of the type of culture they have grown up an or acquired – that is, of the 'lens' through which they perceive and interpret their world. So it is necessary to understand social organization of health and illness in that society which includes the ways in which people have become recognized as ill, the ways that they present this illness to other people, the attributes of those they present their illness to, and the ways that illness is dealt with.

➤ A ten-point inventory of reasons why people proceed from feeling ill towards being diagnosed as diseased was formulated in the 1960s by David Mechanic, a founder of sociological analysis of health/disease. Mechanic realized that there are many psychological and social phases before a person is diagnosed as suffering from an objective medical condition. For Mechanic (1968) the factors affecting an individual illness will depend on whether or not symptoms:

a) are highly visible and recognizable;
b) are regarded as serious/dangerous;
c) disrupt working and family responsibilities and other social routines;
d) repeat or persist;
e) breach the sufferer's tolerance level and /or that of others;
f) are understood well in terms of cause, treatment, and prognosis;
g) are feared greatly or feared only minimally;
h) figure high in the individual's hierarchy of needs when compared with other priorities;
i) are interpreted as with other normal activities rather than disease;
j) Can be treated easily in terms of available resources and time, and without embarrassment.

➤ In his study Morrall (1998) pointed out that the process of 'feeling ill' is not only dependent on the beliefs and actions of the individual, which in themselves are affected by social factors, but also upon behavior of disease-care practitioners.

➤ The term 'sickness' denotes the amalgamation of the two processes of feeling ill and being diagnosed as diseased. It alludes to the existence of a social role especially following a diagnosis, and that are obligations and rights that society confers on diseased individuals

Social illness:

- The social features in maintaining of health and the manifestation of disease is irrefutable. As, Marx describes that appalling social conditions experienced by the poor living in the large industrial cities of that age. He connected the cause of morbidity and mortality among the inhabitants of the slum areas, factory workers, and the unemployed to these social conditions.
- Engel's treatise accounts of how disease cannot be simply understood in terms of biology and pathology. Engels lays the blame for illness on the way in which (capitalist) society is structured, and in particular on the bourgeoisie.
- A study conducted in the late 1990s of the Indian city of Mumbai recorded how the systematic clearance of slums areas for new commercial and residential developments was responsible for eviction of 167,000 people. The children of these slum dwellers have protracted nutritional deprivation, diarrhea, respiratory disease, and skin infections, which were linked to the transitory nature of their residence and the effect this has on the family finances.
- The relationship between socio-economic inequalities and disease inequalities within rich countries is reified in the life expectancy figures with those at bottom of the socio-economic hierarchy dying younger than those at the top, children born into families of low socio-economic status having a much higher risk of death before five years ago.
- The social selection perspective suggests that the lower classes those with meager employment and educational, material deprivation contain most of the unhealthy people in society. Those with physical and mental disease will 'drift' into the disadvantaged stratum of society as a matter of course. The physically and mentally advantaged will maintain good health and gain social superiority. Self-evidently, the uneducated and unemployed, living within poor housing within disruptive communities, are more likely to be ill than are people with high educational and occupational attainment living in expensive and gated residential areas.
- Marmot et al. (1984) have demonstrated that occupational status is a robust predictor of life-threatening conditions. Certain work-based psychosocial factors, such as autonomy and variety or direction and monotony as, experienced by employees, appeared to be critical for good or bad health.
- The Whitehall study (a classical longitudinal research study of the structuralist perspective on analysis of health and diseases) established clearly the relationship between position in social hierarchy and morbidity and mortality. Evidence from this study implies that relative deprivation rather than absolute deprivation is significant determinant of morbidity and mortality. The lower the grade of employee, the higher the death rate.
- Sir Michael Marmot, professor of Epidemiology and Public Health explains the interplay between structural condition and illness. According to him social conditions such as education, nature of jobs, living conditions like housing and availability of adequate nutritious food, quality of health care are the determinants of health and illness.

1.7 Four Dimensions of Health:

World Health Organization defines health as....'a state of complete, physical, mental and social well being and not merely the absence of disease or infirmity'. This definition tells that, there are many paths to wellness that such as spiritual, environmental, emotional and physical health. Ensuring that all aspects of one's health are functioning well will help him develop a better sense of overall wellness. The term wellness can refer to a variety of conditions within the body. While many people associate their wellness to their physical health it can also be used to describe your environmental, mental, intellectual, occupational, emotional or spiritual well-being. These different dimensions of health interact together to help determine one's full quality of life. Following are four major dimensions of health.

➢ **Physical**

• Physical wellness can refer to any of the aspects that are needed to keep the body in top condition. It is the ability of human body to function properly.

• It is about the Structure and function of the body: The body's capacity to carry out everyday activities and be free from illness. It includes fitness, weight, body shape and ability to recover from illness.

• Consuming a healthy diet and getting an adequate amount of exercise to build cardiovascular health, endurance or flexibility are essential to this goal.

• One is responsible for his or her health care which means treating minor conditions and consulting a professional to manage more serious conditions.

• On the path to good physical health, one should Monitor warning signs so one understand when one's body is not getting the nutrition it needs or establishing an unhealthy state.

• One's physical health helps to improve determination, self-control and self-esteem. Sufficient amount of sleep, avoidance of harmful substances like tobacco products, and annual physical exams are some of the tips for maintain a good physical health.

• An ideal health numbers for conditions such as weight, cholesterol, blood pressure or blood sugar etc.

• This dimension of health focuses on the importance of moderate daily physical activity, proper nutrition, maintaining a healthy weight, getting recommended preventive screenings (based on age, gender and health history) and managing conditions to prevent them from getting worse.

• Increasing physical activity is one of the most effective ways to improve and maintain your health. Research shows that physical activity lowers the risk for many chronic conditions (e.g., diabetes, heart disease, obesity, bone and joint problems, and cancer), improves mood and boosts energy. Engaging in physical activities such as walking, bicycling or swimming with another person can provide a framework for a friendship, as well as afford accountability for physical wellness.

➢ **Social**

• Building and maintaining satisfying relationships comes naturally to us as we are social animals. Being socially accepted is also connected to our emotional well-being.

• The ability to make and maintain healthy relationships with other people. e.g. being able to relate to parents, friends, teachers in a way that your community finds acceptable.

• It also includes accepting social standards / norms of behavior, for instance, waiting in queues, behaving appropriately at the cinema.

• This dimension of health focuses on the process of creating and maintaining healthy relationships that provide support, such as from friends and family.

• A joint Yale University/University of Utah research study states, "The strongest evidence that social support is related to health or disease comes from studies of large populations demonstrating that social support or social networks are protective against all-cause mortality. It also appears that social support is negatively associated with cardiovascular death and that it protects against recurrent events and death among persons diagnosed with disease."

- Making time for positive experiences with friends and family can build emotional reserves and strengthen social connections for times of need.
- Social wellness is an ability to interact with people, respect yourself and others, develop meaningful relationships and develop quality communication skills. This allows you to establish a support system of family and friends.
- Those with high social wellness believe that it is important to
    1. Live in harmony with the environment and others.
    2. Consider the common welfare of the community over their own.
    3. Develop interdependent healthy relationships while developing healthy behavior.
    4. Create a balance between their community and the environment.
    - The social dimension of health is made up of the cultural and social aspects of the relationship between patients and health professionals. This relationship is a social negotiation affected by beliefs, practices, interests, and power dynamics. Communication within this relationship can have a powerful impact upon health outcomes. The influence of this relationship upon health is not limited to Western, allopathic, biomedical systems but is equally as important in other medical systems throughout the world.
- The stark fact is that most disease on the planet is attributable to the social conditions in which people live and work . The socially disadvantaged have less access to health services, and get sicker and die earlier than the privileged. Despite impressive technological advances in medicine, global health inequalities are worsening.
- Commonly accepted social determinants of health[edit]
- There is no single definition of the social determinants of health, but there are commonalities, and many governmental and non-governmental organizations recognize that there are social factors which impact the health of individuals.
- In 2003, the World Health Organization (WHO) Europe suggested that the social determinants of health included:
    1. Social gradients (life expectancy is shorter and disease is more common further down the social ladder)
    2. Stress (including stress in the workplace)
    3. Early childhood development
    4. Social exclusion
    5. Unemployment
    6. Social support networks
    7. Addiction
    8. Availability of healthy food
    9. Availability of healthy transportation
- The WHO later developed a Commission on Social Determinants of Health, which in 2008 published a report entitled "Closing the Gap in a Generation". This report identified two broad areas of social determinants of health that needed to be addressed. The first area was *daily living conditions*, which included healthy physical environments, fair employment and decent work, social protection across the lifespan, and access to health care. The second major area

was *distribution of power*, money, and resources, including equity in health programs, public financing of action on the social determinants, economic inequalities, resource depletion, healthy working conditions, gender equity, political empowerment, and a balance of power and prosperity of nations.

- The 2011 World Conference on Social Determinants of Health brought together delegations from 125 member states and resulted in the Rio Political Declaration on Social Determinants of Health. This declaration involved an affirmation that health inequities are unacceptable, and noted that these inequities arise from the societal conditions in which people are born, grow, live, work, and age, including early childhood development, education, economic status, employment and decent work, housing environment, and effective prevention and treatment of health problems.

- The United States Centers for Disease Control defines social determinants of health as "life-enhancing resources, such as food supply, housing, economic and social relationships, transportation, education, and health care, whose distribution across populations effectively determines length and quality of life". These include access to care and resources such as food, insurance coverage, income, housing, and transportation. Social determinants of health influence health-promoting behaviors, and health equity among the population is not possible without equitable distribution of social determinants among groups.

- Woolf states, "The degree to which social conditions affect health is illustrated by the association between education and mortality rates". Reports in 2005 revealed the mortality rate was 206.3 per 100,000 for adults aged 25 to 64 years with little education beyond high school, but was twice as great (477.6 per 100,000) for those with only a high school education and 3 times as great (650.4 per 100,000) for those less educated. Based on the data collected, the social conditions such as education, income, and race were very much dependent on one another, but these social conditions also apply independent health influences.

- Marmot and Bell found that in wealthy countries, income and mortality are correlated as a marker of relative position within society, and this relative position is related to social conditions that are important for health including good early childhood development, access to good quality education, rewarding work with some degree of autonomy, decent housing, and a clean and safe living environment. The social condition of autonomy, control, and empowerment turns are important influences on health and disease, and individuals who lack social participation and control over their lives are at a greater risk for heart disease and mental illness.

➤ **Emotional**

- Emotional wellness focuses on ensuring that you are attentive to your feelings, thoughts and behavior. This includes both positive and negative reactions, though overall you should seek an

optimistic approach to life, enjoying life in spite of occasional disappointment and adjust to change and express your emotions appropriately.

- This dimension of health focuses on an awareness and acceptance of feelings and stressors. Emotional well-being includes the ability to manage your feelings and related behaviors, the ability to cope effectively with stress, and the adaptability to change. There are practical ways to enhance mood, build resilience and improve your response to life's challenges. Just as it requires effort to build or maintain physical health, the same is necessary for emotional health.
- Emotions contribute to almost all aspects of our life, at times, even setting course of actions. Symptoms of emotional problems, such as hopelessness, depression, anxiety, and even suicidal tendencies are not always easily detectable but can lead to dire consequences.
- Awareness and acceptance of our strength and shortcomings is essential for our emotional well-being.

➢ **Spiritual**

- Spiritual wellness involves discovering a set of beliefs and values that brings purpose to your life.
- While different groups and individuals have a variety of beliefs regarding spiritualism but the general search for meaning for our existence is considered essential to creating harmony with yourself and others regardless of the path to spirituality you choose to follow.
- It is considered healthier to find your own path to the meaning of life that allows you to be tolerant of the beliefs of others and life a life that is consistent with your beliefs.

However, these dimensions interact and overlap. They also complement each other to form the whole person. Similarly change in one dimension affect the other dimensions. For example, a person who begins an exercise program to lose weight (physical) may also improve his or her self-esteem (emotional). A college student studying philosophy to fulfill university requirements (intellectual) may discover meaning in life, a purpose for living (spiritual). When someone is ill (physically), he probably doesn't feel like spending time with his friends (social).

1.8 Evolution of Social medicine in India.

1.8.1 What is Social Medicine? Meaning and scope:
- This history dates back (at least) to the early nineteenth century when the systematic study of the relationships between society, disease, and medicine began in earnest. This study—and the forms of medical practice derived from it—became known as **"social medicine."** Over time the term "social medicine" took on varied meanings as it was adapted to differing societies and diverse social conditions. Nonetheless, certain common principles underlie the term:

1. Social and economic conditions profoundly impact health, disease, and the practice of medicine.

2. The health of the population is a matter of social concern.

3. Society should promote health through both individual and social means.

- Social conditions contribute to ill health. This was described as early as the 19th century by Rudolf Virchow, generally considered the founder of social medicine.

- Social medicine, an approach to the prevention and treatment of disease that is based on the study of human heredity, environment, social structures, and cultural values.

- It is the field of medicine that studies the impact of the collective behavior of organized society on individuals belonging to various, often disadvantaged, subgroups within the society. This is found in Engel's phenomenon of Homelessness, Latchkey children, Supermom. Socialized medicine.

- It is a specialized field of medical knowledge concentrating on the social, cultural, and economic impact of medical phenomena. The field of social medicine seeks to: understand how social and economic conditions impact health, disease and the practice of medicine and foster conditions in which this understanding can lead to a healthier society.

- This type of study began formally in the early 19th century. The Industrial Revolution and the subsequent increase in poverty and disease among workers raised concerns about the effect of social processes on the health of the poor.

- Prominent figures in the history of social medicine include Rudolf Virchow, Salvador Allende, and more recently Paul Farmer and Jim Yong Kim.

- More specifically, Farmer et al. (2006) state that "Biosocial understandings of medical phenomena [such as the social determinants of health] are urgently needed". Paul Farmer's view is that modern medicine is focused at the molecular level, and there is a "gap" between social analysis and everyday clinical practices

- Moreover, Farmer, Nizeye, Stulac and Keshavjee (2006) view social medicine with increasing importance as scientific inquiry is increasingly "desocialized". The latter refers to "...a tendency to ask only biological question about what are in fact biosocial phenomena.

- The field of social medicine is most commonly addressed today by public health efforts to understand what are known as social determinants of health.

- Social medicine is distinguished from medico biological and clinical disciplines that study healthy and diseased states of the body.

- Social medicine is closely related to the social sciences, including political economy, sociology, demography, and the general theory of administration. It concentrates primarily on social conditions and studies the interrelationships between social and biological factors in medicine. Evaluations are made primarily on the basis of statistics.

Social medicine also utilizes evaluations made by specialists in various fields, experiments, models, questionnaires, and the historical method.

- The bases of social medicine are associated with the study of occupational diseases, medico topographical data, and public-health statistics. In the late 18th century the use of J. P. Frank's system of medical police promoted the state regulation of public health. In the 19th century the development of social medicine was associated with the rise of capitalism and with bourgeois-democratic revolutions. In Great Britain, France, Germany, and other countries data were gathered on how working and living conditions affected the health of workers. Statistical methods were used in making evaluations, and attempts were made to substantiate scientifically public-health measures. The term "social medicine" was introduced at this time.

- From the late 18th century until the 1870's specific issues were presented in medical-police and social-medicine courses in various countries. At the turn of the 20th century chairs of social medicine were established, and independent courses in social medicine and social hygiene were given by A. V. Korchak-Chepurkovskii in Kiev (from 1906), A. I. Shingarev in St. Petersburg (from 1908), L. Teleky in Vienna (from 1909), and A. Grotjahn in Berlin (from 1912). The subsequent development of social medicine proceeded under the influence of social democratic ideas and the class struggle of the proletariat in capitalist countries.

- The organizational basis of social medicine is the Soviet system of public health, which is directed toward the socioeconomic transformation of society and the elimination of social roots generating diseases and which makes available state measures for the protection of the health of citizens. It is under socialist conditions that social medicine is best able to elaborate the scientific bases for therapeutic preventive measures fostering the harmonious physical and spiritual development of man and promoting maximum life expectancy. The development of social medicine and the introduction of preventive medicine into medical practice and into the system of medical education were promoted by the activities of the sub departments of social medicine created in the First Moscow State University (N. A. Semashko, 1922), the Second Moscow State University (Z. P. Solov'ev, 1923), and the State Institute of Social Medicine (A. V. Mol'kov, 1923). Sub departments of social medicine were later created in all higher medical institutions.

- The leading scientific center on social medicine and public-health administration is the N. A. Semashko All-Union Scientific Research Institute of Social Medicine and the Organization of Public Health of the Ministry of Public Health of the USSR (Moscow). Research is being conducted in the USSR on theoretical issues of social medicine and the organization of public health, on social conditions and the health of the population, and on the scientific foundations of the economics and planning of public health. An automated public-health planning and administration system is being developed, and the scientific foundations of the organization of medical care and the training and education of the population in social medicine are under study. Social medicine is part

of the curriculum at several institutions outside the USSR, including the Institute of Social Hygiene and Health Organization of the People's Republic of Bulgaria, the Academy for Advanced Training of Physicians in the German Democratic Republic, and the Institute of Social Medicine and Organization of Public Health of the Czechoslovak Socialist Republic. All-Union, republic, and local societies of hygienists and public-health physicians have groups specializing in social medicine. International organizations that function in the area of social medicine include the World Health Organization (founded 1948), the International Medical Association for the Study of Living Conditions and Health (founded 1951), and the European Association of Social Medicine (founded 1955).

- In the USSR, social medicine is taught at medical institutes by departments of therapeutics, pediatrics, and public health and hygiene under the control of sub departments of social medicine and public-health organizations (from 1941 to 1966—sub-departments of public-health organizations). Outside the USSR it is controlled by sub departments of social medicine, public-health organizations, and community health protection.

- The most important domain of social medicine is the culture itself. Health professionals and institutions have their own cultures that also go beyond clinical interactions. Health systems and health research both contain agendas, prejudices, and beliefs that can lead to certain perspectives being favored as the most legitimate. Understanding the culture of medicine is essential to understanding health professionals' attitudes toward illness, patients, and treatments

1.8.2   Genesis and evolution of social medicine:

Preventive and Social Medicine (PSM) is relatively a new branch of medicine. It is often considered synonymous with Community Medicine, Public Health, and Community Health in India. All these share common ground, i.e. prevention of disease and promotion of health. In short, PSM provides comprehensive health services ranging from preventive, promotive, curative to rehabilitative services. The importance of the specialty of PSM has been very well recognized and emphasized repeatedly from grass root to international levels, not only in health sector but in other related sectors too. Whereas clinical specialties look after individual patient, PSM has to think and act in terms of whole community. The scope of medicine has expanded during the last few decades to include not only health problems of individuals, but those of communities as well. If we want to achieve Health for All, Community Medicine will definitely be the key factor during the next millennium.

The following points elaborate the evolution of social medicine:

- The industrial revolution of the 18th century while bringing affluence also brought new problems - slums, accumulation of refuse and human excreta, overcrowding and a variety of social problems. Frequent outbreaks of cholera added to the woes Chadwick's report on 'The Sanitary Conditions of Laboring Population (1842)' focused the attention of the people and Government on the urgent need to improve public health. Filth and garbage were recognized as

man's greatest enemies and it lead to great sanitary awakening bringing Public Health Act of 1848 in England, in acceptance of the principle that the state is responsible for the health of the people. The act was made more comprehensive in 1875 when Public Health Act 1875 was enacted. The public health movement in USA followed closely the English pattern. The organized professional body, American Public Health Association was formed in 1872. **The Indian Public Health Association was formed in 1958.**

- Public Health is defined as the process of mobilizing local, state, national and international resources to solve the major health problems affecting communities and to achieve Health For All by 2000 AD.

- Many different disciplines contributed to the growth of Public Health; physicians diagnosed diseases; sanitary engineers built water and sewerage systems; epidemiologists traced the sources of disease outbreaks and their modes of transmission; vital statisticians provided quantitative measures of births and deaths; lawyers wrote sanitary codes and regulations; public health nurses provided care and advice to the sick in their home; sanitary inspectors visited factories and markets to enforce compliance with public health ordinances; and administrators tried to organize everyone within the limits of the health departments budgets. Public Health thus involved Economics, Sociology, Psychology, Law, Statistics, and Engineering as well as biological and clinical sciences. Soon another important and emerging branch of medicine i.e., Microbiology became an integral part of Public Health. Public Health during the 19th Century was around sanitary regulations and the same underwent changes

- Preventive Medicine developed as a branch of medicine distinct from Public Health. By definition, preventive medicine is applied to 'healthy' people, customarily by actions affecting large numbers or populations. Its primary objective is prevention of disease and promotion of health. It got a firm foundation only after the discovery of causative agents of diseases and the establishment of the germ theory of disease. The development of laboratory methods for the early detection of disease was a further advance.

- Social Medicine has varying meanings attached to it. By derivation, it is the study of man as a social being in his total environment. It may be identified with care of patients, prevention of disease, administration of medical services; indeed with almost any subject in the extensive field of health and welfare. In short, social medicine is not a new branch of medicine but rather a new orientation of medicine to the changing needs of man and society.

- Community Medicine has been defined as that specialty which deals with populations…. and comprises those doctors who try to measure the needs of the population, both sick and well, who plan and administer services to meet those needs, and those who are engaged in research and teaching in the field.

- Decades old concept of health care approach has experienced a dramatic change. Today health is not merely an absence of disease; it is related to quality of life instead. Health is considered a means of productivity. Thus health development is essential to socio-economic development as a whole. Since health is an integral part of development, all sectors of society have an effect on health. Scope of medicine has extended from individual to community. Study of health and disease in population is replacing study of disease in man. Germ theory of disease gave place to

newer concepts - multi-factorial causation. Social and behavioral aspects of the disease have been accorded a new priority. Contemporary medicine is no longer solely an art and science for the diagnosis and treatment of diseases. It is also the science for the prevention of disease and promotion of health. Today technical sophistication of modern medicine is not an answer to everyday common ailments of the vast poor in the country. Appropriate technology and cheaper interventions like Oral Rehydration Solution (ORS), immunization, etc are increasingly being applied as life saving measures and for disease prevention in community health care. Physicians' role is no longer confined to diagnosing and treating those who come to the clinic. He is also responsible for those who need his service but cannot come to the clinic. Health of the people is not only the concern of health care providers. It is the responsibility of the community also to identify and solve their own health problems through their active participation.

- All these changes in concept and ideas of health and health care system are embodied in community health care. The spate of new ideas and concepts, for example, increasing importance given to social justice and equity, recognition of crucial role of community participation called for the new approaches to make medicine in the service of humanity more effective.

- Alma-Ata declaration in 1978 specified that Primary Health Care approach was the way of achieving the goal of Health **For All** by 2000 AD. Primary Health Care approach stressed that "essential health care should be made universally accessible to individuals and acceptable to them, through their full participation and at a cost the community and the country can afford".

1.8.3: Development of preventive and social medicine:

- The Public Health administration in India actually started in 1869 with the appointment of a Sanitary Commission. The first Municipal Act was passed in 1884 in Bengal. But in the Indian context J. P. Grant had visualized in 1939 that foreign models could not be suited for First Doctor Intervention or for Primary Health Care. His recommendations were also incorporated in Bhore Committee Report 1946, for building Community Physicians. The Bhore Committee's Report laid the foundation of modern public health care in India.

- On the recommendations of Medical Education Conference in 1955, departments of Preventive and Social Medicine were established in Medical colleges all over the country. The experimental learning of our predecessors and Gurus provided the foundation and led to growth and expansion of the frontiers of the subject of Community Medicine. It has today evolved as a field of learning that contributes immensely to the progress and development of societies, more significantly in developing nations like India. The professionals of Community Medicine have a major responsibility to shoulder i.e., to work for the health and well being of the people of India and contribute to education and production of basic doctors, well versed with handling community health problems. The objective of medical education is to produce a basic doctor who is competent to give comprehensive health care to individual, family and community. We need to bring about many changes, reforms in current medical education for achieving the desired objective.

- These departments have teaching / training, service and research components. But initially more emphasis was placed on teaching / training aspect. Beyond 1975, faculty members of Community Medicine were enriched with the field experiences in training, monitoring and evaluation with active participation in various National Programmes like ICDS (Integrated Child Development Scheme), EPI (Expanded Program on Immunization), UIP (Universal Immunization Program), CSSM (Child Survival and Safe Motherhood programme), NACP (National AIDS Control Program), RCH (Reproductive and Child Health programme) and have shared their experiences with the District / State / National Health Programme managers and also translated their experiences in Undergraduate and Postgraduate training and teaching.There are variations in teaching / training in Preventive and Social Medicine in different states of India which reflects the cultural diversity and varying needs of the local community. The research component has been a very poorly developed component of PSM so far mainly because of scarcity of funds.

- Medical colleges have the primary function of imparting undergraduate medical education. These colleges form the majority of institutions in India, which provide professional postgraduate qualification in Public Health. A school of public health like All India Institute of Hygiene and Public Health, Calcutta, especially established for the purpose without the responsibility of undergraduate medical education is an exception.

- It is noted that many medical colleges are unable to have good community-oriented, field-based programmes for demonstration and participatory education of the undergraduates. Medical colleges, by and large, remain isolated from health care system and play very limited role in public health services. However, desirable and positive changes through various approaches are taking place in the medical education system all over the world and in our country to enable it to stand up to the expectations of the country in the context of its overall social-economic-health development process e.g., by reorientation of curriculum, by community-based integrated teaching or by making medical colleges assume direct responsibility in providing health care, etc.

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1.8.4 : Challenges

- In the field of Public Health & Preventive Medicine, tremendous changes have taken place, but greater changes can be anticipated in the coming decades. Ideas and policies cannot be static and planning must have enough flexibility to cope with the fast-changing world of science and technology, of industrialization and urbanization. It is obvious that new horizons and super-specialties are fast emerging in Preventive and Social Medicine, like Epidemiology, MCH (Maternal and Child Health), IEC (Information Education Communication), Health Management, Health Economics, Nutrition, Demography, Health System Research, Environmental Health, etc. Current developments in Information Technology will certainly alter the face of Preventive and Social Medicine in the coming future.

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- There are many challenges in the field of Public Health. One of the challenges, which are successfully met, is "Eradication of Smallpox". This is a wonderful achievement which all of us are proud of. Another disease, which is successfully eliminated, is Guinea worm disease. There were setbacks in some of the programmes like Malaria, Tuberculosis that made us rethink and re-modify the strategies and re-implement these national health programmes. As we are able to control some diseases, there will be new emerging as well re-emerging diseases. This faculty has to be remain alert all the time and prepared for meeting the new challenges

Summary:

- Health is a social issue because personal well-being depends on society's technology as well as its distribution of resources. Culture shapes definitions of health and patterns of health care.
- Historically, human health was poor by today's standards. Health improved dramatically because of industrialization and later because of medical advances.
- Poor nations suffer from inadequate sanitation, hunger, and other problems linked to poverty. In the poorest nations, half the children do not survive to adulthood.
- The sociology of health and illness requires a global approach of analysis because the influence of societal factors which also varies throughout the world. Diseases are examined and compared based on the traditional medicine, economics, religion, and culture that is specific to each region.
- There are obvious differences in patterns of health and illness across societies, over time, and within particular society types. There has historically been a long-term decline in mortality within industrialized societies, and on average, life-expectancies are considerably higher in developed, rather than developing or undeveloped, societies. Patterns of global change in health care systems make it more imperative than ever to research and comprehend the sociology of health and illness.
- There are enduring differences between social classes in relation to health. In terms of early mortality, morbidity and a range of other health indicators disadvantaged groups have considerably poorer outcomes than advantaged groups. There are two current theories attempt to explain class and health inequalities: Psycho-social and Neo-material. The psycho-social perspective highlights how societies lacking in social cohesion have poor health, while the neo-material perspective emphasizes access to resources.

- Research indicates that ethnic minority groups display an ill-health burden. The reason for this burden of ill-health mainly relate to socio-economic factors, the effects of racism and negative experiences of medical and health services rather than a genetic or cultural explanation. People from ethnic minority groups are more likely to have lower paid and more insecure jobs, worse housing and greater chances of being in poverty than the majority population.
- The sociological study of gender and health is in a period of change. Gender relations are increasingly complex with many challenges to male dominance in society. Gender theories now emphasize the complexities of many varied forms of masculinities and femininities.
- Many more people in contemporary society are reporting and experiencing distress and depression. Sociology of health helps us understand how mental health is framed in and by society. The attitudes of others and wider society greatly affect the well-being of those experiencing distress. Wider social inequalities are visible in the distribution of diagnosed and reported mental health problems.
- Different theoretical approaches are vital to fully understand health and illness. A major part of functional analysis is the sick-role, which excuses the ill person from routine social responsibilities. The Symbolic-interaction paradigm investigates how health and medical treatments are largely matters of socially constructed definitions. Social-conflict analysis focuses on unequal distribution of health and medical care. Feminist theory makes a substantial contribution to the understanding of health and illness by providing an analysis of gender relations on the basis of the way in which female inequality has been structured and maintained in society.
- Health promotion is the process of enabling people to increase control over the determinants of health and thus improve their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions.
- In the field of sociology in medicine, sociologists work as applied investigators or technicians, seeking to answer questions of interest to their sponsors, whether government agencies, foundations, hospitals, or medical schools. Depending on the ingenuity of the researcher. Sociology of medicine, in contrast, focuses on testing sociological hypotheses, using medicine as an arena for studying basic issues in social stratification, power and influence, social organization, socialization, and the broad context of social values.
- On the social psychological level, Mechanic has extended the early work on the sick role to consider illness behavior and what constitutes trust. Parsons made a major contribution in identifying the components of the sick role in terms of what was expected of the patient.
- By contrast, to health illness refers to imbalance. Something is out of sync. Malinowski made a major contribution to our understanding of theories of illness and help seeking by analyzing how individuals seek help for illness or seek to restore balance when things are out of sorts. In his examination of the workings of magic, science and religion, Malinowski concluded that individuals seek help for maladies according to their cultural and societal frames. Subjective illness is the experiences of disease, including the feeling relating to changes in bodily states, and the consequences having to bear that ailment. Social illness is the social features in maintaining of health and the manifestation of disease.

- There are four dimensions of health e.g. physical, social, intellectual and spiritual. All these dimensions interact and overlap. They also complement each other to form the whole person. Similarly change in one dimension affect the other dimensions.
- Social medicine, an approach to the prevention and treatment of disease that is based on the study of human heredity, environment, social structures, and cultural values. It is a specialized field of medical knowledge concentrating on the social, cultural, and economic impact of medical phenomena. The field of social medicine seeks to: understand how social and economic conditions impact health, disease and the practice of medicine and foster conditions in which this understanding can lead to a healthier society.

Key Words

Health – a state of complete physical, mental' and social well-being.

The biomedical model – a model of disease and illness that regards them as the consequence of certain malfunctions of the human body.

Holistic approach – Involving a focus on the whole rather than on specific parts or aspects.

socialization– the life long social experience by which individuals develop their human potential and learn culture.

Sick role – patterns of behavior defined as appropriate for people who are ill.

Structure - any relatively stable pattern of social behavior.

Class- a complex stratification of society based on access to and control of power, status and economic resources.

Psycho-social perspective- how societies lacking social cohesion have poor health.

Neo-material perspective- how societies lacking access to resources have poor health.

Race- biological difference between people based on physical features.

Ethnicity- the cultural heritage and identity of a group of people.

Racism- the supposed racial superiority of one group over another.

Gender- the social, cultural and psychological differences between men and women.

Gender roles- attitudes and activities that that a society links to each sex.

mortality- the incidence of death in a country's population.

Stigma- attitude that discredits someone's full acceptance in a particular situation.

Functionalism- an explanation of human society as a collection of inter-related sub-structures.

Symbolic interactionism - a frame work for building theory that sees society as the product of the everyday interactions of individuals.

Marxism- a frame work for building theory that sees society as an arena of inequality that generates conflict and change.

Feminism- explains social structures as fundamentally based on inequalities between women and men.

Postmodernism- understanding the social world around us.

Mystical causation- theory which accounts for the impairment of health as the automatic consequence of some act or experience of the victim.

Animistic causation- theory which ascribes the impairment of health to the behavior of some personalized supernatural entity – a soul, ghost, spirit or god.

Social role- behavior expected of someone holds a particular status.

Subjective illness- subjective experience of feeling unwell.

Social illness- socio-economic inequalities causing illness

Social medicine- an approach to the prevention and treatment of disease that is based on the study of human heredity, environment, social structures, and cultural values.

Further Readings:

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3. The MIND website has a wealth of useful and interesting information: http:/ / www.mind.org.uk/
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Unit-II:

Hospital as Social Organization, Types of Hospitals-General Hospitals, Specializing Hospitals. Functions of hospitals, Interpersonal relationship in Hospital settings.

Unit-II

2.0. Objectives of the Unit
2. 1.Hospital as Social Organization

   2.2.1 History of hospitals

      2.2.1.1   Hospitals in medieval Islam

      2.2.1.2   Medieval Europe

      2.2.1.3   Early modern & Enlightenment Europe

      2.2.1.4   19th century

      2.2.1.5. The modern hospital

   2.2.2 Ownership and control

   2.2.3   Financing

   2.2.4   Departments

2.3.   Types of Hospitals-General Hospitals, Specializing Hospitals:

2.4.   Functions of hospitals:

   2.4.1.Major functions of hospitals:
   2.4.2   Some critical points regarding functions of hospitals:
       2.4.2.1 Unequal distribution of health services Contributing to Health Inequalities across status groups:
       2.4.2.2   Social institutions and health service organizations (hospitals):

       2.4.2.3   The structure of health care organizations and the quality of health services:

       2.4.2.4   Health services in the twenty-first Century: Policy implications, future challenges, and reform:
2.5   Interpersonal relationship in Hospital settings:

2.0. Objectives of the Unit:

The main objective of this unit is to provide information on the health care system as an important component of health sociology. After the completion of studying this unit the students will gain some fundamental knowledge on the following topics:

- ❖ Structure and functions of hospital.
- ❖ The correlation between unequal distribution of health services and health inequalities
- ❖ Meaning of Interpersonal relationship in hospital setting and its importance.
- ❖ Theories and studies on Interpersonal relationship.
- ❖ Development of Trans-Cultural nursing care

2. 1.Hospital as Social Organization

Public and professional interest in health services has increased dramatically over the last two decades. Medical sociologists have been interested in the structure, organization, dynamics, and impact of health services for well over 50 years. Our healthcare system has evolved and changed dramatically over the same period, shifting from one focused on providing acute care for immediate and emergent health problems to a more diffuse system struggling to support individuals with chronic and long term conditions while also controlling costs (Wholey and Burns 2000). Not surprisingly, medical sociological interest in health services has followed suit and expanded to examine a wider variety of settings, conditions, and processes within the formal health care delivery system. Scholarship initially focused largely on understanding the structural and institutional underpinnings of healthcare systems, and later on exploring the variability in access to health care across social groups. More recently, sociological health services research has concentrated on the structure of and dynamics within health service organizations and how these factors shape both access and clinical outcomes for different groups and communities.

Before managed care, hospitals operated largely as autonomous units. Today, most are evolving to become the nuclei of wider, regionally focused health networks formed through the acquisition or merger of specialty and allied health care agencies and the development of new ambulatory care facilities (e.g., urgent care centers, outpatient surgery centers) and specialty branch hospitals (e.g., children's, cardiac, orthopedic hospitals; Andersen and Mullner 1989; Cuellar and Gertler 2003; Weinberg 2003). Sociologists have been instrumental in highlighting the challenges associated with integrating care, as well as the inter- and intra-organizational dynamics that are occurring within increasingly complex healthcare systems (Flood and Fennel 1995; Light 2004; Scott et al. 2000). Understanding these organizational changes is critical because they reflect fundamental shifts in the nature of medical work and the delivery of health services. As health care organizations have become more highly specialized, internally differentiated technologically oriented, and more tightly integrated (Scott et al. 2000), the professional boundaries of medical work have blurred. Initially, medical sociologists suggested that these organizational changes had the potential to lead to the "deprofessionalization" of medicine (Haug 1973)and to undermine physicians' professional dominance within the health care system (Light 2004).Indeed, the greater emphasis on the "business of health care" and the rise of health administrators clearly have changed the traditional role of physicians by reducing or restricting their authority over clinical decision-making (Hafferty and Light1995). Today's complex health systems represent fundamentally new configurations of an increasingly broad array of professional expertise that is altering the long-standing system of professional. In this chapter, the

health care system has been elaborately discussed focusing mainly on hospital system. Following are some of the points focusing on hospital as a social organization.

- Hospital word has been derived from the Latin word 'HOSPES' meaning 'a host or guest' or 'hotel', hostel.

- Some also believe that the origin of the hospital from the word 'HOSPITUM' a rest house for travelers or night shelter showing 'hospitality' to the guests.

- Hospital is a social organization and logical combination of the activities of a number of persons with different level of knowledge and skill for achieving a common goal of patient care through a hierarchy of authority and responsibility.

- Hospital as a social organization process through grouping the activities in workable units and connected by authority, communication and control.

- According to World Health Organization:"The 'hospital is an integral part of a social and medical organization, the function of which is to provide the population complete healthcare, both curative and preventive, and whose out-patient services reach out to the family in its home environment; the hospital is also a centre for the training of health workers and for bio-social research."

- Hospital is a social organization and a rational combination of the activities of a number of persons with different level of knowledge and skills for achieving a common goal of patient care through a hierarchy of authority and responsibility.

- Hospital organization is very peculiar and differs from other organizations. Hence called a 'MATRIX' organization.

- Hospital as a **'MATRIX' organization** is a mix of product and function where people of similar skills are grouped together to execute activities to achieve organizational objective.

- In a hospital some part of the organization has scalar type of function while others are informally structured.

- As a social organization the hospital provides patient care with a multi-functional team comprising of people with different level of knowledge and skill.

- Hospital, an institution that is built, staffed, and equipped for the diagnosis of disease; for the treatment, both medical and surgical, of the sick and the injured; and for their housing during this process. The modern hospital also often serves as a centre for investigation and for teaching.

2.2.1   History of hospitals:

The earliest documented institutions aiming to provide cures were ancient Egyptian temples. In ancient Greece, temples dedicated to the healer-god Asclepius, known as Asclepieia functioned as centers of medical advice, prognosis, and healing. Asclepeia provided carefully controlled spaces conducive to healing and fulfilled several of the requirements of institutions created for healing. Under his Roman name Æsculapius, he was provided with a temple (291 BC) on an island in the Tiber in Rome, where similar rites were performed.

As early as 4000 bce , religions identified certain of their deities with healing. The temples of Saturn, and later of Asclepius in Asia Minor, were recognized as healing centers. Brahmanic hospitals were established in Sri Lanka as early as 431 bce, and King Ashoka established a chain of hospitals in Hindustan about 230 bce. Around 100 bce the Romans established hospitals (valetudinarian) for the treatment of their sick and injured soldiers; their care was important because it was upon the integrity of the legions that the power of ancient Rome was based.

The Romans constructed buildings called valetudinaria for the care of sick slaves, gladiators, and soldiers around 100 B.C., and many were identified by later archaeology. While their existence is considered proven, there is some doubt as to whether they were as widespread as was once thought, as many were identified only according to the layout of building remains, and not by means of surviving records or finds of medical tools. Saint Sampson the Hospitable built some of the earliest hospitals in the Roman Empire. It can be said, however, that the modern concept of a hospital having been converted to Christianity, abolished all pagan hospitals and thus created the opportunity for a new start. Until that time disease had isolated the sufferer from the community. The Christian tradition emphasized the close relationship of the sufferer to the members of the community, upon whom rested the obligation for care. Illness thus became a matter for the Christian church.

About 370 ce St. Basil the Great established a religious foundation in Cappadocia that included a hospital, an isolation unit for those suffering from leprosy, and buildings to house the poor, the elderly, and the sick. Following this example, similar hospitals were later built in the eastern part of the Roman Empire. Another notable foundation was that of St. Benedict of Nursia at Montecassino, founded early in the 6th century, where the care of the sick was placed above and before every other Christian duty. It was from this beginning that one of the first medical schools in Europe ultimately grew at Salerno and was of high repute by the 11th century. This example led to the establishment of similar monastic infirmaries in the western part of the empire.

The Hôtel-Dieu of Lyon was opened in 542 and the Hôtel-Dieu of Paris in 660. In these hospitals more attention was given to the well-being of the patient's soul than to curing bodily ailments. The manner in which monks cared for their own sick became a model for the laity. The monasteries had an infirmitorium, a place to which their sick were taken for treatment. The monasteries had a pharmacy and frequently a garden with medicinal plants. In addition to caring for sick monks, the monasteries opened their doors to pilgrims and to other travelers.

Institutions created specifically to care for the ill also appeared early in India. Fa Xian, a Chinese Buddhist monk who travelled across India ca. 400 CE, recorded in his travelogue that: The heads of the Vaisya [merchant] families in them [all the kingdoms of north India] establish in the cities houses for dispensing charity and medicine. All the poor and destitute in the country, orphans, widowers, and childless men, maimed people and cripples, and all who are diseased, go to those houses, and are provided with every kind of help, and doctors examine their diseases. They get the food and medicines which their cases require, and are made to feel at ease; and when they are better, they go away of themselves. The earliest surviving encyclopedia of medicine in Sanskrit is the Carakasamhita (Compendium of Caraka). According to Dr.Wujastyk, the description by Fa Xian is one of the earliest accounts of a civic hospital system anywhere in the world and, coupled with Caraka's description of how a clinic should be equipped, suggests that India may have been the first part of the world to have evolved an organized cosmopolitan system of institutionally-based medical provision.

According to the Mahavamsa, the ancient chronicle of Sinhalese royalty, written in the sixth century A.D., King Pandukabhaya of Sri Lanka (reigned 437 BC to 367 BC) had lying-in-homes and hospitals (Sivikasotthi-Sala) built in various parts of the country. This is the earliest documentary evidence we have of institutions specifically dedicated to the care of the sick anywhere in the world. Mihintale Hospital is the oldest in the world. Ruins of ancient hospitals in Sri Lanka are still in existence in Mihintale, Anuradhapura, and Medirigiriya.

The declaration of Christianity as accepted religion in the Roman Empire drove an expansion of the provision of care. Following the First Council of Nicaea in 325 A.D. construction of a hospital in every cathedral town was begun. Among the earliest were those built by the physician Saint Sampson in Constantinople and by Basil, bishop of Caesarea in modern-day Turkey. Called the "Basilias", the latter resembled a city and included housing for doctors and nurses and separate buildings for various classes of patients. There was a separate section for lepers. Some hospitals maintained libraries and training programmes, and doctors compiled their medical and pharmacological studies in manuscripts. Thus in-patient medical care in the sense of what we today consider a hospital was an invention driven by Christian mercy and Byzantine innovation. Byzantine hospital staff included the Chief Physician (archiatroi), professional nurses (hypourgoi) and the orderlies (hyperetai). By the twelfth century, Constantinople had two well-organised hospitals, staffed by doctors who were both male and female. Facilities included systematic treatment procedures and specialised wards for various diseases.

A hospital and medical training centre also existed at Gundeshapur. The city of Gundeshapur was founded in 271 CE by the Sasanian king Shapur I. It was one of the major cities in Khuzestan province of the Persian empire in what is today Iran. A large percentage of the populations were Syriacs, most of whom were Christians. Under the rule of Khusraw I, refuge was granted to Greek Nestorian Christian philosophers including the scholars of the Persian School of Edessa (Urfa)(also called the Academy of Athens), a Christian theological and medical university. These scholars made their way to Gundeshapur in 529 following the closing of the academy by Emperor Justinian. They were engaged in medical sciences and initiated the first translation projects of medical texts. The arrival of these medical practitioners from Edessa marks the beginning of the hospital and medical centre at Gundeshapur.[21] It included a medical school and hospital (bimaristan), a pharmacology laboratory, a translation house, a

library and an observatory. Indian doctors also contributed to the school at Gundeshapur, most notably the medical researcher Mankah. Later after Islamic invasion, the writings of Mankah and of the Indian doctor Sustura were translated into Arabic at Baghdad.

2.2.1.1   Hospitals in medieval Islam:

The first prominent Islamic hospital was founded in Damascus, Syria in around 707 with assistance from Christians. However most agree that the establishment at Baghdad was the most influential; it opened during the Abbasid Caliphate of Harun al-Rashid in the 8th century. The bimaristan (medical school) and bayt al-hikmah (house of wisdom) were established by professors and graduates from Gundeshapur and was first headed by the Christian physician Jibrael ibn Bukhtishu from Gundeshapur and later by Islamic physicians.

In the ninth and tenth centuries the hospital in Baghdad employed twenty-five staff physicians and had separate wards for different conditions. The Al-Qairawan hospital and mosque, in Tunisia, were built under the Aghlabid rule in 830 and was simple, but adequately equipped with halls organised into waiting rooms, a mosque, and a special bath. The first hospital in Egypt was opened in 872 and thereafter Fsprang up all over the empire from Islamic Spain and the Maghrib to Persia. The first Islamic psychiatric hospital opened in Baghdad in 705. Many other Islamic hospitals also often had their own wards dedicated to mental health.

During this era, physician licensure became mandatory in the Abbasid Caliphate. In 931 AD, Caliph Al-Muqtadir learned of the death of one of his subjects as a result of a physician's error. He immediately ordered his muhtasib Sinan ibn Thabit to examine and prevent doctors from practicing until they passed an examination. From this time on, licensing exams were required and only qualified physicians were allowed to practice medicine.

2.2.1.2   Medieval Europe:

The church at Les Invalides in France showing the often close connection between historical hospitals and churches.

Medieval hospitals in Europe followed a similar pattern to the Byzantine. They were religious communities, with care provided by monks and nuns. (An old French term for hospital is hôtel-Dieu, "hostel of God.") Some were attached to monasteries; others were independent and had their own endowments, usually of property, which provided income for their support. Some hospitals were multi-functional while others were founded for specific purposes such as leper hospitals, or as refuges for the poor, or for pilgrims: not all cared for the sick. The first Spanish hospital, founded by the Catholic Visigoth bishop Masona in 580AD at Mérida, was a xenodochium designed as an inn for travelers (mostly pilgrims to the shrine of Eulalia of Mérida) as well as a hospital for citizens and local farmers. The hospital's endowment consisted of farms to feed its patients and guests.

The Ospedale Maggiore, traditionally named Ca' Granda (i.e. Big House), in Milan, northern Italy, was constructed to house one of the first community hospitals, the largest such undertaking of the fifteenth century. Commissioned by Francesco Sforza in 1456 and designed by Antonio Filarete it is among the first examples of Renaissance architecture in Lombardy.

The Normans brought their hospital system along when they conquered England in 1066. By merging with traditional land-tenure and customs, the new charitable houses became popular and were distinct from both English monasteries and French hospitals. They dispensed alms and some medicine, and were generously endowed by the nobility and gentry who counted on them for spiritual rewards after death.

Religion continued to be the dominant influence in the establishment of hospitals during the middle Ages. The growth of hospitals accelerated during the Crusades, which began at the end of the 11th century. Pestilence and disease were more potent enemies than the Saracens in defeating the crusaders. Military hospitals came into being along the traveled routes; the Knights Hospitallers of the Order of St. John in 1099 established in the Holy Land a hospital that could care for some 2,000 patients. It is said to have been especially concerned with eye disease, and it may have been the first of the specialized hospitals. This order has survived through the centuries as the St. John Ambulance. Throughout the Middle Ages, but notably in the 12th century, the number of hospitals grew rapidly in Europe. Arab hospitals—such as those established at Baghdad and Damascus and in Córdoba in Spain—were notable for the fact that they admitted patients regardless of religious belief, race, or social order. The Hospital of the Holy Ghost, founded in 1145 at Montpellier in France, established a high reputation and later became one of the most important centers in Europe for the training of doctors. By far the greater number of hospitals established during the middle Ages, however, were monastic institutions under the Benedictines, who are credited with having founded more than 2,000.

The middle Ages also saw the beginnings of support for hospital-like institutions by secular authorities. Toward the end of the 15th century, many cities and towns supported some kind of institutional health care: it has been said that in England there were no fewer than 200 such establishments that met a growing social need. This gradual transfer of responsibility for institutional health care from the church to civil authorities continued in Europe after the dissolution of the monasteries in 1540 by Henry VIII, which put an end to hospital building in England for some 200 years. The loss of monastic hospitals in England caused the secular authorities to provide for the sick, the injured, and the handicapped, thus laying the foundation for the voluntary hospital movement. The first voluntary hospital in England was probably established in 1718 by Huguenots from France and was closely followed by the foundation of such London hospitals as the Westminster Hospital in 1719, Guy's Hospital in 1724, and the London Hospital in 1740. Between 1736 and 1787, hospitals were established outside London in at least 18 cities. The initiative spread to Scotland, where the first voluntary hospital, the Little Hospital, was opened in Edinburgh in 1729. The first hospital in North America (Hospital de Jesús Nazareno) was built in Mexico City in 1524 by Spanish conquistador Hernán Cortés; the structure still stands. The French established a hospital in Canada in 1639 at Quebec city, the Hôtel-Dieu du Précieux Sang, which is still in operation (as the Hôtel-Dieu de Québec), although not at its original location. In 1644 Jeanne Mance, a French noblewoman, built a hospital of ax-hewn logs on the island of

Montreal; this was the beginning of the Hôtel-Dieu de St. Joseph, out of which grew the order of the Sisters of St. Joseph, now considered to be the oldest nursing group organized in North America. The first hospital in the territory of the present-day United States is said to have been a hospital for soldiers on Manhattan Island, established in 1663. The early hospitals were primarily almshouses, one of the first of which was established by English Quaker leader and colonist William Penn in Philadelphia in 1713. The first incorporated hospital in America was the Pennsylvania Hospital, in Philadelphia, which obtained a charter from the crown in 1751.

2.2.1.3   Early modern & Enlightenment Europe:

In Europe the medieval concept of Christian care evolved during the sixteenth and seventeenth centuries into a secular one. After the dissolution of the monasteries in 1540 by King Henry VIII the church abruptly ceased to be the supporter of hospitals, and only by direct petition from the citizens of London, were the hospitals St Bartholomew's, St Thomas's and St Mary of Bethlehem's (Bedlam) endowed directly by the crown; this was the first instance of secular support being provided for medical institutions. 1820 Engraving of Guy's Hospital in London one of the first voluntary hospitals to be established in 1724.

The voluntary hospital movement began in the early 18th century, with hospitals being founded in London by the 1710s and 20s, including Westminster Hospital (1719) promoted by the private bank C. Hoare & Co and Guy's Hospital (1724) funded from the bequest of the wealthy merchant, Thomas Guy. Other hospitals sprang up in London and other British cities over the century, many paid for by private subscriptions. St. Bartholomew's opened in London in 1730 and the London Hospital in 1752.

These hospitals represented a turning point in the function of the institution; they began to evolve from being basic places of care for the sick to becoming centers of medical innovation and discovery and the principle place for the education and training of prospective practitioners. Some of the era's greatest surgeons and doctors worked and passed on their knowledge at the hospitals. They also changed from being mere homes of refuge to being complex institutions for the provision of medicine and care for sick. The Charité was founded in Berlin in 1710 by King Frederick I of Prussia as a response to an outbreak of plague.

The concept of voluntary hospitals also spread to Colonial America; the Pennsylvania Hospital opened in 1752, New York Hospital in 1771, and Massachusetts General Hospital in 1811. When the Vienna General Hospital opened in 1784 (instantly becoming the world's largest hospital), physicians acquired a new facility that gradually developed into one of the most important research centers.

Another Enlightenment era charitable innovation was the dispensary; these would issue the poor with medicines free of charge. The London Dispensary opened its doors in 1696 as the first such clinic in the British Empire. The idea was slow to catch on until the 1770s, when many such organizations began to appear, including the Public Dispensary of Edinburgh (1776), the Metropolitan Dispensary and Charitable Fund (1779) and the Finsbury Dispensary (1780). Dispensaries were also opened in New York 1771, Philadelphia 1786, and Boston 1796.

2.2.1.4 19th century:

English physician Thomas Percival (1740-1804) wrote a comprehensive system of medical conduct, 'Medical Ethics, or a Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons (1803) that set the standard for many textbooks. A ward of the hospital at Scutari where Florence Nightingale worked and helped to restructure the modern hospital.

In the mid 19th century, hospitals and the medical profession became more professionalized, with a reorganization of hospital management along more bureaucratic and administrative lines. The Apothecaries Act 1815 made it compulsory for medical students to practice for at least half a year at a hospital as part of their training.

Florence Nightingale pioneered the modern profession of nursing during the Crimean War when she set an example of compassion, commitment to patient care and diligent and thoughtful hospital administration. The first official nurses' training programme, the Nightingale School for Nurses, was opened in 1860, with the mission of training nurses to work in hospitals, to work with the poor and to teach. Nightingale was instrumental in reforming the nature of the hospital, by improving sanitation standards and changing the image of the hospital from a place the sick would go to die, to an institution devoted to recuperation and healing. She also emphasized the importance of statistical measurement for determining the success rate of a given intervention and pushed for administrative reform at hospitals.

By the late 19th century, the modern hospital was beginning to take shape with a proliferation of a variety of public and private hospital systems. By the 1870s, hospitals had more than trebled their original average intake of 3,000 patients. In continental Europe the new hospitals generally were built and run from public funds. The National Health Service, the principle provider of health care in the United Kingdom, was founded in 1948.

During the nineteenth century, the Second Viennese Medical School emerged with the contributions of physicians such as Carl Freiherr von Rokitansky, Josef Škoda, Ferdinand Ritter von Hebra, and Ignaz Philipp Semmelweis. Basic medical science expanded and specialization advanced. Furthermore, the first dermatology, eye, as well as ear, nose, and throat clinics in the world were founded in Vienna, being considered as the birth of specialized medicine.

2.2.1.5. The modern hospital:

To better serve the wide-ranging needs of the community, the modern hospital has often developed outpatient facilities, as well as emergency, psychiatric, and rehabilitation services. In addition, "bed less hospitals" provide strictly ambulatory (outpatient) care and day surgery. Patients arrive at the facility for short appointments. They may also stay for treatment in surgical or medical units for part of a day or for a full day, after which they are discharged for follow-up by a primary care health provider.

Hospitals have long existed in most countries. Developing countries, which contain a large proportion of the world's population, generally do not have enough hospitals, equipment, and trained staff to handle the volume of persons who need care. Thus, people in these countries do not always receive the benefits of modern medicine, public health measures, or hospital care, and they generally have lower life expectancies.

In developed countries the hospital as an institution is complex, and it is made more so as modern technology increases the range of diagnostic capabilities and expands the possibilities for treatment. As a result of the greater range of services and the more-involved treatments and surgeries available, a more highly trained staff is required. A combination of medical research, engineering, and biotechnology has produced a vast array of new treatments and instrumentation, much of which requires specialized training and facilities for its use. Hospitals thus have become more expensive to operate, and health service managers are increasingly concerned with questions of quality, cost, effectiveness, and efficiency.

2.2.2 Ownership and control:

As a social organization the ownership and control of hospitals is a major issue. The hospital ownership and control underwent significant analysis and change in the late 20th and early 21st centuries. Such transformation was prevalent in developed countries, particularly those like India where fiscal sustainability is problematic.

In many countries hospitals are owned and operated by the government. In Great Britain, except for a small number run by religious orders or serving special groups, most hospitals are within the National Health Service. The local hospital management committee answers directly to the regional hospital board and ultimately to the Department of Health and Social Security. In the United States most hospitals are neither owned nor operated by governmental agencies. In some instances hospitals that are part of a regional health authority are governed by the board of the regional authority, and hence these hospitals no longer have their own boards.

In Canada some hospitals are owned by religious orders and are contracted to deliver publicly funded services. Other hospitals may be owned by municipalities or provincial or territorial governments.

Worldwide, many hospitals are associated with universities; others were founded by religious groups or by public-spirited individuals. Mental health facilities traditionally have been the responsibility of state or provincial governments, while military and veterans hospitals have been provided by the federal government. In addition, there are a number of municipal and county general hospitals.

2.2.3 Financing:

Because hospitals may serve specific populations and because they may be not-for-profit or for-profit, there exist a variety of mechanisms for hospital financing. Almost universally, hospital-construction costs are met at least in some part by governmental contributions. Operating costs, however, are taken care of in different ways. For example, funds may come from private endowments or gifts, general funds of some unit of government, funds collected by insurance carriers from subscribers, or some combination thereof. In some countries, operating costs may be supplemented in part by public or private sources that pay charges on uninsured or inadequately insured patients or by out-of-pocket payment by these individuals. Hospitals are usually funded by the public sector, by health organizations (for profit or nonprofit), health insurance companies, or charities, including direct charitable donations. Historically, hospitals were often founded and funded by religious orders or charitable individuals and leaders. Today, hospitals are largely staffed by professional physicians, surgeons, and nurses, whereas in the past, this work was usually performed by the founding religious orders or by volunteers.

In many countries and in Europe in particular, the financial support of services in hospitals tends to be collectivized, with funding provided through public revenues, social insurance, or a combination of the two. Thus, the costs of hospital operation are covered infrequently by payments made directly by patients. Details vary somewhat from country to country. In Sweden, for example, most hospital operating costs are financed by public revenues collected by regional governments. Many other European countries follow a similar model, with operating costs for hospitals paid out of national insurance funds; such is the case in the Netherlands, Finland, Norway, and elsewhere. In contrast, other countries, such as the United States, rely heavily on private insurance funds.

Private health insurance corporations or agencies exist in many countries. These entities may offer different or more services relative to national health insurance, although generally at additional cost as well. Private insurance funds offer an alternative mechanism of hospital financing.

2.2.4   Departments:

Hospitals vary widely in the services they offer and therefore, in the departments (or "wards") they have. Each is usually headed by a Chief Physician. They may have acute services such as an emergency department or specialist trauma centre, burn unit, surgery, or urgent care. These may then be backed up by more specialist units such as:

- Emergency department
- Cardiology
- Intensive care unit
- Pediatric intensive care unit
- Neonatal intensive care unit
- Cardiovascular intensive care unit
- Neurology
- Oncology
- Obstetrics and gynecology

Some hospitals will have outpatient departments and some will have chronic treatment units such as behavioral health services, dentistry, dermatology, psychiatric ward, rehabilitation services, and physical therapy. Common support units include a dispensary or pharmacy, pathology, and radiology, and on the non-medical side, there often are medical records departments, release of information departments, Information Management, Clinical Engineering, Facilities Management, Dining Services, and Security departments.

2.3 Types of Hospitals-General Hospitals, Specializing Hospitals:

Some patients go to a hospital just for diagnosis, treatment, or therapy and then leave ('outpatients') without staying overnight; while others are 'admitted' and stay overnight or for several days or weeks or months ('inpatients'). Hospitals usually are distinguished from other types of medical facilities by their ability to admit and care for inpatients whilst the others often are described as clinics. Likewise, Hospitals may be compared and classified in various ways: by ownership and control, by type of service rendered, by length of stay, by size, or by facilities and administration provided. Examples include the general hospital, the specialized hospital, the short-stay hospital, and the long-term-care facility. For the purpose of the present chapter we will focus on general hospitals and specializing hospitals.

➢ **General hospitals:**

- The best-known type of hospital is the general hospital, which is set up to deal with many kinds of disease and injury, and normally has an emergency department to deal with immediate and urgent threats to health. Larger cities may have several hospitals of varying sizes and facilities. Some hospitals have their own ambulance service.

- General hospitals may be academic health facilities or community-based entities. They are general in the sense that they admit all types of medical and surgical cases, and they concentrate on patients with acute illnesses needing relatively short-term care.

- Community general hospitals vary in their bed numbers. Each general hospital, however, has an organized medical staff, a professional staff of other health providers (such as nurses, technicians, dietitians, and physiotherapists), and basic diagnostic equipment. In addition to the essential services relating to patient care, and depending on size and location, a community general hospital may also have a pharmacy, a laboratory, sophisticated diagnostic services (such as radiology and angiography), physical therapy departments, an obstetrical unit (a nursery and a delivery room), operating rooms, recovery rooms, an outpatient department, and an emergency department. Smaller hospitals may diagnose and stabilize patients prior to transfer to facilities with specialty services

- In larger hospitals there may be additional facilities: dental services, a nursery for premature infants, an organ bank for use in transplantation, a department of renal dialysis (removal of wastes from the blood by passing it through semi permeable membranes, as in the artificial kidney), equipment for inhalation therapy, an intensive care unit, a volunteer-services department, and, possibly, a home-care program or access to home-care placement services.

- The complexity of the general hospital is in large part a reflection of advances in diagnostic and treatment technologies. Such advances range from the 20th-century introduction of antibiotics and laboratory procedures to the continued emergence of new surgical techniques, new materials and equipment for complex therapies (e.g., nuclear medicine and radiation therapy), and new approaches to and equipment for physical therapy and rehabilitation.

- The legally constituted governing body of the hospital, with full responsibility for the conduct and efficient management of the hospital, is usually a hospital board. The board establishes policy and, on the advice of a medical advisory board, appoints a medical staff and an administrator. It exercises control over expenditures and has the responsibility for maintaining professional standards.

- The administrator is the chief executive officer of the hospital and is responsible to the board. In a large hospital there are many separate departments, each of which is controlled by a department head. The largest department in any hospital is nursing, followed by the dietary department and housekeeping. Examples of other departments that are important to the functioning of the hospital include laundry, engineering, stores, purchasing, accounting, pharmacy, physical and occupational therapy, social service, pathology, X-ray, and medical records.

- The medical staff is also organized into departments, such as surgery, medicine, obstetrics, and pediatrics. The degree of departmentalization of the medical staff depends on the specialization of its members and not primarily on the size of the hospital, although there is usually some correlation between the two. The chiefs of the medical-staff departments, along with the chiefs of radiology and pathology, make up the medical advisory board, which usually holds regular meetings on medical-administrative matters. The professional work of the individual staff members is reviewed by medical-staff committees. In a large hospital the committees may report to the medical advisory board; in a smaller hospital, to the medical staff directly, at regular staff meetings.

- General hospitals often also have a formal or an informal role as teaching institutions. When formally designed as such, teaching hospitals are affiliated with undergraduate and

postgraduate education of health professionals at a university, and they provide up-to-date and often specialized therapeutic measures and facilities unavailable elsewhere in the region. As teaching hospitals have become more specialized, general hospitals have become more involved in providing general clinical training to students in a variety of health professions.

- Another method of providing health care in a hospital for those able to pay for it, in both developed and developing countries, is the provision of a limited number of beds for private patients within a large general hospital otherwise financed to some degree by public funds. In the United Kingdom and, for example, in West Africa, these beds usually form part of the ward unit, the patient being required to pay for certain amenities such as a measure of privacy, unrestricted visiting, attractively served food, and a more liberal routine. Alternatively, many large general hospitals are able to offer much more costly accommodations in so-called private blocks—that is, in a part of the hospital specially designed and equipped for private patients. Patients in a private block pay a large portion of the total cost of their medical care, including that of surgery.

➢ **Specializing hospitals:**

- Hospitals that specialize in one type of illness or one type of patient can generally be found in the developed world. In large university centers where postgraduate teaching is carried out on a large scale, such specialized health services often are a department of the general hospital or a satellite operation of the hospital.

- Types of specialized hospitals include trauma centers, rehabilitation hospitals, children's hospitals, seniors' (geriatric) hospitals, and hospitals for dealing with specific medical needs such as psychiatric problems, certain disease categories such as cardiac, oncology, or orthopedic problems, and so forth. In Germany specialized hospitals are called Fachkrankenhaus; an example is Fachkrankenhaus Coswig (thoracic surgery).

- Changing conditions or modes of treatment have lessened the need or reduced the number of some types of specialized institutions; this may be seen in the cases of **tuberculosis, leprosy, and mental hospitals**. On the other hand, specialized surgical centers and cancer centers have increased in number.

    ✓ Tuberculosis and leprosy hospitals:

    Between 1880 and 1940, tuberculosis hospitals provided rest, relaxation, special diets, and fresh air, and even if the

tuberculosis was in an early stage, a stay of more than two years was thought necessary to effect a healing of the disease; a permanent cure was not considered entirely feasible. Today the use of antibiotics, along with advances in chest surgery and routine X-ray programs, has meant that the treatment of tuberculosis need not be carried out in a specialized facility.

✓ Leprosy :

Leprosy has been known for centuries to be contagious. Lazar houses (hospitals for individuals with infectious disease) were established throughout Europe in the Middle Ages to isolate those with leprosy, at that time a common disease, from the community. In the 14th century there may have been some 7,000 leper houses in France alone, and some of the earliest hospitals in England were established for lepers. An intense campaign for leprosy elimination begun in the early 1990s, leprosy is now relatively rare. The purpose of the modern leprosarium is not so much isolation as it is treatment. The chronic form of the disease is treated by surgical correction of deformities, occupational therapy, rehabilitation, and sheltered living in associated villages. Acute leprosy is treated in general hospitals, clinics, and dispensaries.

✓ Mental health facilities:

Psychiatric patients traditionally have been cared for in long-stay mental health facilities, formerly called asylums or mental hospitals. Today the majority of large general hospitals have a psychiatric unit, and many individuals are able to maintain lives as regular members of the community. There are still facilities that specialize in the treatment of mental illness. The hospital stay of many persons with chronic mental illness has been shortened by modern medication and better understanding on the part of the public. Patients are encouraged to participate in facility-based activities and programs. They may be encouraged to return to the community, beginning with trial visits at home, or they may be placed in assisted-living or group homes. Every effort is now made, through the use of appropriate medication and support services, to have the patient integrated into the community.

Even those individuals who require custodial care are no longer isolated from contact with their relatives, friends, and the community at large. In addition, the strong correlation between mental illness and addiction has been noted and has given rise to numerous programs incorporating the simultaneous treatment of both conditions. Such programs are prevalent in developed countries in particular. In some cases special hospitals addressing both mental illness and addiction have been established—for instance, the Centre for Addiction and Mental Health in Toronto.

- Long-term-care facilities are a special feature of specializing hospitals. Historically, long-term-care facilities were homes for the elderly, the infirm, and those with chronic irreversible and disabling disorders, especially if the patients were indigent. Medical and nursing care was minimal. Today, however, long-term-care facilities have a more active role in health care. Some facilities are transitional from an acute hospital setting to the community. Others have residents who have a need for professional health care but do not need the intensive care found in an acute-care facility. As a result, long-term-care facilities often are staffed with health professionals and are equipped to care for patients with extensive needs for daily living or to help patients prepare to live at home or with a member of the family. Long-term-care facilities represent a significant extension of the hospital health care system, helping to conserve expensive facilities for the acutely ill and improving the prospects of the chronically disabled.

- Many countries have private hospitals that specialize in the treatment of specific diseases. For example, private facilities may be designed specifically for cataract or joint surgery. Small private hospitals are often called nursing homes, many of which provide little more than accommodation and simple nursing, the patient being under the care of a general practitioner or of a visiting consultant physician. Medical practice in the towns of developing countries is characterized by a proliferation of many small private hospitals, usually owned by doctors that have developed to meet the widespread need for hospital care not otherwise available.

- Specialized hospitals can help reduce health care costs compared to general hospitals. For example, Narayana Hrudayalaya's Bangalore cardiac unit, which is specialized in cardiac surgery, allows for significantly greater number of patients. It has 3000 beds (more than 20 times the average American hospital) and in pediatric heart surgery alone, it performs 3000 heart operations annually, making it by far the largest such facility in the world. Surgeons are paid on a fixed salary instead of per operation, thus the costs to the hospital drops when the number of procedures increases, taking advantage of economies of scale. Additionally, it is argued that costs go down as all its specialists become efficient by working on one "production line" procedure

- Specialized hospitals vary widely in the services they offer and therefore, in the departments (or "wards") they have. Each is usually headed by a Chief Physician. They may have acute services such as an emergency department or specialist trauma centre, burn unit, surgery, or urgent care. These may then be backed up by more specialist units such as:

  - ❖ Emergency department
  - ❖ Cardiology
  - ❖ Intensive care unit
  - ❖ Pediatric intensive care unit
  - ❖ Neonatal intensive care unit
  - ❖ Cardiovascular intensive care unit
  - ❖ Neurology
  - ❖ Oncology
  - ❖ Obstetrics and gynecology

- Some of the specializing hospitals will have outpatient departments and some will have chronic treatment units such as behavioral health services, dentistry, dermatology, psychiatric ward, rehabilitation services, and physical therapy.

- Common support units of these hospitals include a dispensary or pharmacy, pathology, and radiology, and on the non-medical side, there often are medical records departments, release of information departments, Information Management, Clinical Engineering, Facilities Management, Dining Services, and Security departments.

2.4.   Functions of hospitals:

The technical discussion of the Tenth World Health Assembly was held in 1957, the subject of which was "The Role of the Hospital in the Public Health Programme". Some two hundred participants attended the sessions under the general chairmanship of Dr. A. J. Metcalfe, Director-General of Health of Australia. Participants were split into nine groups, and the nine group reports were consolidated to make a general statement. From the start of the discussions the cards were stacked in favour of an extension of hospital functions for it is recorded that the groups were all but unanimous accepting the definition of a hospital put out in the first report of the Expert Committee on Organization of Medical Care of the World Health Organization: ***"The hospital is an integral part of a social and medical organization, the function of which is to provide the population complete healthcare, both curative and preventive, and whose out-patient services reach out to the family in its home environment; the hospital is also a centre for the training of health workers and for bio-social research."***

2.4.1.Major functions of hospitals:

The main function of a hospital is to provide the population with complete health care; it also functions as the centre for the training of health workers. A hospital is generally a vital part of a social and medical organization.

Following are some of the broad categories of Hospital functions:

- Medical care - which involves the treatment and management of patients through the staff of physicians.

- Patient Support - which relates directly to patient care and includes nursing, dietary diagnostic, therapy, pharmacy and laboratory services.

- Administrative - which concerns the execution of policies and directions of the hospital governing discharge of support services in the area of finance, personnel, materials and property, housekeeping, laundry, security, transport, engineering and board and other maintenance. Besides these the following are some major responsibilities coming under administrative service:

  - ❖ To plan, direct and coordinate financial operations of the hospital.
  - ❖ To prepare work and financial plan and provide fund estimates for programs and projects.
  - ❖ To manage the receipt and disbursement of cash/ collections.
  - ❖ To administer personnel development programs, policies and standards;
  - ❖ To give advice on matters affecting policies, enforcement and administration of laws, rules and regulations.
  - ❖ To procure, store, manage and issue the inventory and disposal of unserviceable hospital equipment and materials; and
  - ❖ To provide general services such as repairs and maintenance, housekeeping, laundry, transport and security.

- Teaching - Vocational, Undergraduate, Postgraduate, Continuing education.

- Research - Basic research, Clinical research, Health services research, Educational research.

- Employment - Inside hospital : Health professionals, other health care workers
  Outside hospital: Suppliers, Transport services.

2.4.2   Some critical points regarding functions of hospitals:

Medical sociologists assert that the delivery of health services is much more than simply the application of scientific and technical knowledge. Health care services are delivered by people to people within various social environments, which can influence the way medical technology is delivered or received and, perhaps most important, the clinical outcomes for people seeking help.

More over the rising costs and inconsistent quality of health care have raised significant questions among professionals, policy makers, and the public about the way health services are being delivered. For the past 50 years, medical sociologists have made significant contributions in improving our understanding of the nature and impact of the organizations (hospitals) that constitute our health care system. In this section, three central issues in the sociology of health services have been discussed:
(1) Health services unequally distributed, contributing to health inequalities across status groups;
(2) social institutions reproduce health care inequalities by constraining and enabling the actions of health service organizations, health care providers, and consumers;
(3) the structure and dynamics of health care organizations shape the quality, effectiveness, and outcomes of health services for different groups and communities;
(4) the policy implications for future health care reform efforts.

2.4.2.1 Unequal distribution of health services Contributing to Health Inequalities across status groups:

One of the fundamental concerns of medical sociologists over the past 50 years has been to document and explain gender, socioeconomic, and racial-ethnic differentials in health outcomes. Among the early explanations for these patterns were disparities in the distribution of health services among social groups, and substantial attention was devoted to documenting systematic differences in access to health care. More recently, evidence has emerged suggesting that the adverse impact of health care disparities on population health is increasing, highlighting the need for additional research (Lesser and Cunningham 1997). As a result, sociologists have taken a renewed interest and adopted a more complex and comprehensive approach to health services research, examining the nature, quality, and timeliness of care received under a variety of illness conditions.

➢ *Gender*

Sociological research has documented significant gender differences in help-seeking. Women are more likely than men to visit a doctor for an array of both physical and mental health problems (Courtenay 2000; Green and Pope 1999; Kessler, Brown, and Broman 1981). They are also more apt to have a regular physician and to obtain preventative screenings (Bostick et al. 1993; Centers for Disease Control 1998; Powell-Griner, Anderson, and Murphy 1997). However, men who do consult a health professional may receive better treatment than women for the same condition. The evidence is

particularly strong in the case of heart disease. Women who present with symptoms of cardiac disease are less likely to be referred for diagnostic tests, given cardiac drugs, or instructed to make lifestyle changes. Conversely, they are three to five times more likely to be sent home without any treatment (Lockyer and Bury 2002; McKinlay 1996). These patterns delay diagnosis and contribute to higher mortality rates among women with heart disease relative to men.

➢ *Socioeconomic Status*

Decades of research by sociologists suggests that people with less income and education face greater obstacles accessing health services than their more well-off counterparts, despite having higher health care needs (Dutton 1978; Katz and Hofer 1994). Disparities are particularly marked in the area of primary care (Rundall and Wheeler 1979). For example, adults and children of lower socioeconomic status (SES) are less likely to have routine physical examinations and screening procedures, such as prenatal care, immunizations, mammograms, and colonoscopies (Goldman and Smith 2002; Lantz, Weigers, and House 1997; McDonald and Coburn 1988). Moreover, they are less likely to receive medical intervention in a timely manner, and they often receive less intensive and lower quality treatments (Williams 1990). Together, these patterns result in poorer long-term outcomes and higher emergency room and hospitalization rates for conditions that would not normally require them (Padgett and Brodsky 1992; Pappas et al. 1997).

➢ *Race and Ethnicity*

Because income and educational attainment are so closely linked to race and ethnicity in America, patterns of health care inequality observed in racial-ethnic minority groups are similar to those found in low-SES populations (Williams and Collins 1995). That is, racial-ethnic minorities generally have less access to health services, in particular primary and preventative care, and they also tend to receive delayed treatment and lower quality acute and long-term care than whites (Blendon et al. 1989; Smedley, Stith, and Nelson 2003; Williams 1990). Though these patterns are better established in African American populations, studies suggest they also extend to Latinos, Asian Americans, and Native Americans (Angel and Angel 2006; Collins, Hall, and Neuhaus 1999; Fiscella et al. 2002). While much of the disparity in health services use can be explained by SES differentials, race-ethnicity tends to exhibit a modest, independent effect on health services use. These effects have been attributed to racial discrimination by health services providers and racial segregation of minorities into communities with less access to high-quality health services (Polednak 1993; Williams and Collins 1995).

2.4.2.2 Social institutions and health service organizations (hospitals):

A unique strength of the sociological perspective is the focus on underlying social structural mechanisms of phenomena that ostensibly occur at the individual level (McKinlay 1996). Sociologists have long conceptualized medicine as a social institution, highlighting the influence of macro factors on help-seeking and the practice of health care in everyday life (Freidson 1970; Mechanic 1975; Parsons 1951). The institution of medicine is characterized by a powerful set of social norms, rules, values, and practices that provides a blueprint for the behavior of individuals and organizations (e.g., physicians,

patients, hospitals, HMOs, etc.), and systematically structures the relationships between them. Sociologists have contributed much to our understanding of the ways that culturally and historically shaped institutional forces constrain the behavior of health care providers and consumers, reproducing health care inequalities across social groups (Light 2004). Sociologists have been instrumental in documenting changes in the institution of medicine over the twentieth century. In what Scott and colleagues (2000) call the era of professional dominance (1945–1965), the motivating ideology in medicine was commitment to quality care. Additionally, there was a strong sense of obligation to provide health care to all, regardless of a person's ability to pay for it (Klarman 1963). Accordingly, the poor received free care from physicians and hospitals, and the population at large paid on a sliding scale according to their means. In the era of federal involvement (1966–1982), concern with equitable access prevailed, but the government increasingly took over responsibility for funding and regulating the fair distribution of health care (Scott et al. 2000). At the same time, health services expenditures began to increase rapidly, and concerns about cost containment began to overshadow the long-standing commitment to quality care and equity that had characterized the institution of medicine since its inception (Brown 1979). In the current era of managerial control and market mechanisms (Scott et al. 2000), the health care sector is conceptualized as an industry, or economic system, and efficiency and profit are central motivating values. Changes in health policy (and ultimately practice) enacted by the Reagan administration began as part of a broader political movement characterized by welfare state retrenchment and by the shifting of government control to competitive market forces (O'Connor 1998). These events, described in greater detail by Mechanic and McAlpine (2010, in this issue), culminated in the corporatization of health care and the managed care ethos that pervades the institution of medicine today.

There is a Separate and Unequal distribution of health service in the Public and Private Health Care Sectors. This trend has important implications for the types and quality of care received by lower status groups. For instance, managed care organizations minimize risk by denying coverage to sicker, less profitable patients and spreading the risk out among a large consumer group that contains both healthy and sick individuals. These practices shift much of the financial responsibility for indigent care (i.e., those who are unable to pay for services) to physician groups and hospitals, pressuring them to balance their budgets by cutting costs associated with uninsured or publicly insured patients. At the same time, professional resources and government funds are increasingly being diverted to the profitable private sector (Waitzkin 2000). This has forced many public health facilities to close their doors, shrinking the public sector and widening the health gap between the rich and the poor. Sociologists have demonstrated that the result of this profit driven funding environment is essentially two divergent health care systems, public and private, characterized by radically different experiences and outcomes (Dutton 1978; Lutfey and Freese 2005; Smedley et al. 2003). Supporters of the for-profit sector have argued that those without private insurance can still access private health services through Medicare and Medicaid reimbursements. On the contrary, sociologists have identified numerous barriers that minimize use of the private sector by the publicly insured: (1) *Medicare and Medicaid often pay less than private market value for a given service, forcing the patient to pay the difference in cost; (2) Medicare and Medicaid policies are notoriously complex, prompting confusion and fear of incurring fees in the private sector; (3) Community and geographic barriers may restrict access to private facilities and providers, even when patients are publicly insured (Macintyre, MacIver, and Sooman 1993; Williams and Collins 2001); (4) Finally, private facilities and providers may overtly or subtly discourage publicly-insured (and uninsured) patients from using their services.* At even greater risk for slipping through the cracks of our health care system are the working poor and lower middle class—those whose incomes neither qualify them for public insurance nor allow them to afford private coverage (Seccombe and Amey 1995).

1.4.2.3 The structure of health care organizations and the quality of health services:

Seeking to understand the implications of organizational structure and dynamics in health services settings, a number of medical sociologists have focused more narrowly on organizations. Indeed, much of the classical work in medical sociology during the 1960s and 1970s explored various aspects of health care organizations, especially the general, acute-care hospitals (Coe 1978; Goss1963; Wilson 1963), as well as medical schools, physician offices, and psychiatric hospitals (Coe 1978; Freidson 1970; Strauss et al. 1963). With advances in technology and economic opportunities in the health care sector, and with the epidemiological shift from acute to more chronic and long-term health conditions, the types and varieties of health care organizations expanded dramatically from the 1960s onward. Nevertheless, these early studies had enormous descriptive value and contributed to a fundamental understanding of our emerging health system. They also highlighted a myriad of organizational challenges in delivering health services, including the depersonalization and devaluing of patients (Coe 1978); the interpersonal dynamics between doctors and patients (Freidson 1970; Glaser and Strauss 1965; Goffman 1961) the power relationships and conflicts among health professional groups (Goss 1963); and the tendency toward bureaucratic medical decision making and treatment (Freidson 1970; Goss 1963; Strauss et al. 1963). Most importantly, this body of work sensitized a generation of medical sociologists to the nature of medical work and established a reference point that continues to inform the field. In more recent years, medical sociologists have examined critical organizational changes that have had implications for how and what types of care are delivered, as well as how effective the care is for various social groups.

2.4.2.4   Health services in the twenty-first Century: Policy implications, future challenges, and reform:

- ❖ Expanding government's regulatory role in the delivery of health services must necessarily be accompanied by *a better marriage of research and policy*. In recent years, policy makers have called for more "comparative effectiveness" research, specialized research that compares the cost and clinical efficacy of treatments for particular conditions. Recent efforts to improve care have gravitated toward performance measurement and linking payment to concrete outcomes. While a focus on outcomes is undoubtedly valuable, existing research has barely scratched the surface of the broad and complex social and organizational factors that shape efficiency and effectiveness. In this regard, sociological research is important because it underscores that quality care is determined not only by what services are provided, but also *how* they are delivered, *by whom*, and *to whom.*

- ❖ Policy makers should identify locations for building facilities, increasing funding, and augmenting services and providers that are optimally useful and attractive to those in underserved communities.

- ❖ It is necessary to consider how the uninsured and underinsured currently utilize those services that are available, and how to bring people at the margins into the health care system. For instance, incentivizing the use of primary, preventative, and follow-up health care among those currently relying on emergency room services may be an effective strategy.

2.5 Interpersonal relationship in Hospital settings:

2.5.1 What is Interpersonal relationship?

- An interpersonal relationship is a strong, deep, or close association or acquaintance between two or more people that may range in duration from brief to enduring. This association may be based on inference, love, solidarity, regular business interactions, or some other type of social commitment. Interpersonal relationships are formed in the context of social, cultural and other influences. The context can vary from family or kinship relations, friendship, marriage, relations with associates, work, clubs, neighborhoods, and places of worship. They may be regulated by law, custom, or mutual agreement, and are the basis of social groups and society as a whole.

- The study of interpersonal relationships involves several branches of the social sciences, including such disciplines as sociology, psychology, anthropology, and social work. Interpersonal skills are extremely vital when trying to develop a relationship with another person. The scientific study of relationships evolved during the 1990s and came to be referred to as 'relationship science, which distinguishes itself from anecdotal evidence or pseudo-experts by basing conclusions on data and objective analysis. Interpersonal ties are also a subject in mathematical sociology.

- Interpersonal relationships are dynamic systems that change continuously during their existence. Like living organisms, relationships have a beginning, a lifespan, and an end. They tend to grow and improve gradually, as people get to know each other and become closer emotionally, or they gradually deteriorate as people drift apart, move on with their lives and form new relationships with others.

- Positive psychologists use the various terms "flourishing, budding, blooming, blossoming relationships" to describe interpersonal relationships that are not merely happy, but instead characterized by intimacy, growth, and resilience. Flourishing relationships also allow a dynamic balance between focus on the intimate relationships and focus on other social relationships.

- Individuals in an interpersonal relationship must share common goals and objectives. They should have more or less similar interests and think on the same lines. It is always better if individuals come from similar backgrounds.

- Individuals in an interpersonal relationship must respect each other's views and opinions. A sense of trust is important.

- Individuals must be attached to each other for a healthy interpersonal relationship.

- Transparency plays a pivotal role in interpersonal relationship. It is important for an individual to be honest and transparent.

➢ **A list of Interpersonal Skills includes**:

- Verbal Communication - What we say and how we say it.
- Nonverbal Communication - What we communicate without words, body language is an example.
- Listening Skills - How we interpret both the verbal and non-verbal messages sent by others.
- Negotiation - Working with others to find a mutually agreeable outcome.
- Problem Solving - Working with others to identify, define and solve problems.
- Decision Making – Exploring and analyzing options to make sound decisions.
- Assertiveness – Communicating our values, ideas, beliefs, opinions, needs and wants freely.

➢ **Forms of Interpersonal relationship**

An interpersonal relationship can develop between any of the following:

- Individuals working together in the same organization.
- People working in the same team.
- Relationship between a man and a woman (Love, Marriage).
- Relationship with immediate family members and relatives.
- Relationship of a child with his parents.
- Relationship between friends.

2.5.2. Types of communication in the care setting :

Communication is an important component in the health care field. Employees in hospitals, nursing homes and other medical settings need to communicate regularly with patients and residents about medical procedures, daily care tasks and the patient's overall health. Because of the

importance of communication, many schools and health care training programs are teaching future employees how to communicate first. Following are the different types of communication in the care setting.

- Verbal vs. Non-Verbal:

    Before a health care worker performs any medical procedure or care task with a patient, it's important they use verbal communication to inform the patient. This allows the patient to know what to expect. Verbal communication can also be used by the patient to inform the health care worker how they are feeling, what concerns they have and any other questions the patient may have. Non-verbal communication in the health care setting comes from eyes, hands and other parts of the body. Providing eye contact, not crossing the arms and leaning in when talking to a patient are non-verbal ways to communicate you care.

- Formal vs. Informal:

    Formal communication is often found in hospital policies and documents. This type of communication can be very rigid, leaving little or no room for feedback or deviation. Health care workers use formal communication when explaining hospital policies to patients and their families. Informal communication is less structured, and often allows for more interaction and communication between patients and caregivers. Conversing with patients about their interests, families and daily activities generally occurs using informal communication.

- Technology-Aided:

    Not all patients are able to communicate on their own with their care givers. In these instances, many use technology-aided communication devices to hear or speak. For example, patients who are unable to speak may type their thoughts into a computer that announces them out loud.

- Signs and Symbols:

    Patient may need to point to signs or symbols to communicate. Many health care settings are full of signs and symbols that communicate quickly what a patient or visitor needs to know. Using this type of communication is beneficial in care settings, as it allows individuals who are unable to read or understand a specific language to still know what is being communicated.

2.5.3   Importance of Effective interpersonal Communication in Healthcare:

- Correct Diagnosis:

Effective communication in the healthcare industry is incredibly important in aiding in the correct diagnosis of an individual's condition. It is very important that both the healthcare providers and the patient are very clear in what they say to one another. If the patient is unclear, inconsistent or limited in the information he provides regarding his symptoms and past experiences, the diagnosis the healthcare providers comes up with may be inaccurate, leading to mistreatment of the condition.

- History:

It is very important that the patient is very clear in communicating her medical history to healthcare professionals. Drug allergies, medical conditions, previous surgeries and illnesses can provide critical information to doctors and nurses while the patient is in the hospital. Failure to effectively communicate these parts of a medical history can put a patient's life at risk. For example, failure to mention an allergy to penicillin can cause a patient to go into anaphylactic shock.

- Treatment:

Communication is a very crucial part of the treatment process. Healthcare professionals must effectively communicate instructions for medication and home treatment to the patient. A misunderstanding could result in an overdose or the worsening of the condition. Patients must ask questions about their treatment if they are unclear on the instructions.

- Legal Processes:

Effective communication is important for legal issues pertaining to treatment. A thorough understanding of diagnoses and treatments must be established before a healthcare professional can proceed. Documentation of all communications can become important should something go wrong. Documentation of the communication that has taken place can provide a defense for the hospital or ammunition for the plaintiff.

- Medical Progress:

Communication is critical for advancing medical progress. Information gathered at a hospital or doctor's office can help track things like outbreaks of the flu or other communicable diseases. Information can inform healthcare providers on the need to stockpile certain medications, ultimately saving lives.

2.5.4   Effective Interpersonal Communication Practices in Health Care Settings:

Health care providers and patients share responsibility for communicating with one another. One of the most important elements for improving client satisfaction, compliance and health outcomes is to promote effective interpersonal communications between the health care provider and the client. A patient who believes the health care provider has his best interest at heart and cares about his progress can be more likely to comply with treatment methods and reveal essential information about his health problems so providers can make more accurate diagnoses.

2.5.5   Interpersonal theory in nursing practice:

➢ Nursing is no longer a vocation, but a profession. Since the time of Florence Nightingale, it has formed a definite part of hospital organization. woman now enters the profession—one who does not consider nursing as a good vocation alone, or look upon it from the viewpoint of the idealism of its service; but one who also views it in its broader perspective, thinking of its ,educative and social service. The nurse is an educator and a social worker whether she is, conscious of it or not. Dr. Haven Emerson goes so far as to say:

> "*I have often felt that there is among the nursing group the largest potential power for the correction of social ills that exists within the country, because nobody else knows what is the horror, the fear, that 'hangs over people from unemployment, as the nurse does. Nobody sees what it means to be politically "hounded the way the nurse does of the home which is subject to political catastrophe. The nurse knows well what it means for a family breadwinner to suffer a reduction of wages. The nurse is the eyes and conscience of the community in seeing and judging those matters which adversely affect the health and life, the survival of babies and children and parents in the home.*"

In the hospital the nurse contacts all departments. An interrelationship exists between her and the medical staff, the adjunct departments, and the administration. Often she is the only, confidante of the patient. She must keep a correct record of her observations, of symptoms, or of any physical or mental changes of the patient. She must co-operate with the administration in reporting the seriously ill. No hospital today is considered efficient which does not have a well-qualified, well-disciplined nursing staff. Good nursing service is one of its greatest assets.

➢ **Peplau's theory of interpersonal relations:**

• Hildegard E. Peplau, one of the world's leading nurses and known too many as the "Nurse of the Century". Dr. Peplau is the only nurse to serve the American Nurses Association (ANA) as Executive Director and later as President. She was also elected to serve two terms on the board of the International Council of Nurses (ICN). Peplau is universally regarded as the mother of psychiatric nursing. Her theoretical and clinical work led to the development of the distinct specialty field of psychiatric nursing. Peplau's seminal book, Interpersonal Relations in nursing (1952), was completed in 1948. Publication was delayed for 4 years because at that time it was considered too revolutionary for a nurse to publish a book without a physician co-author. Peplau's book has been widely credited with transforming nursing from a group of skilled workers to a fully fledged

profession. Since the publication of Peplau's work, interpersonal process has been universally integrated into nursing education and nursing practices worldwide. It has been argued that Dr. Peplau's life and work produced the greatest changes in nursing practice since Florence Nightingale. (Anita Werner O'Toole, et.al, 1989)

- Peplau's theory of interpersonal relations provides a useful framework for investigating clinical phenomena and guiding nurses' actions. While the case data are encouraging, it is suggested that there is a need to test the clinical effectiveness of Peplau's concepts by utilizing experimental research designs. Hildegard Peplau interpersonal theory incorporates communication and relationship concepts from Harry Stack Sullivans's Interpersonal Theory. (Joyce, 2005)

- Through this interpersonal relationship, nurses assess and assist people to: (a) achieve healthy levels of anxiety interpersonally and (b) facilitate healthy pattern integrations interpersonally, with the overall goal of fostering well-being, health, and development. This relationship also provides the context for the nurse to develop, apply, and evaluate theory-based knowledge for nursing care. Nurse interpersonal competencies, investigative skill, and the theoretical knowledge as well as patient characteristics and needs are well important dimensions in the process and outcomes of the relationship.

- The structure of the interpersonal relationship was originally described in four phases. Her theory focuses primary on the nurse-client relationship in which problem-solving skills are developed. Four phases occur during this interactive process: *orientation, identification, exploitation and resolution*. Forchuk (1991), with the support of Peplau, clarified the structure as consisting of three main phases: **orientation, working** (which incorporated identification and exploitation), and **termination**. In a 1997 publication, Peplau endorsed this three phase view and explained that the phases were overlapping, each having unique characteristics. Throughout theses phases the nurse functions cooperatively with the patient in the **nursing roles** of:
  - *Counseling Role* - working with the patient on current problems.
  - *Leadership Role* - working with the patient democratically.
  - *Surrogate Role* - figuratively standing in for a person in the patient's life.
  - *Stranger* - accepting the patient objectively.
  - *Resource Person* - interpreting the medical plan to the patient.
  - *Teaching Role* - offering information and helping the patient learn.

  - **Forchuk's structurural classification of interpersonal relationship:**

- ✓ The **orientation phase** marks a first step in the personal growth of the patient and is initiated when the patient has felt need and seeks professional assistance. The nurse focuses on knowing the patient as a person and uncovering erroneous preconceptions, as well as gathering information about the patient's mental health problem. The nurse and patient collaborate on a plan, with consideration of the patient's educative needs. Throughout the process, the nurse recognizes that the power to accomplish the tasks at hand resides within the patient and is facilitated through the workings of the therapeutic relationship. (Peplau, H.E, 1952)

- ✓ The focus of the **working phase** is on: (a) the patient's efforts to acquire and employ knowledge about the illness, available resources, and personal strengths, and (b) the nurse's enactment of the roles of resource person, counselor, surrogate and teacher in facilitating the patient's development toward well-being. The relationship is flexible enough for the patient to function dependently, independently, or interdependently with the nurse, based on the patient's developmental capacity, level of anxiety, self-awareness, and needs.

- ✓ **Termination** is the final phase in the process of the therapeutic interpersonal relationship. Patients move beyond the initial identification with the nurse and engage their own strengths to foster health outside the therapeutic relationship. In addition to addressing closure issues, the nurse and patient engage in planning for discharge and potential needs for transitional care. (Joyce J. Fitzpatrick, Meredith Wallace, 2005)

- Peplau's theoretical model can be categorized as a middle-range theory. It is narrower in scope than conceptual model or grand theory and addresses a clearly defined number of measurable concepts (e.g., therapeutic relationship, anxiety). The theory has specific focus on the characteristics and process of the therapeutic relationship as a nursing method to help manage anxiety and foster healthy development. As such, the model is directly applicable to research and practice.

- This theory is also historically significant for, it propelled psychiatric nursing from custodial based care to interpersonal relationship theory based care. Peplau is considered the founder of professional

psychiatric mental health nursing and was the first to initiate an area of advanced practice nursing. Her theoretical ideas continue to be significant in contemporary nursing for their relevance in not only psychiatric mental health nursing practice but practice anywhere a nurse patient relationship exits. **Applications of the theory are found in individual psychotherapy, reminiscence therapy, terminal illness care, and group and family therapy**. Practices based upon Peplau's theory range from hospital to community and home based. (Peplau, H.E, 1952)

- Peplau's theory has provided an enduring educational foundation for teaching the nurse patient relationships as a pivotal nursing process in all contexts of practice. A common philosophy underlying all nursing curricular is a belief in the value of a therapeutic nurse patient relationship that promotes active participation of patients in their health care. Peplau's theoretical work has also promoted a paradigm of professionalization and empowerment for educating nurse for the 21st century.

- The reawakening of nursing by Peplau's ideas in the 1950s continues today through exploration, study, and use of the science based practice of interpersonal relations theory. Analysis of this theory reveals that it is effective in long term care, home health and psychiatric setting where time allows for the development of a nurse client relationship and hopefully a resolution to promote health. However the theory's effectiveness is limited in short term, acute care nursing setting, where hospitalizations last for only few hours or for few days. It is also ineffective when the client is considered to be group of individuals, a family, or a community.

2.5.6 Nurse–client relationship:

It is the nurse–client interaction that is toward enhancing the client's well-being, and the client may be an individual, a family, a group or a community. Peplau thought the basic element of the relationship is what goes on between the nurse and patient (Interpersonal Theory). The relationship depends on the interaction of thoughts, feelings, and actions of each person. The patient will experience better health when all their needs are fully considered in the relationship. Following are some points describing positively on nurse-client relationship.

- **Contract-Setting:** the time, place and purpose of meetings as well as conditions for termination are established between the nurse and client.
- **Boundaries:** roles of participants are clearly defined, the nurse is defined as a professional helper, the client's needs and problems are the focus of the interaction.
- **Confidentiality**: the nurse should share information only with professional staff who needs to know. The nurse should obtain client's written permission to share information with others outside the treatment team.
- **Therapeutic nurse behaviors**: a.) self-awareness; b.) genuine, warm and respectful; c.) empathy; d.) cultural sensitivity; e.) collaborative goal setting; f.) responsible, ethical practice.

2.5.7.Nurse–client relationship some studies:

➢ In 2005, **McNaughton** performed a case study with five nurse–client groups to determine if Hildegard Peplau's theory of the nurse–client relationship was correct. Audio recordings and the Relationship Form, which rates the interaction during each phase of the nurse–client relationship on a scale of 1 (beginning of orientation phase) to 7 (end of resolution phase), examined the phases the relationship went through. During the orientation phase, the nurse assessed the client, identified problems, and discussed plans for the visit. In the working phase, the client identified their problems, asked questions, and recognized the nurse was beneficial. In the resolution phase, problems were solved, the client became independent and established goals and the relationship ended. The findings of the study support Peplau's theory for the development of the nurse–client relationship because as the relationship progressed through the phases the interaction increased.

➢ **Coatsworth-Puspoky, Forchuk, and Ward-Griffin** conducted a study on clients' perspectives in the nurse–client relationship. Interviews were done with participants from Southern Ontario, ten had been hospitalized for a psychiatric illness and four had experiences with nurses from community-based organizations, but were never hospitalized. The participants were asked about experiences at different stages of the relationship. The research described two relationships that formed the "bright side" and the "dark side". The "bright" relationship involved nurses who validated clients and their feelings. For example, one client tested his trust of the nurse by becoming angry with her and revealing his negative thoughts related to the hospitalization. The client stated, "she's trying to be quite nice to me ... if she's able to tolerate this occasional venomous attack, which she has done quite well right up to now, it will probably be a very beneficial relationship" (350). The "dark" side of the relationship resulted in the nurse and client moving away from each other. For example, one client stated, "the nurses' general feeling was when someone asks for help, they're being manipulative and attention seeking" (351). The nurse didn't recognize the client who has an illness with needs therefore; the clients avoided the nurse and perceived the nurse as avoiding them. One patient reported, "the nurses all stayed in their central station. They didn't mix with the patients ... The only interaction you have with them is medication time" (351). Neither trust nor caring was exchanged so perceptions of mutual avoiding and ignoring resulted. One participant stated, "no one cares. It doesn't matter. It's just; they don't want to hear it. They don't want to know it; they don't want to listen" (352). The relationship that developed depended on the nurse's personality and attitude. These findings bring awareness about the importance of the nurse–client relationship.

➢ Building trust is beneficial to how the relationship progresses. **Wiesman** used interviews with 15 participants who spent at least three days in intensive care to investigate the factors that helped develop trust in the nurse–client relationship. Patients said nurses promoted trust through attentiveness, competence, comfort measures, personality traits, and provision of information. Every participant stated the attentiveness of the nurse was important to develop trust. One said

the nurses "are with you all the time. Whenever anything comes up, they're in there caring for you" (57). Competence was seen by seven participants as being important in the development of trust. "I trusted the nurses because I could see them doing their job. They took time to do little things and made sure they were done right and proper," stated one participant (59). The relief of pain was seen by five participants as promoting trust. One client stated, "they were there for the smallest need. I remember one time where they repositioned me maybe five or six times in a matter of an hour" (60). A good personality was stated by five participants as important. One said, "they were all friendly, and they make you feel like they've known you for a long time" (61). Receiving adequate information was important to four participants. One participant said, "they explained things. They followed it through, step by step" (63). The findings of this study show how trust is beneficial to a lasting relationship.

➢ **Yamashita, Forchuk, and Mound** conducted a study to examine the process of nurse case management involving clients with mental illness. Nurses in inpatient, transitional, and community settings in four cities in Ontario were interviewed. The interviews show the importance of providing emotional support to the patients. One nurse stated that if the client knows "somebody really cares enough to see how they are doing once a week … by going shopping with them or to a doctor's appointment. To them it means the world" (66). The interviews showed it was crucial to include the family as therapeutic allies. A nurse stated that "we're with the families. We can be with them as oppositional and overly involved and somewhere else in between, and we're in contact with them as much as they want" (66). With frequent contact the nurse was able to discuss possibilities with the family. The study reaffirmed the importance of emotional support in the relationship.

➢ Humour is important in developing a lasting relationship. **Astedt-Kurki, Isola, Tammentie, and Kervinen** asked readers to write about experiences with humour while in the hospital through a patient organization newsletter. Letters were chosen from 13 chronically ill clients from Finland. The clients were also interviewed in addition to their letters. The interviews reported that humour played an important role in health. A paralyzed woman said, "well you have to have a sense of humour if you want to live and survive. You have to keep it up no matter how much it hurts" (121). Humour helped clients accept what happened by finding a positive outlook. One participant stated, "… when you're sick as you can be and do nothing but lie down and another person does everything in her power to help, humour really makes you feel good" (121). Humour also serves as a defense mechanism, especially in men. A participant said, "for male patients humour is also a way of concealing their feelings. It's extremely hard for them to admit they're afraid" (123). The patient finds it easier to discuss difficult matters when a nurse has a sense of humour. "A nurse who has a sense of humour, that's the sort of nurse you can talk to, that's the sort of nurse you can turn to and ask for help ..." reported a participant (123). This study lends support that if humour is generally important to people, then in times of change it will remain important.

2.5.8   Understanding culture and transcultural Nursing Care:

➢ **What is Culture :**

  • Set of values, beliefs and traditions, that are held by a specific group of people and handed down from generation to generation.

  • Culture is also beliefs, habits, likes, dislikes, customs and rituals learn from one's family.

  • Culture is the learned, shared and transmitted values, beliefs, norms and life way practices of a particular group that guide thinking, decisions, and actions in patterned ways.

  • Culture is learned by each generation through both formal and informal life experiences.

  • Language is primary through means of transmitting culture.

  • The practices of particular culture often arise because of the group's social and physical environment.

  • Culture practice and beliefs are adapted over time but they mainly remain constant as long as they satisfy needs.

  • Illness and diseases as a social phenomenon also greatly influenced and shaped by culture and belief system of that particular society.

  • **Two types** of care is highly necessary in a health care setting so far as culture is concerned: **Culturally congruent care**:

      Care that fits the people's valued life patterns and set of meanings -which is generated from the people themselves, rather than based on predetermined criteria.

  and **culturally competent care:**

      the ability of the practitioner to bridge cultural gaps in caring, work with cultural differences and enable clients and families to achieve meaningful and supportive caring.

➢ **What is transcultural Nursing Care:**

- Although it is a common knowledge and it is widely accepted that people differ in culture among various racial groups, yet this established fact is hardly ever considered when administering nursing care.

- Due to the apparent relevance on the emerging challenge in the lack of attention to these cultural differences in health care practice resulted in an inferior nursing care.

- More and more health care organizations including educational institutions and nursing associations are becoming more aware of the significance of culture to nursing practice, which led to the development of Transcultural Nursing Care.

- Madeleine Leininger is considered as the founder of the theory of transcultural nursing. Her theory has now developed as a discipline in nursing. Evolution of her theory can be understood from her books: Culture Care Diversity and Universality (1991), Transcultural Nursing (1995) and Transcultural Nursing (2002).

- Transcultural nursing theory is also known as Culture Care theory. Theoretical framework is depicted in her model called the Sunrise Model (1997).

- According to Leininger Transcultural nursing is a comparative study of cultures to understand similarities (culture universal) and difference (culture-specific) across human groups.

- Leininger (1991) identified three nursing decision and action modes to achieve culturally congruent care.

    1. Cultural preservation or maintenance.

    2. Cultural care accommodation or negotiation.

    2. Cultural care repatterning or restructuring.

> **Major concepts of Leininger regarding transcultural nursing**:

- Illness and wellness are shaped by a various factors including perception and coping skills, as well as the social level of the patient.

- Cultural competence is an important component of nursing.

- Culture influences all spheres of human life. It defines health, illness, and the search for relief from disease or distress.

- Religious and Cultural knowledge is an important ingredient in health care.

- The health concepts held by many cultural groups may result in people choosing not to seek modern medical treatment procedures.

- Health care provider need to be flexible in the design of programs, policies, and services to meet the needs and concerns of the culturally diverse population, groups that are likely to be encountered.

- Most cases of lay illness have multiple causalities and may require several different approaches to diagnosis, treatment, and cure including folk and Western medical interventions.

- The use of traditional or alternate models of health care delivery is widely varied and may come into conflict with Western models of health care practice.

- Culture guides behavior into acceptable ways for the people in a specific group as such culture originates and develops within the social structure through inter personal interactions.

- For a nurse to successfully provide care for a client of a different cultural or ethnic to background, effective intercultural communication must take place.

➤ **Significance of cultural diversity in health care practice:**

Every patient's attitude and behaviour towards their health and illness differ in many ways, but the most profound difference that must be religiously considered is the role of the underlying cultural factors affecting the patient's outlook on their health condition. Even biological differences as a result of both hereditary and environmental factors which forms the genetic diversity among human beings is a contributing factor that varies greatly in determining why some individuals are more susceptible to certain diseases and why specific drugs have differing effects to certain individuals. Thus, awareness of the nurse on the prevalence and susceptibility of specific individuals to certain types of diseases, or the suitability of certain medication with a certain group of people enables the nurse to detect early signs and symptoms for effective intervention and immediate prevention.

➢ **Society and Culture:**

It should also be taken into serious consideration to recognize the fact that even though culture with its existing structure are subject to change brought about by the effect of social shifts as immigrants learn to adapt to their host culture, yet still, we cannot ignore or dismiss the possibility that culture change occurs in unpredictable stages, that people in a growing culturally diverse population strive to maintain their traditional cultural habits and beliefs even with the prevailing dominant values and traditions of the host society. Failure to recognize this logical truth is the very reason that substantiates for the failure of the health care system resulting in a substandard patient care.

Since there is a wide variation of culturally influenced health behaviours and beliefs as a result of culturally induced traditional interpretation of illness and disease and their causes, the need to develop a diverse nursing approach to consistently meet each distinct behaviour and belief is essentially important to serve as determinants from which a careful analysis and conclusion can be derive from, and to relate them to these individual preferences in order to render a careful nursing assessment and diagnosis, which when not appropriately recognized and not carefully applied to nursing practice may cause tension and confusion between the nurse and the patient, wherein the nurse would most likely rely only on pure assumptions and make inaccurate assessments which would result in the delivery of unsuitable nursing care.

➢ **Factors affecting health care intervention resulting from cultural diversity:**

In a culturally diverse health care setting in a multi-ethnic society, health care providers can only accomplish optimal patient care by developing a sense of deeper understanding, patience and tolerance on the variation of cultural beliefs and practices of culturally diverse individuals. The exhibited effects on individuals influenced by their cultural values and beliefs are manifested in their behaviour ranging from the way they seek medical attention or by the way they view or respond to the care and treatment of the health care provider

The following examples provide some insights about these culturally influenced behaviours:

• Expression of pain:

There are many forms of habits and behavior that the health care provider must learn to recognize in a multicultural health care setting. For instance, the most obvious response of most hospital patients is to immediately complain upon feeling any slightest discomfort wherein the most common reaction of the patient would be to seek immediate medical attention the very instant they feel even the smallest amount of pain, yet patients from Asian countries exhibit calm endurance of pain and may not ask for any medication at all.

✓ The Chinese are particularly known to endure pain without medication. It is a part of their traditional discipline to hold back the pain and strongly believe that it is an act of courtesy on their part to refuse pain medication for the sake of the greater good of the

majority who have greater need of the pain medication. In other words, it is traditionally impolite and shameful for a Chinese to be prioritized just to relieve his own discomfort while there are others who are suffering with much worst condition than him.

✓ Similarly, it is also a common practice for most Asian women to refrain from showing their feelings of pain or discomfort during childbirth, because crying out in pain is an emotional outburst of complaint; hence it would be a disgrace not to gratify oneself to appreciate the suffering of childbirth as a wonderful experience of motherhood. By being aware of such traditional Asian customs and belief, the nurse must learn to be observant to check for any signs of restlessness in the patient in order to determine the need for treatment or medication even if the patient persistently refuses to submit to medical procedures by trying to conceal their pain or discomfort.

✓ But while it is a customary habit for most Asian women to be tolerant to the pain and discomfort of childbirth, Middle Eastern and Hispanic women tend to express their childbirth experience (including any other feelings of pain) very loudly. But health care providers should be very careful not to always confine their thoughts to theoretical assumptions base on this cultural pattern by categorizing loud expression of pain as a normal condition based on the conception of the cultural traits inherent with this particular group of people. It would be wrong to ignore the Middle Eastern and Hispanic women's loud screams by assuming this expression as their usual traditional response to pain without doing any further nursing assessment on the cause of the excruciating pain which could potentially be an indication that something is really very wrong.

- Coin rubbing as self medication:

    Health care providers may also find that the Asian's traditional practice of rubbing their body with a coin to be a very disturbing act of inflicting pain to the body. Coin rubbing is a traditional type of healing which is widely practiced by most Asians that often gives the impression of human torture. The purpose of coin rubbing is an attempt to quickly stimulate the healing of illness but would result in the presence of red welts on the surface of the skin where the coin is rubbed. This practice is also often mistaken for child abuse when applied by the elders to a child. The result of coin rubbing is also known to cause incorrect diagnosis due to the deceptive appearance of the noticeable red welts, which is often firstly identified and initially assumed as some form of distinguishable symptom despite its irrelevance to the real cause of illness.

    In this case, If the health care provider is aware that the red welts were caused by the traditional healing practice of coin rubbing, then the health care provider will not be distracted away from the real cause of the illness, allowing them to explore other possibilities instead of

the visible red welts by focusing on the other symptoms associated with the illness to determine a correct diagnosis and a suitable course of action.

- Women and family honor:

    Another unique traditional practice and belief influenced by culture that must be expected and respected by the health care provider is the effect of a strictly practiced tradition owing to a firm conviction to the value of female purity as the foundation of family honor, like that of the restricted Middle Eastern culture that strictly prohibits male nurses to examine their women. In this case, health care institutions should make appropriate arrangements to exclusively provide only female nurses and staff to attend exclusively to Middle Eastern women patients. The room of the Middle Eastern women patient should also be treated with utmost privacy that permission to enter the room should always be with the informed consent of the husband or with the eldest male of her immediate family. Strict compliance to ask permission from the husband or the eldest male in the family should also be adhered to when performing other activity that requires the Middle Eastern women to undergo any medical procedures.

- Eye Contact:

Another culturally influenced behaviour which can often be misunderstood by the nurse as a strange mannerism is the avoidance of eye contact by the Asian patients, a behaviour which is often regarded offensive and misinterpreted as a sign of rejection of trust, but when perceived correctly as a culturally influenced behaviour is in fact an act of acknowledging respect for the superiority of the nurse over the individual's health and well-being.

Thus, health care providers should also be aware that direct eye contact may be regarded as sexually provocative and should be avoided between men and women when tending to Middle Eastern patient or when conversing with their immediate family.

➢ **Health practices in different cultures :**

- Use of Protective Objects :
  Protective objects can be worn or carried or hung in the home- charms worn on a string or chain around the neck, wrist, or waist to protect the wearer from the evil eye or evil spirits.

- Use of Substances:
   It is believed that certain food substances can be ingested to prevent illness. E.g. eating raw garlic or onion to prevent illness or wear them on the body or hang them in the home.

- Religious Practices :
  Burning of candles, rituals of redemption etc..

- Traditional Remedies:
  The use of folk or traditional medicine is seen among people from all walks of life and cultural ethnic back ground.

- Healers:
  Within a given community, specific people are known to have the power to heal.

- Immigration:
  Immigrant groups have their own cultural attitudes ranging beliefs and practices regarding these areas.

- Gender Roles:
  In many cultures, the male is dominant figure and often they take decisions related to health practices and treatment. In some other cultures females are dominant. In some cultures, women are discriminated in providing proper treatment for illness.

- Beliefs about mental health:
  Mental illnesses are caused by a lack of harmony of emotions or by evil spirits. Problems in this life are most likely related to transgressions committed in a past life.

- Economic Factors :
  Factors such as unemployment, underemployment, homelessness, lack of health insurance poverty prevent people from entering the health care system.

- Time orientation:
  It is varies for different cultures groups.

- Personal Space:
  Respect the client's personal space when performing nursing procedures. The nurse should also welcome visiting members of the family and extended family.

- **Effect of cultural diversity among health practitioners and effective solutions:**

- In a multicultural health care setting, difference in cultural values and belief is also known to cause disagreement among health care workers. Known occurrences of such conflict and misunderstanding have transpired as a result of work related issues involving differences in opinions and practices among cultures.

- The conflict often arises from a huge gap on the understanding of how a particular culture should appropriately behave or interact to the other culture, each imposing their own cultural value to the other. When such conflict resulting from cultural differences among the health care

workers is not resolved, the health care system will suffer thus affecting the delivery of health care to the general patient population.

- To eliminate all possibilities of cultural factions among cultures in the organization, it would be helpful for health care institutions to provide trainings and seminars to bridge the gap in order to cultivate understanding between cultural differences.

- Developing awareness of cultural factors affecting working relationship will help promote understanding of the reasons behind the conflicting issues, which will re-establish compatibility between opinions and belief to put aside and settle the differences.

- Another effective solution is to assign a counselor to act as intermediary between co-workers to resolve opposing issues in order to bring a harmonious working relationship between co-workers within the organization.

- **Nursing process and role of nurse**:

  - Determine the client's cultural heritage and language skills.

  - Determine if any of his health beliefs relate to the cause of the illness or to the problem.

  - Collect information that any home remedies the person is taking to treat the symptoms.

  - Nurses should evaluate their attitudes toward ethnic nursing care.
  - Self-evaluation helps the nurse to become more comfortable when providing care to clients from diverse backgrounds

  - Understand the influence of culture, race &ethnicity on the development of social emotional relationship, child rearing practices & attitude toward health.

  - Collect information about the socioeconomic status of the family and its influence on their health promotion and wellness

  - Identify the religious practices of the family and their influence on health promotion belief in families.

  - Understanding of the general characteristics of the major ethnic groups, but always individualize care.

- The nursing diagnosis for clients should include potential problems in their interaction with the health care system and problems involving the effects of culture.

- The planning and implementation of nursing interventions should be adapted as much as possible to the client's cultural background.

- Evaluation should include the nurse's self-evaluation of attitudes and emotions toward providing nursing care to clients from diverse socio-cultural backgrounds.

- Self-evaluation by the nurse is crucial as he or she increases skills for interaction.

2.5.9 Importance of Communication Skills for developing interpersonal relationship in Nursing:

- Both verbal and nonverbal communication skills aid nurses in their work. A soothing voice while answering questions and a friendly smile both send a message to the patient. Clear descriptions of symptoms aid the doctor in choosing a course of treatment. When the nurse is faced with a patient suffering disfiguring injury or illness, her calm demeanor in dealing with him can help ease his mind about acceptance in the world.

- Another type of communication is the accurate written record maintained by the nurse on the patient's behalf. Clear, concise notes make follow up easier and improve continuity of care between caregivers. If the nurses on each shift know what was done during the other shifts, quality of care can remain more consistent.

- A good communicator-nurse expedites the flow of information between doctor and patient. This flow must not be interrupted by an unpleasant patient or physician. It includes the nurse's skilled observation of the patient's mental and physical condition, interpretation of the physician's orders and interaction with the patient and family.

- The nurse can make a difference in how well the patient follow doctor's orders by explaining the importance of each step. She can also clarify any points the patient doesn't fully understand. The patient must understand dosing instructions in order to get the most benefit from medication and treatment. The nurse employs strong communication skills in assisting the patient to help himself on the path to healing.

- The human being within the patient's condition can feel neglected with medical procedures and jargon surrounding him. When the nurse takes time to talk to him as a person, she gives human dignity back to him. She can answer questions about upcoming tests and alleviate fears. By acknowledging him as an individual rather than just a case, she offers a gift as important as the medication prescribed for him.

- The nurse's actions and words must go together to offer the most benefit to the patient. Any conflict between them will disorient the patient and undermine his confidence in the nurse. The patient deserves sincerity from his nurse.

2.5.10 Effective Interpersonal Communication Practices in Health Care Settings:

- Two-Way Dialogue:

    Interaction between client and provider should be a two-way street where both speak and listen without interruption, ask questions, express opinions, exchange information and fully understand what the other is saying. To achieve positive outcomes, the client and the provider should show mutual respect and make important decisions jointly. The provider should establish rapport with the patient and summarize the information the patient provides throughout the conversation to elicit his perspective.

- Caring Atmosphere:

    Patients need to believe that their provider is committed to their welfare. The provider should make the patient feel secure by being attentive, making eye contact and showing empathy. Patients feel cared for when the provider spends adequate time with them. Today's physicians order diagnostic tests to determine the cause of ailments; most patients appreciate the emotional connection of providers actually putting their hands on them more than the care provided by an unemotional machine.

- Verbal Communication:

    The health care providers should choose words the client comprehends rather than medical jargon that may be confusing to patients. Clients also need to take into account any dialects or accents they may have that make it difficult for the provider to understand. Health care providers should inform their patients in a way they understand about treatments, courses of disease, preventions, expected outcomes and possible complications. When they do, patients generally do better and are more satisfied with the care provided them.

- Non-Verbal Communication:

    Tone, attitude and gestures convey as much as words. Smiling, listening thoughtfully and sitting at the same eye level as the patient enhances communication. Cultural customs

account for much of the non-verbal communication difficulties. In some cultures, for example, direct eye contact is a positive sign while in other cultures, it may seem aggressive or improper. Simple gestures that do not require great effort, such as a warm greeting or a thoughtful question, can have significant results and are less likely to be misinterpreted.

- Social Interaction:

Another aspect of effective communication in health care is social interactions. Almost everyone involved in the health care process will have interaction with the patient at one moment or another. Having the ability to discern what is appropriate or inappropriate in various situations is essential for effective communication. Health care professionals need to build a relationship with patients at a distance. Health care professionals should connect with patients on certain levels, and refrain from engaging too emotionally and socially with the patients.

- Considerations:

Health care professionals carry the responsibility of educating and listening at the same time. An effective health care communicator needs to be able to ask the appropriate questions to gather needed information while listening to the responses in detail. The level at which a health care professional is able to effectively listen and respond with accuracy, compassion and understanding, dictates the level of satisfaction the patient will experience.

- Satisfactory Outcome:

When effective communication is used in health care, the outcome is almost always satisfaction. The ability to communicate effectively and properly understand a patient's needs, concerns and desires will not only provide satisfaction to the patient but also for the health care professional. If a health care professional is able to communicate appropriately, he or she will have a deeper level of accomplishment which will lead to greater motivation in his or her job, resulting in an improved health care system.

2.5.11 Barriers to Effective Interpersonal Communication:

- Psychological Barriers:

Psychological barriers may include shyness or embarrassment. Sometimes, a patient may present herself or himself as being abrupt or difficult when she or he may actually be nervous. If a patient is already prejudiced before meeting a doctor, this will cause a barrier.

- Cultural Barriers:

    It should also be noted here that communication barrier is the most familiar obstacle that can be experienced by the health care provider in an actual face to face encounter with patients in a multicultural health care setting, as would a simple human interaction as a direct eye contact which can have implications to some cultural meanings.

    Other aspects of culture affecting communication can also include issues such as in the Asian culture wherein there is great respect placed on the eldest male as the head and decision maker of the family, therefore all nursing intervention instructions from the health care provider to the Asian patient should be conveyed only through this eldest Asian male and not directly to the patient.

- Language Barriers:

    A communication barrier may be present because both parties do not share a common language. Interpreters and translators may be used to good effect in these circumstances. If a patient is deaf or visually impaired, this presents an obvious barrier that needs to be addressed prior to the meeting. Speech impediments or dysphasia as a result of a stroke or other brain problem can present a barrier. The use of jargon and over-complicated language creates barriers to communication.

    Efficient nursing assessment and intervention is very dependent on effective communication, which requires a clear and unobstructed exchanging of thoughts, feelings and experiences between the patient and the health care provider or even among health care providers. When health care providers and patients do not speak a common dialect, the use of an interpreter is often the only alternative means to convey the right message.

- Environmental Barriers:

    Environmental barriers to communication can include noise and lack of privacy. An environment which is too hot or cold will not be conducive to effective communication. Sometimes in a hospital setting these are the obstacles which negatively influence proper interpersonal relation between the patient and the service providers.

2.6.Summary:

- Hospital is a social organization and logical combination of the activities of a number of persons with different level of knowledge and skill for achieving a common goal of patient care through a hierarchy of authority and responsibility.

- The 'hospital is an integral part of a social and medical organization, the function of which is to provide the population complete healthcare, both curative and preventive, and whose out-patient services reach out to the family in its home environment; the hospital is also a centre for the training of health workers and for bio-social research.

- Hospital as a **'MATRIX' organization** is a mix of product and function where people of similar skills are grouped together to execute activities to achieve organizational objective.

- Institutions created specifically to care for the ill appeared early in India. The earliest surviving encyclopedia of medicine in Sanskrit is the Carakasamhita. Caraka's description of how a clinic should be equipped, suggests that India may have been the first part of the world to have evolved an organized cosmopolitan system of institutionally-based medical provision.

- The first prominent Islamic hospital was founded in Damascus, Syria in around 707 with assistance from Christians. However, religion continued to be the dominant influence in the establishment of hospitals during the middle Ages. The middle ages also saw the beginnings of support for hospital-like institutions by secular authorities.

- In the mid 19th century, hospitals and the medical profession became more professionalized, with a reorganization of hospital management along more bureaucratic and administrative lines. The Apothecaries Act 1815 made it compulsory for medical students to practice for at least half a year at a hospital as part of their training.

- Florence Nightingale pioneered the modern profession of nursing during the Crimean War when she set an example of compassion, commitment to patient care and diligent and thoughtful hospital administration. The first official nurses' training programme, the Nightingale School for Nurses, was opened in 1860, with the mission of training nurses to work in hospitals, to work with the poor and to teach.
- Nightingale was instrumental in reforming the nature of the hospital, by improving sanitation standards and changing the image of the hospital from a place the sick would go to die, to an institution devoted to recuperation and healing. She also emphasized the importance of statistical measurement for determining the success rate of a given intervention and pushed for administrative reform at hospitals.

- To better serve the wide-ranging needs of the community, the modern hospital has often developed outpatient facilities, as well as emergency, psychiatric, and rehabilitation services.

- In developed countries the hospital as an institution is complex, and it is made more so as modern technology increases the range of diagnostic capabilities and expands the possibilities for treatment. A combination of medical research, engineering, and biotechnology has produced a vast array of new treatments and instrumentation, much of which requires specialized training and facilities for its use.

- In many countries hospitals are owned and operated by the government. In Great Britain, except for a small number run by religious orders or serving special groups, most hospitals are within the National Health Service. The local hospital management committee answers directly to the regional hospital board and ultimately to the Department of Health and Social Security. In the United States most hospitals are neither owned nor operated by governmental agencies. In some instances hospitals that are part of a regional health authority are governed by the board of the regional authority, and hence these hospitals no longer have their own boards.

- Almost universally, hospital-construction costs are met at least in some part by governmental contributions. Operating costs, however, are taken care of in different ways like funds may come from private endowments or gifts, general funds of some unit of government, funds collected by insurance carriers from subscribers, or some combination thereof.

- Some important departments of a hospital are; Emergency department, Cardiology, Intensive care unit, Pediatric intensive care unit, Neonatal intensive care unit, cardiovascular intensive care unit, Neurology, Oncology, Obstetrics and gynecology.

- Some hospitals will have outpatient departments and some will have chronic treatment units such as behavioral health services, dentistry, dermatology, psychiatric ward, rehabilitation services, and physical therapy. Common support units include a dispensary or pharmacy, pathology, and radiology, and on the non-medical side, there often are medical records departments, release of information departments, Information Management, Clinical Engineering, Facilities Management, Dining Services, and Security departments.

- There are two types of hospitals: general hospitals and specializing hospitals. General hospitals deal with many kinds of disease and injury, and normally have an emergency department to deal with immediate and urgent threats to health. Larger cities may have several hospitals of varying sizes and facilities. Some hospitals have their own ambulance service.

- General hospitals often also have a formal or an informal role as teaching institutions. When formally designed as such, teaching hospitals are affiliated with undergraduate and postgraduate education of health professionals at a university, and they provide up-to-date and often specialized therapeutic measures and facilities unavailable elsewhere in the region. As

teaching hospitals have become more specialized, general hospitals have become more involved in providing general clinical training to students in a variety of health professions.

- Hospitals that specialize in one type of illness or one type of patient are known as specializing hospitals. In large university centers where postgraduate teaching is carried out on a large scale, such specialized health services often are a department of the general hospital or a satellite operation of the hospital.

- Types of specialized hospitals include trauma centers, rehabilitation hospitals, children's hospitals, seniors' (geriatric) hospitals, and hospitals for dealing with specific medical needs such as psychiatric problems, certain disease categories such as cardiac, oncology, or orthopedic problems etc.

- Long-term-care facilities are a special feature of specializing hospitals. Some facilities are transitional from an acute hospital setting to the community. Others have residents who have a need for professional health care but do not need the intensive care found in an acute-care facility. Long-term-care facilities represent a significant extension of the hospital health care system, helping to conserve expensive facilities for the acutely ill and improving the prospects of the chronically disabled.

- The main function of a hospital is to provide the population with complete health care; it also functions as the centre for the training of health workers. Some important functions of hospital include: medical care, patient support, administrative, teaching, research and employment.

- There are some critical issues come indirectly within the scope of hospital function like: Unequal distribution of health services contributing to health inequalities across status groups, social institutions reproducing health care inequalities by constraining and enabling the actions of health service organizations, the structure and dynamics of health care organizations shaping the quality, effectiveness, and outcomes of health services for different groups and communities.

- An interpersonal relationship is a strong, deep, or close association or acquaintance between two or more people. Interpersonal relationships are formed in the context of social, cultural and other influences. The context can vary from family or kinship relations, friendship, marriage, relations with associates, work, clubs, neighborhoods, and places of worship. They may be regulated by law, custom, or mutual agreement, and are the basis of social groups and society as a whole.

- Effective communication in the healthcare industry is incredibly important in aiding in the correct diagnosis of an individual's condition and treatment. It is very important that both the healthcare providers and the patient are very clear in what they say to one another.

- Effective Interpersonal Communication Practices has a great importance in health care settings. One of the most important elements for improving client satisfaction, compliance and health outcomes is to promote effective interpersonal communications between the health care provider and the client.

- Peplau is universally regarded as the mother of psychiatric nursing. Her theoretical and clinical work led to the development of the distinct specialty field of psychiatric nursing. According to Peplau's theory interpersonal relations provides a useful framework for investigating clinical phenomena and guiding nurses' actions. Her theory focuses primary on the nurse-client relationship in which problem-solving skills are developed. Four phases occur during this interactive process: *orientation, identification, exploitation and resolution*.

- Forchuk (1991), with the support of Peplau, clarified the structure as consisting of three main phases: **orientation, working,** and **termination.**

- The **orientation phase** marks a first step in the personal growth of the patient and is initiated when the patient has felt need and seeks professional assistance. The nurse focuses on knowing the patient as a person and uncovering erroneous preconceptions, as well as gathering information about the patient's mental health problem. The focus of the **working phase** is on: (a) the patient's efforts to acquire and employ knowledge about the illness, available resources, and personal strengths, and (b) the nurse's enactment of the roles of resource person, counselor, surrogate and teacher in facilitating the patient's development toward well-being. **Termination** is the final phase in the process of the therapeutic interpersonal relationship. Patients move beyond the initial identification with the nurse and engage their own strengths to foster health outside the therapeutic relationship.

- The nurse–client interaction enhances the client's well-being. The relationship between both depends on the interaction of thoughts, feelings, and actions of each person. The patient will experience better health when all their needs are fully considered in the relationship. Contract-Setting, boundaries, confidentiality, and therapeutic nurse behaviors are some factors contributing better nurse-client relationship.

- Culture is unique to every society. Illness and diseases as a social phenomenon also greatly influenced and shaped by culture and belief system of that particular society. Transcultural Nursing Care comes due to the apparent relevance on the emerging challenge in the lack of

attention to these cultural differences in health care practice resulted in an inferior nursing care. More and more health care organizations including educational institutions and nursing associations are becoming more aware of the significance of culture to nursing practice, which led to the development of Transcultural Nursing Care.

- Madeleine Leininger is considered as the founder of the theory of transcultural nursing. Her theory has now developed as a discipline in nursing. Evolution of her theory can be understood from her books: Culture Care Diversity and Universality (1991), Transcultural Nursing (1995) and Transcultural Nursing.

- To eliminate all possibilities of cultural factions among cultures in the organization, it would be helpful for health care institutions to provide trainings and seminars to bridge the gap in order to cultivate understanding between cultural differences. Development of awareness of cultural factors affecting working relationship will also help promote understanding of the reasons behind the conflicting issues, which will re-establish compatibility between opinions and belief to put aside and settle the differences. Another effective solution is to assign a counselor to act as intermediary between co-workers to resolve opposing issues in order to bring a harmonious working relationship between co-workers within the organization.

- It is very important to develop communication skill among nurses for a better interpersonal relationship in a hospital setting. The nurse's actions and words must go together to offer the most benefit to the patient. Both verbal and nonverbal communication skills, the accurate written record maintained by the nurse, the nurse's skilled observation of the patient's mental and physical condition, interpretation of the physician's orders and interaction with the patient and family, acknowledging the patient as an individual rather than just a case are some of the skills highly necessary for a health worker for development of interpersonal relationship.

- Two-way dialogue between the patient and the doctor/nurse with mutual respect for each other, caring atmosphere where patient feel secure by being attentive, effective verbal, non verbal communication and social interaction are effective interpersonal communication practices in health care settings.

- Major barriers to effective interpersonal communication are psychological barriers where shyness or embarrassment, nervousness of the patient cause a barrier and disrupt interpersonal relationship. Likewise obstacle that can be experienced by the health care provider in an actual face to face encounter with patients is multicultural health care setting. Language Barriers where both parties do not share a common language and Environmental Barriers where noise and lack of privacy, environment which is too hot or cold are not at all conducive to effective

communication. These barriers in a hospital setting are the obstacles which negatively influence proper interpersonal relation between the patient and the service providers.

2.7.Key words:

Medical sociologists- Medical Sociologist are interested in the study of health, health behavior and medical institutions.

Health services- an activity performed in relation to an individual that is intended or claimed by the individual or the person performing it to assess, record, maintain or improve his/her health.

Health care system – the organization of people, institutions, and resources to deliver health care services to meet the health needs of target populations.

Health care delivery system – healthcare delivery system is the organization of people, institutions, and resources that deliver health care services to meet the health needs of target populations.

Hospitals– a social organization and logical combination of the activities of a number of persons with different level of knowledge and skill for achieving a common goal of patient care through a hierarchy of authority and responsibility.

Deprofessionalization – the process by which members of a high-status occupation lose the facility to have autonomous control over its internal affairs and the behaviour of its membership.

Social organization – a sociological concept, defined as a pattern of relationships between and among individuals and groups.

Bio-social research– the in behavioral and social science that studies personality disorders and mental illnesses and disabilities to biologically-determined personality traits reacting to environmental stimuli.

Matrix organization – a mix of product and function where people of similar skills are grouped together to execute activities to achieve organizational objective.

Public hospitals – a public hospital or government hospital is a hospital which is owned by a government and receives government funding. This type of hospital provides medical care free of charge, the cost of which is covered by the funding the hospital receives.

Primary care health provider- those physicians and Nurse Practitioners who deliver comprehensive health care in the clinic setting e.g. take care of a wide variety of problems--acute medical illnesses such as common colds, sinus infections, stomach problems, and skin rashes, for example, but also more chronic health problems like acne, depression, asthma, high blood pressure, and allergies.

Life expectancies- the expected (in the statistical sense) number of years of life remaining at a given age.

Outpatients- patients who go to a hospital just for diagnosis, treatment, or therapy and then leave without staying overnight.

Inpatients- patients who are 'admitted' and stay overnight or for several days or weeks or months

General hospital- the hospital, which is set up to deal with many kinds of disease and injury, and normally has an emergency department to deal with immediate and urgent threats to health.

Specializing hospitals- Hospitals that specialize in one type of illness or one type of patient,

Social institutions- any structure or mechanism of social order governing the behaviour of a set of individuals within a given community.

Interpersonal relationship- a strong, deep, or close association or acquaintance between two or more people that may range in duration from brief to enduring.

Verbal Communication - what we say and how we say.

Nonverbal Communication - what we communicate without words, body language is an example.

Health care provider – A health care provider is an individual or an institution that provides preventive, curative, promotional or rehabilitative health care services in a systematic way to individuals, families or communities.

Culture- the values, beliefs, behavior and material objects that together form a people's way of life.

Transcultural Nursing- Transcultural nursing is how professional nursing interacts with the concept of culture

Cultural diversity- the variety of human societies or cultures in a specific region, or in the world as a whole.

Social Interaction- a dynamic, changing sequence of social actions between individuals or groups.

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Unit-III: Community Health- the concept, Community health problems in India and Concept of Integrated health service

Unit-III

3.0. Objectives of the Unit:

3.1   Community Health- the concept:

3.1.2   Scope of Community health:

3.1.2   Some related concepts:

3.2.   Interface between public health and primary healthcare:

3.3   Community health problems in India:

> **3.3.1   Health in India**

> **3.3.4   Major Health issues:**

> **3.3.4   Schemes and plans for major community health problems in India**

> **3.4 Rural Healthcare Infrastructure:**

> **3.5. Central and state Government Role:**

>   **3.6.Concept of Integrated health service:**

> **3.7   Integrated Child Development Services in India:**

> **3.8. Summary:**

> **3.9. Key Words**

> **3.10. Further Readings:**

3.0. Objectives of the Unit:

The main objective of this unit is to inform the readers about the community health system in India. After the completion of studying this unit the students will gain some fundamental knowledge on the following topics:

- ❖ The concept of community Health
- ❖ Major health issues in India
- ❖ Major government schemes and programmes to combat the community health problems
- ❖ Concept of Integrated health approach to health care in India
- ❖ The concept of Integrated Child Development Services in India: its structure, function , scope, impact and drawbacks.

3.1 Community Health- the concept:

Community is a small or large group in which people share no particular interest but the basic condition of life it-self. The basic criterion of community is that all of one's social relationship may be found within it .Community health, a field of public health, is a discipline which concerns itself with the study and improvement of the health characteristics of biological communities. While the term community can be broadly defined, community health tends to focus on geographical areas rather than people with shared characteristics. The health characteristics of a community are often examined using geographic information system (GIS) software and public health datasets. Some projects, such as Info Share or GEOPROJ combine GIS with existing datasets, allowing the general public to examine the characteristics of any given community in participating countries. Well-being is influenced by a wide array of **socio-demographic characteristics**, **relevant variables** range from the proportion of residents of a given age group to the overall life expectancy of the community. Medical interventions aimed at improving the health of a community range from improving access to medical care to public health communications campaigns. Recent research efforts have focused on how the built environment and socio-economic status affect health. Success of community health programmes relies upon the transfer of information from health professionals to the general public using one-to-one or one to many communication (Mass communication). The latest shift is towards Health marketing.

3.1.1 Scope of Community health:

Community health may be studied within three broad categories:

- **Primary healthcare:** Primary healthcare refers to interventions that focus on the individual or family such as hand-washing, immunization, circumcision. Traditionally, a population health approach has been a public health focus. More recently. However, the Primary Health Care Strategy set a new direction for primary health care, which traditionally provided treatment services focusing on individuals, not communities or populations. Primary health care services are now to focus on better public health for a population and actively work to reduce health inequalities between different groups. There is now a clearer interface between public health and primary health care and a closer alignment in their overarching priorities. Primary care is often used as the term for the health care services which play a role in the local community. It can be provided in different settings, such as Urgent care centers which provide services to patients same day with appointment or walk-in bases.

    Primary care involves the widest scope of health care, including all ages of patients, patients of all socioeconomic and geographic origins, patients seeking to maintain optimal health, and patients with all manner of acute and chronic physical, mental and social health issues, including multiple chronic diseases. Consequently, a primary care practitioner must possess a wide breadth of knowledge in many areas. Continuity is a key characteristic of primary care, as patients usually prefer to consult the same practitioner for routine check-ups and preventive care, health education, and every time they require an initial consultation about a new health problem. The International Classification of Primary Care (ICPC) is a standardized tool for understanding and analyzing information on interventions in primary care by the reason for the patient visit.

    Common chronic illnesses usually treated in primary care may include, for example: hypertension, diabetes, asthma, COPD, depression and anxiety, back pain, arthritis or thyroid dysfunction. Primary care also includes many basic maternal and child health care services, such as family planning services and vaccinations. In the United States, the 2013 National Health Interview Survey found that skin disorders (42.7%), osteoarthritis and joint disorders (33.6%), back problems (23.9%), disorders of lipid metabolism (22.4%), and upper respiratory tract disease (22.1%, excluding asthma) were the most common reasons for accessing a physician.

    In context of global population aging, with increasing numbers of older adults at greater risk of chronic non-communicable diseases, rapidly increasing demand for primary care services is expected around the world, in both developed and developing countries. The World Health Organization attributes the provision of essential primary care as an integral component of an inclusive primary health care strategy.

- **Secondary healthcare**: Secondary healthcare refers to those activities which focus on the environment such as draining puddles of water near the house, clearing bushes and spraying insecticides to control vectors like mosquitoes. It includes acute care: necessary treatment for a short period of time for a brief but serious illness, injury or other health condition, such as in a hospital emergency department. It also includes skilled attendance during childbirth, intensive care, and medical imaging services.

    The "secondary care" is sometimes used synonymously with "hospital care". However many secondary care providers do not necessarily work in hospitals, such as psychiatrists, clinical psychologists, occupational therapists or physiotherapists (physiotherapists are also primary care providers and a referral is not required to see a physiotherapist), and some primary care services are delivered within hospitals. Depending on the organization and policies of the national health system, patients may be required to see a primary care provider for a referral before they can access secondary care. For example in the United States, which operates under a mixed market health care system, some physicians might voluntarily limit their practice to secondary care by requiring patients to see a primary care provider first, or this restriction may be imposed under the terms of the payment agreements in private or group health insurance plans. In other cases medical specialists may see patients without a referral, and patients may decide whether self-referral is preferred.

    Allied health professionals, such as physical therapists, respiratory therapists, occupational therapists, speech therapists, and dietitians, also generally work in secondary care, accessed through either patient self-referral or through physician referral.

- **Tertiary healthcare:** Tertiary healthcare refers to those interventions that take place in a hospital setting such as intravenous rehydration or surgery. Tertiary care is specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary referral hospital.

    Examples of tertiary care services are cancer management, neurosurgery, cardiac surgery, plastic surgery, treatment for severe burns, advanced neonatology services, palliative, and other complex medical and surgical interventions.

As per census 2001, India is a country of 102.70 crores of people, out of whom majority (around 73%) lives in rural areas. There is a terrific imbalance between the availability of natural and capital resources Vis-a- Vis the required amount of these resources for all round growth and development of

this population. Therefore, this enormity of population leads to sustenance of poverty and ill-health, which results into the falling standard of living for quite substantial proportion of people. This sort of situation is unacceptable as it defeats our national developmental goals. Hence, the need for population controls.

To achieve this avowed objective as well as execution of various national health programmes, a vast health infrastructure in the shape of Community Health Centers (CHCs)(30 bedded hospital on each 80-120 thousand population), Primary Health Centers (PHCs) (on each 20-30 thousand population) and Sub-Centers (SCs)(on each 3-5 thousand population) has been created. In September 2004, a network of 3,222 CHCs, 23, 109 PHCs and 1, 42,655 Sub- Centers had been functioning in the rural and semi-urban areas of the country (GOI, 2006, 456).

A Community Health Center is staffed with a Medical Specialist, a child specialist, a gynecologists, a surgeon and a lady doctor along with around 25 other paramedical and support staff. A Primary Health Centre (PHC) is staffed with a medical officer, a pharmacist, a staff nurse, block extension educator/ health educator, lab technician, one male and one female health worker and 4-5 other support staff. At the Sub-Center level, a team of health workers (one male and one female) is stationed at the village itself. The overall administrative responsibility of running these centers rests with the MO of the PHC/CHC.

3.1.2 Some related concepts:

- **Population health:**

Population health has been defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group". It is an approach to health that aims to improve the health of an entire human population. This concept does not refer to animal or plant populations. A priority considered important in achieving this aim is to reduce health inequities or disparities among different population group due to the social determinants of health, SDOH. The SDOH include all the factors: social, environmental, cultural and physical the different populations are born into, grow up and function with throughout their lifetimes which potentially have a measurable impact on the health of human populations. The Population Health concept represents a change in the focus from the individual-level, characteristic of most mainstream medicine. It also seeks to complement the classic efforts of public health agencies by addressing a broader range of factors shown to impact the health of different populations. The World Health Organization's Commission on Social Determinants of Health, reported in 2008, that the SDOH factors were responsible for the bulk of diseases and injuries and these were the major causes of health inequities in all countries. In the US, SDOH were estimated to account for 70% of avoidable mortality.

From a population health perspective, health has been defined not simply as a state free from disease but as "the capacity of people to adapt to, respond to, or control life's challenges and changes".

The World Health Organization (WHO) defined health in its broader sense in 1946 as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

- **population health as an approach:**

  Public health takes a population health approach, which places a greater emphasis on community health including:
  - ✓ The population as a whole
  - ✓ The role of the community
  - ✓ Health promotion and preventative care, and
  - ✓ The need to involve a range of professionals

- **Population Health: the determinants of health :**

A population health approach also takes into account all factors that determine a Person's health and wellbeing, and it plan how these factors can be addressed. These factors are called the determinants of health and include:

  - ✓ Peace, shelter and food
  - ✓ Education and sufficient income
  - ✓ A stable eco-system
  - ✓ Sustainable resource use
  - ✓ Social justice and equity, etc

- **Healthy People 2020:**

  Healthy People 2020 is a web site sponsored by the US Department of Health and Human Services, representing the cumulative effort of 34 years of interest by the Surgeon General's office and others. It identifies 42 topics considered Social determinants of health and approximately 1200 specific goals considered to improve population health. It provides links to the current research available for selected topics and identifies and supports the need for community involvement considered essential to address these problems realistically.

- **The human role of economic inequality:**

  Recently, human role has been encouraged by the influence of population growth. There has been increasing interest from epidemiologists on the subject of economic inequality and its relation to the health of populations. There is a very robust correlation between socioeconomic status and health. This correlation suggests that it is not only the poor who tend to be sick when everyone else is healthy, heart disease, ulcers, type 2 diabetes, rheumatoid arthritis, certain types of cancer, and premature aging. Despite the reality of the SES Gradient, there is debate as to its cause. A number of researchers (A. Leigh, C. Jencks, A. Clarkwest—see also Russell Sage working papers) see a definite link between

economic status and mortality due to the greater economic resources of the better-off, but they find little correlation due to social status differences. Other researchers such as Richard G. Wilkinson, J. Lynch, and G.A. Kaplan have found that socioeconomic status strongly affects health even when controlling for economic resources and access to health care. Most famous for linking social status with health are the Whitehall studies—a series of studies conducted on civil servants in London. The studies found that, despite the fact that all civil servants in England have the same access to health care, there was a strong correlation between social status and health. The studies found that this relationship stayed strong even when controlling for health-affecting habits such as exercise, smoking and drinking. Furthermore, it has been noted that no amount of medical attention will help decrease the likelihood of someone getting type 1 diabetes or rheumatoid arthritis—yet both are more common among populations with lower socioeconomic status. Lastly, it has been found that amongst the wealthiest quarter of countries on earth (a set stretching from Luxembourg to Slovakia) there is no relation between a country's wealth and general population health, suggesting that past a certain level, absolute levels of wealth have little impact on population health, but relative levels within a country do. The concept of psychosocial stress attempts to explain how psychosocial phenomenon such as status and social stratification can lead to the many diseases associated with the SES gradient. Higher levels of economic inequality tend to intensify social hierarchies and generally degrade the quality of social relations—leading to greater levels of stress and stress related diseases. Richard Wilkinson found this to be true not only for the poorest members of society, but also for the wealthiest. Economic inequality is bad for everyone's health. Inequality does not only affect the health of human populations. David H. Abbott at the Wisconsin National Primate Research Center found that among many primate species, less egalitarian social structures correlated with higher levels of stress hormones among socially subordinate individuals. Research by Robert Sapolsky of Stanford University provides similar findings.

3.2 Interface between public health and primary healthcare:

A population health approach is not new for public health. Public health is about keeping people healthy and improving the health of populations rather than treating diseases, disorders and disabilities in individuals. Public health, particularly health promotion, has an important role in re-orienting the health sector towards a population health approach.

Public health knowledge and skills within the Primary Health Organizations' workforce will assist PHOs to achieve their population health goals; not only at an individual worker level, but also at an organizational level. The challenge for the traditional primary healthcare approach is to learn new ways of working. The challenge for public health is to evolve public health focused workforce development and training, so that it is applicable to the primary care workforce.

3.3 Community health problems in India:

India was one of the pioneers in health service planning with a focus on community health care. In 1946, the Health Survey and Development Committee, headed by Sir Joseph Bhose recommended

establishment of a well structured and comprehensive health service with a sound community health care infrastructure. However, the quality of Indian healthcare is varied. In major urban areas, healthcare is of adequate quality, approaching and occasionally meeting Western standards. However, access to quality medical care is limited or unavailable in most rural areas, although rural medical practitioners are highly sought after by residents of rural areas as they are more financially affordable and geographically accessible than practitioners working in the formal public health care sector.

Social development through improvement in health status can be achieved through improving the access to and utilization of Health, Family Welfare and Nutrition service with special focus on underserved and under privileged segment of population.

3.3.1   Health in India:

India has a universal health care system run by the constituent states and territories of India. The Constitution charges every state with "raising the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties". The National Health Policy was endorsed by the Parliament of India in 1983 and updated in 2002. Parallel to the public health sector, and indeed more popular than it, is the private medical sector in India. Both urban and rural Indian households tend to use the private medical sector more frequently than the public sector, as reflected in surveys.

- **Twelfth Five Year Plan Strategy(2012-2017):**

Based on the recommendation of HLEG (High Level Expert Group) Report and other stakeholder consultations, the key elements of Twelfth Five Year plan strategy was outlined. The long term objective of this strategy was to establish a system of Universal Health Coverage (UHC) in the country. Following are the 12th plan period strategy: Substantial expansion and strengthening of public sector health care system, freeing the vulnerable population from dependence on high cost and often unreachable private sector health care system.

- ✓ Health sector expenditure by central government and state government, both plan and non-plan will have to be substantially increased by the twelfth five year plan. It was increased from 0.94 per cent of GDP in tenth plan to 1.04 per cent in eleventh plan. The provision of clean drinking water and sanitation as one of the principal factors in control of diseases is well established from the history of industrialized countries and it should have high priority in health related resource allocation. The expenditure on health should increase to 2.5 per cent of GDP by the end of Twelfth Five Year Plan.

- ✓ Financial and managerial system will be redesigned to ensure efficient utilization of available resources and achieve better health outcome. Coordinated delivery of services within and across sectors, delegation matched with accountability, fostering a spirit of innovation are some of the measures proposed.

- ✓ Increasing the cooperation between private and public sector health care providers to achieve health goals. This will include contracting in of services for gap filling, and various forms of effectively regulated and managed Public-Private Partnership, while also ensuring that there is no compromise in terms of standards of delivery and that the incentive structure does not undermine health care objectives.

- ✓ The present Rashtriya Swasthya Bhima Yojana (RSBY) which provides cash less in-patient treatment through an insurance based system should be reformed to enable access to a continuum of comprehensive primary, secondary and tertiary care. In twelfth plan period entire Below Poverty Line(BPL) population will be covered through RSBY scheme. In planning health care structure for the future, it is desirable to move from a 'fee-for-service' mechanism, to address the issue of fragmentation of services that works to the detriment of preventive and primary care and also to reduce the scope of fraud and induced demand.

- ✓ In order to increase the availability of skilled human resources, a large expansion of medical schools, nursing colleges, and so on, is therefore is necessary and public sector medical schools must play a major role in the process. Special effort will be made to expand medical education in states which are under-served. In addition, a massive effort will be made to recruit and train paramedical and community level health workers.

- ✓ The multiplicity of Central sector or Centrally Sponsored Schemes has constrained the flexibility of states to make need based plans or deploy their resources in the most efficient manner. The way forward is to focus on strengthening the pillars of the health system, so that it can prevent, detect and manage each of the unique challenges that different parts of the country face.

- ✓ A series of prescription drugs reforms, promotion of essential, generic medicine and making these universally available free of cost to all patients in public facilities as a part of the Essential Health Package will be a priority.

- ✓ Effective regulation in medical practice, public health, food and drugs is essential to safeguard people against risks and unethical practices. This is especially so given the information gaps in the health sector which make it difficult for individual to make reasoned choices.

- ✓ The health system in the Twelfth Plan will continue to have a mix of public and private service providers. The public sector health services need to be strengthened to deliver both public health related and clinical services. The public and private sectors also need to coordinate for the delivery of a continuum of care. A strong regulatory system would

supervise the quality of services delivered. Standard treatment guidelines should form the basis of clinical care across public and private sectors, with the adequate monitoring by the regulatory bodies to improve the quality and control the cost of care.

- **Drawbacks:**

The 12th five year plan document on health has received a lot of criticism for its limited understanding of universal health care and failure to increase public expenditure on health.

- ✓ While the HLEG report recommends an increase in public expenditure on health from 1.58 per cent of GDP currently to 2.1 per cent of GDP by the end of 12th five year plan it is far lower than the global median of 5 per cent.

- ✓ The lack of extensive and adequately funded public health services pushes large numbers of people to incur heavy out of pocket expenditures on services purchased from the private sector.

- ✓ Out of pocket expenditures arise even in public sector hospitals, since lack of medicines means that patients have to buy them. This results in a very high financial burden on families in case of severe illness.

- ✓ Though, the 12th plan document express concern over high out-of-pocket (OOP) expenditure, it does not give any target or time frame for reducing this expense.

- ✓ OOP can be reduced only by increasing public expenditure on health and by setting up wide spread public health service providers. But the planning commission is planning to do this by regulating private health care providers.

- ✓ Instead of developing a better public health system with enhanced health budget, 12th five year plan document plans to hand over health care system to private institutions.

- ✓ The 12th plan documents express concern over Rashtriya Swasthya Bhima Yojana being used as a medium to hand over public funds to private sector through insurance route. This has also incentivized unnecessary treatment which in due course will increase costs and premiums.

- ✓ There has being complaints about high transaction cost for this scheme due to insurance intermediaries. RSBY does not take into consideration state specific variation in disease profiles and health needs.

- ✓ There is no reference to nutrition as key component of health and for universal Public Distribution System (PDS) in the plan document or HLEG recommendation.
- ✓ In the section of National Rural Health Mission (NRHM) in the document, the commitment to provide 30-50 bed Community Health Centers (CHC) per lakh population is missing from the main text.

- ✓ It was east for the government to recruit poor women as ASHA (Accredited Social Health Activist) workers but it has failed to bring doctors, nurses and specialist in this area. The ASHA workers who are coming from a poor background are given incentive based on performance. These people lose many days job undertaking their task as ASHA worker which is not incentivized properly.

- • **Quality:**

The quality of Indian healthcare is varied. In major urban areas, healthcare is of adequate quality, approaching and occasionally meeting Western standards. However, access to quality medical care is limited or unavailable in most rural areas, although rural medical practitioners are highly sought after by residents of rural areas as they are more financially affordable and geographically accessible than practitioners working in the formal public health care sector.

3.3.2   Major Health issues:

India was one of the pioneers in health service planning with a focus on primary health care. In 1946, the Health Survey and Development Committee, headed by Sir Joseph Bhose recommended establishment of a well structured and comprehensive health service with a sound primary health care infrastructure. Social development through improvement in health status can be achieved through improving the access to and utilization of Health, Family Welfare and Nutrition service with special focus on underserved and under privileged segment of population.

Under the Constitution, health is a state subject. Central Government can intervene to assist the state governments in the area of control/eradication of major communicable and non-communicable diseases, broad policy formulation, medical and Para-medical education combined with regulatory measures, drug control and prevention of food adulteration, Child Survival and Safe Motherhood (CSSM) and immunization programme. However, there are numerous health problems in India, like water supply and sanitation continue to be a challenge, only one of the three Indians has access to improved sanitation facilities such as toilet. India's HIV/AIDS epidemic is growing threat. Cholera epidemics are not unknown. The maternal mortality in India is the second highest in the world. India is one of the four countries worldwide where polio has not yet been successfully eradicated and one third of the world's

tuberculosis cases are in India. Three out of four children who died from measles in 2008 were in India. According to the World Health Organization 900,000 Indians die each year from drinking contaminated water and breathing in polluted air. Following are some of the major community health problems in India.

- **Malnutrition:**

  According to a 2005 report, 42% of India's children below the age of three were malnourished, which was greater than the statistics of sub-Saharan African region of 28%. Although India's economy grew 50% from 2001–2006, its child-malnutrition rate only dropped 1%, lagging behind countries of similar growth rate. Malnutrition impedes the social and cognitive development of a child, reducing his educational attainment and income as an adult. These irreversible damages result in lower productivity. Major nutritional problems in India are Protein Energy Malnutrition (PEM), Iodine Deficiency Disorder (IDD), Vitamin-A deficiency and anemia.

- **High infant mortality rate:**

Approximately 1.72 million children die each year before turning one. The under five mortality and infant mortality rates have been declining, from 202 and 190 deaths per thousand live births respectively in 1970 to 64 and 50 deaths per thousand live births in 2009. However, this decline is slowing. Reduced funding for immunization leaves only 43.5% of the young fully immunized. A study conducted by the Future Health Systems Consortium in Murshidabad, West Bengal indicates that barriers to immunization coverage are adverse geographic location, absent or inadequately trained health workers and low perceived need for immunization. Infrastructure like hospitals, roads, water and sanitation are lacking in rural areas. Shortages of healthcare providers, poor intra-partum and newborn care, diarrheal diseases and acute respiratory infections also contribute to the high infant mortality rate.

- **Diseases:**

Diseases such as dengue fever, hepatitis, tuberculosis, malaria and pneumonia continue to plague India due to increased resistance to drugs. In 2011, India developed a totally drug-resistant form of tuberculosis. India is ranked 3rd highest among countries with the amount of HIV-infected patients. Diarrheal diseases are the primary causes of early childhood mortality. These diseases can be attributed to poor sanitation and inadequate safe drinking water in India. India also has the world's highest incidence of Rabies.

However in 2012 India was polio-free for the first time in its history. This was achieved because of the Pulse Polio Programme started in 1995-96 by the government of India. Indians are also at particularly high risk for atherosclerosis and coronary artery disease. This may be attributed to a genetic predisposition to metabolic syndrome and adverse changes in coronary artery vasodilatation. NGOs

such as the Indian Heart Association and the Med win Foundation have been created to raise awareness of this public health issue.

- **Poor sanitation:**

As more than 122 million households have no toilets, and 33% lack access to latrines, over 50% of the population (638 million) defecate in the open.(2008 estimate.). This is relatively higher than Bangladesh and Brazil (7%) and China (4%). Although 211 million people gained access to improved sanitation from 1990–2008, only 31% use the facilities provided. Only 11% of Indian rural families dispose of stools safely whereas 80% of the population leave their stools in the open or throw them in the garbage. Open air defecation leads to the spread of disease and malnutrition through parasitic and bacterial infections.

- **Safe drinking water:**

Access to protected sources of drinking water has improved from 68% of the population in 1990 to 88% in 2008. However, only 26% of the slum population has access to safe drinking water, and 25% of the total population has drinking water on their premises. This problem is exacerbated by falling levels of groundwater caused mainly by increasing extraction for irrigation. Insufficient maintenance of the environment around water sources, groundwater pollution, excessive arsenic and fluoride in drinking water pose a major threat to India's health.

- **Kala Azar:**

Kala-azar is a serious public health problem. Kala-azar control was being provided by the Government of India out of the National Malaria Eradication Programme (NMEP), until 1990-91. The Centre provides insecticide, anti-Kala-azar drugs and technical guidance to the affected states.

- **Female health issues:**

Women's health in India involves numerous issues. Some of them include the following:

- ✓ **Malnutrition**: Most Indian women are malnourished. The average female life expectancy today in India is low compared to many countries. In many families, especially rural ones, the girls and women face nutritional discrimination within the family, and are anemic and malnourished. The main cause of female malnutrition in India is the tradition requiring women to eat last, even during pregnancy and when they are lactating.

- ✓ **Breast Cancer**: One of the most severe and increasing problems among women in India, resulting in higher mortality rates.

- ✓ **Stroke:** Polycystic ovarian disease (PCOD): PCOD increases the infertility rate in females. This condition causes many small cysts to form in the ovaries, which can negatively affect a woman's ability to conceive.

- ✓ **Maternal Mortality**: the maternal mortality in India is the second highest in the world. Only 42% of births in the country are supervised by health professionals. Most women deliver with help from women in the family who often lack the skills and resources to save the mother's life if it is in danger. According to UNDP Human Development Report, 88% of pregnant women (15-49) were found to be suffering from anemia.

- • **Rural health :**

Rural India contains over 68% of India's total population, and half of all residents of rural areas live below the poverty line, struggling for better and easy access to health care and services. Health issues confronted by rural people are many and diverse – from severe malaria to uncontrolled diabetes, from a badly infected wound to cancer. Postpartum maternal illness is a serious problem in resource-poor settings and contributes to maternal mortality, particularly in rural India. A study conducted in 2009 found that 43.9% of mothers reported they experienced postpartum illnesses six weeks after delivery.

3.3.4   Schemes and plans for major community health problems in India:

Health care in India is the responsibility of constituent states and territories of India. The constitution charges every state with "raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties". The National Health Policy was endorsed by the parliament of India in 1983 and updated in 2002.

The art of Health care in India can be traced back nearly 3500 years. From the early days of Indian history the Ayurvedic tradition of medicine has been practiced. Public health system in India suffers from many problems which includes insufficient funding, shortage of facilities leading to overcrowding severe shortage of trained health personnel. There is also lack of accountability in the public health delivery mechanisms. Following are some major schemes and plans for tackling community health problems in India.

- • **National Health Programmes:**

(i) Kala Azar:

Kala-azar is a serious public health problem endemic in Bihar and West-Bengal. Kala-azar control was being provided by the Government of India out of the National Malaria Eradication Programme

(NMEP), until 1990-91. The Centre provides insecticide, anti-Kala-azar drugs and technical guidance to the affected states.

During the Ninth Plan, the focus was on ensuring effective implementation of the programme so as to prevent outbreaks and eventually to control infection. DDT continued to be the mainstay for insecticide spray as the vector (phlebotomus argentites) is still susceptible to DDT.

(ii) Malaria:

National Anti-Malaria Programme was implemented in 1958, which reduced the annual incidence of malaria to one lakh in 1965. Deaths due to malaria were completely eliminated. But resurgence of malaria necessitated review of vigorous anti-malaria activities. The Modified Plan of, Operation (MPO) was implemented from April, 1977, which reduce the incidence of malaria to 1.66 million in 1987 from 6.47 million in 1976.

In view of the high incidence of malaria and resource, constraints in seven north-eastern states, 100 per cent Central Government assistance was provided with effect from December, 1994. For effective control of malaria, the Enhanced Malaria Control Project was launched in September 1997, with World Bank assistance, under which 100 hard core and tribal predominant districts of Andhra Pradesh, Bihar, Gujarat, Madhya Pradesh, Maharashtra, Rajasthan and Orissa and 19 problematic towns of various states have been included.

(iii) National Filaria Control Programme:

It was launched in 1955 and it took up several activities including: (a) delimitation of the problem in hitherto unsurveyed areas and (b) control in urban areas through recurrent anti-larval measures and anti parasite measures. At present about 49.87 million urban populations is protected by anti-larval measures through 206 control units, 199 filaria clinics and 27 filaria survey units

(iv) Japanese Encephalitis:

Japanese Encephalitis (JE) has been reported in the country since mid-fifties and caused by virus and spread by mosquitoes has a mortality ratio of 30 to 45 per cent. Due to development of irrigation projects and changing pattern of water resource management there has been a progressive increase in the number of states reporting cases of J.E. in India. The National Malaria Eradication Programme (NMEP) has been implementing, the recommendations of the Expert Committee on J.E. control. Under

the Ninth Plan, Information, Education and Communication (IEC) activities to ensure community awareness and co-operation, for prevention and control of vector borne diseases will be intensified.

(v) Tuberculosis:

Tuberculosis is a major health problem in India. Studies carried out by the Indian Council of Medical Research (ICMR) in the fifties and sixties showed that:

- ✓ Unlike the situation in developed countries, BCG did not protect against adult TB and BCG given at/soon after birth provided some protection against TB in infancy and early childhood.
- ✓ Domiciliary treatment with anti TB drugs was safe and effective.

❖ National Tuberculosis Control Programme:

It was initiated in 1962 as a CSS, which aimed at earl) case detection in symptomatic patients reporting to the health system through sputum microscopy and X-ray and effective domiciliary treatment with standard chemotherapy The short course chemotherapy introduced in selectee districts in 1983, has shortened the duration of treatment to nine months.

The Revised National Tuberculosis Programme (RNTCP) was launched in the country on March 1, 1997, and is proposed to be implemented in a phased manner in 102 districts of the country, covering a population of 271 million, with the assistance of World Bank.

Under; the Ninth Plan, the NTCP (National TB Control Programme will be strengthened in 203 Short Course Chemotherapy (SCC) districts as a transitional step to adopt the RNTCF Under the Ninth-Plan, standard regime will be strengthened in the remaining non SCC districts and Central Institutions, State TB cells, and state TB Training Institutions throughout the country will be strengthened.

(vi) Dengue:

Dengue fever is a viral disease which is transmitted through the bites of female Aedes mosquitoes. There are four serotypes of Dengue virus which are prevalent in India since 1950. Dengue viral infection may remain a symptom attic/manifest itself either as undifferentiated febrile illness (Viral syndrome), Dengue fever (DF) or Dengu haemorrhaphic fever (DHF).

An outbreak of Dengue was reported in Delhi in 1996, when 10,252 cases and 42 deaths reported, and was also reported from U.P, Punjal Haryana, Tamil Nadu, and Karnataka. Formulation of a National Dengue Control Programme is under consideration of the Central Government.

During the Ninth-Plan efforts was made to:

(a) Establish an organized system of surveillance and monitoring.

(b) Strengthen facilities for early diagnosis and prompt treatment.

(c) Intensify IEC efforts to ensure that all households implement pre-domestic measures to reduce breeding of Aedes.

(vii) Leprosy:

The National Leprosy Eradication Programme (NLEP) was launched in 1983 as hundred percent centrally sponsored schemes with the availability of Multi Drug Therapy (MDT). It became possible to cure leprosy cases within a short period (6-24 months) of treatment. The NLEP programme was initially taken up in endemic districts and was extended to all over the country from 1994 with World Bank assistance. The first round of Modified Leprosy Elimination Campaign (MLEC) is to be implemented in all the states and UTs to create mass awareness.

(viii) Blindness:

It is estimated that there are 12.5 million economically blind persons in India. Of these over 80 per cent of blindness is due to cataract. The National Blindness Control Programme started in 1976 as 100 per cent centrally sponsored programme with the objective of providing comprehensive eye care services at primary, secondary and tertiary health care level and achieving substantial reduction in the prevalence of eye disease in general and blindness in particular.

The activities under the programme are yet to show an impact in reducing the prevalence of blindness to the goal level of 0.3 per cent by the year 2000 A.D. A major thrust was given under the Eight Plan to strengthen the programme in Jammu and Kashmir and Karnataka. Funds from domestic budget as well as EAP were provided for this. At the tertiary level of opthalmic care there are eleven regional institutes of ophthalmology including the apex institute, Dr. Rajendra Prasad Centre for Ophthalmic Sciences in the All India Institute of Medical Sciences, New Delhi.

The programme priorities during the Ninth-Plan is to improve the quality of cataract surgery, clear the backlog of cataract cases, improve quality of case by skill upgradation of eye case personnel, improve service delivery through NGO and Public Sector collaboration and increase coverage of eye care delivery among underprivileged population. The targets set up under Ninth-Plan are 17.5 million cataract operations and 100,000 corneal implants in between the period 1997-2002.

- **Sexually Transmitted Disease:**

Control of Sexually Transmitted Disease (STDs) was introduced as a national control programme by the Government of India during the Fourth Five Year Plan (1967). Since STD was one of the major determinants for transmission of HIV infection, the programme has been merged with National AIDS Control Programme (NACO). There is involvement of private practitioners in STD control through Indian Medical Association (IMA).

- **HIV:**

Realizing the gravity of the epidemiological nature of HIV infection, the Government of India launched a National AIDS Control Programme in 1987. In 1992, National AIDS Control Organization was established and a 5 year strategic plan was implemented with a US $ 84 million soft loan from the World Bank and another US $ 1.5 million in the form of technical assistance from the World Health Organization. Under the Chairmanship of Minister of Health and Family Welfare, National AIDS Committee has been constituted. The apex Government of India body for HIV surveillance is the National AIDS Control Organization (NACO). The majority of HIV surveillance data collected by the NACO is done through annual unlinked anonymous testing of parental clinic (or antenatal clinics) and sexually transmitted infection clinic attendees. Annual reports of HIV surveillance are freely available on NACO's website. The government of India has also raised concerns about the role of intravenous drug use and prostitution in spreading AIDS, especially in north-east India and certain urban pockets.

✓ National AIDS Control Programme in Five-Yearly Plan:

I. More effective implementation of the Programme to ensure safety of blood/blood products.

II. Increasing the number of HIV testing network.

III. Augmenting STD, HIV/AIDS case facilities.

IV. Improving hospital infection control and waste management to reduce accidental infection.

V. Improving HIV/AIDS awareness, counseling and care.

VI. Strengthening Sentinel Surveillance. Components of NACP (Phase II)

VII. Reducing HIV transmission among poor and marginalized section of community at the highest risk of infection by targeted intervention, STD control and condom promotion;

VIII. Reducing the spread of HIV among the general population by reducing blood based transmission and promotion of IEC, voluntary testing and counseling;

IX. Developing capacity for community based low cost care for people living with AIDS;

X. Strengthening implementation capacity at the National, States and Municipal corporations levels through the establishment of appropriate organizational arrangements and increasing timely access to reliable information and

XI. Forging inter-sectoral linkages between public, private and voluntary sectors.

- **Iodine Deficiency Disorders:**

Iodine Deficiency Disorders (IDD) has been recognized as a public health problem in India since mid-twenties. IDD is not only a problem in sub-Himalayan region but also in reverie and coastal areas. It is estimated that 61 million populations are suffering from endemic goitre and about 8.8 million people have mental/motor handicap due to iodine deficiency.

The National Goitre Control Programme was initiated in 1962 as a 100 per cent centrally funded, centre sector programme with the objective of conducting goitre survey, and supplying good quality iodized salt to areas having high IDD, health education and resurvey after five years. In 1985, the government decided to iodise the entire edible salt in the country by 1992 in a phased manner. To date the production of iodated salt is 42 lakh MT per annum. The NGCP was renamed and redesigned as National Iodine Deficiency Disorders Control Programme (NIDDCP) to emphasize the importance of all the IDDs.

During the Ninth-Plan the major objective of the NIDDCP programme is,

(1) Production of adequate quantity of iodised salt of appropriate quality.

(2) Appropriate packaging at the site of production to prevent deterioration of quality of salt during transport and storage.

(3) Facilities for testing the quality of salt not only at production level but also at the retail outlets and household level so that consumers get and use good quality salt.

(4) IEC to ensure that people consume only good quality iodised salt.

(5) Survey of IDD and setting up of district level IDD monitoring laboratories for estimation of iodine content of salt and urinary iodine excretion.

- **Disease Surveillance Programme:**

National Surveillance Programme for Communicable Diseases which has potential of causing large outbreaks such as acute diarrheal diseases, viral hepatitis, dengue/DHF, Japanese encephalitis, leptospirosis and plague. The objective of the programme is capacity building at the district level for strengthening the disease surveillance system and appropriate response to outbreaks.

- **Mental Health:**

The National Mental Health Programme was started in 1982. The programme did not make much headway either in the Seventh or Eight Plan. The Mental Health Act (1987), which came into existence from April 1993, requires that each State/UT set up its own state level Mental Health Authority as a statutory obligation. Majority of the State/ UTs have complied with this and have formed a Mental Health Authority.

- **Cancer:**

The Cancer Control Programme was initiated in 1975- 76 as 100 per cent centrally funded centre sector project. It was renamed as National Cancer Control Programme in 1985. The objectives of the programme are

I. Primary prevention of tobacco related cancers.

II. Secondary prevention of cancer cervix.

III. Extension and strengthening of treatment facilities on a national scale.

Iv. Intensification of IEC activities so that people seek care at the onset of symptoms.

v. Provisions of diagnostic facilities in primary and secondary case level so that cancers are detected at early stages when curative therapy can be administered.

vi. Filling up of the existing gaps in radiotherapy units in a phased manner so that all diagnosed cases do receive therapy without any delay as near to their residence as is feasible.

vii. IEC to reduce tobacco consumption and avoid life styles which could lead to increasing risk of cancers.

- **National Diabetes Control Programme:**

The National Diabetes Control Programme has included a pilot programme in Seventh Five Year Plan. It was initiated in Tamilnadu and in one district in J and K.

- **Guinea Worm Eradication Programme:**

In 1983-84, India became the first country to launch an eradication programme against the disease, which had been causing great human suffering where safe drinking water is not available. The programme was implemented through existing primary health care infrastructure along with Ministry of Rural Development and the State public health engineering departments.

- **Yaws Eradication Programme:**

It can be cured and prevented by a single injection of long acting (benzathine benzyl) penicillin. Yaws is amenable to eradication. The pilot project to eradicate the disease in Koraput district was started in 1996-97. The programme has been extended to districts in Madhya Pradesh, Andhra Pradesh, Maharastra and Gujarat in 1997-98 and 1998-99. The programme is proposed to be extended to all affected districts during the Ninth Plan for which Rs. 4 crore have been earmarked.

- ## Medical Professionals:

In a 2005 World Bank study, World Bank reported that "a detailed survey of the medical knowledge of medical practitioners for treating five common conditions in Delhi found that the average doctor in a community health care center has around a 50-50 chance of recommending a harmful treatment". Random visits by government inspector showed that 40% of public sector medical workers were not found at the workplace.

- ## Medical Relief and Supplies:

Medical Services are primarily provided by Central and State government, apart from Charitable, voluntary and private institution.

3.4 Rural Healthcare Infrastructure:

The Indian health care industry is seen to be growing at a rapid pace and is expected to become a US$280 billion industry by 2022. According to the investment commission of India the health care sector has experienced phenomenal growth of 12 percent per annum in the last 4years. Rising income levels and growing elderly population are all factors that are driving this growth.

In addition, changing demographics, diseases profiles and the shift from chronic to life style diseases in the country has led to increased spending on health care delivery. Even so, the vast majority of the country suffers from a poor standard of health care infrastructure which has not kept up with the growing economy. Despites having centers of excellence in healthcare delivery, these facilities are limited and are inadequate in meeting the current health care demands.

Most public health facilities lack efficiency, are understaffed and have poorly maintained or outdated medical equipment. Approximately one millon people, mostly women and children, die in India each year due to inadequate health care. 700 million people have no access to specialist care and 80% of specialists live in urban areas. In addition to poor infrastructure India faces a shortage of trained medical personal especially in rural areas where access to care is altogether limited.

In order to meet manpower shortages and reach world standards India would require investments of up to $20 billion over the next 5 years. Forty percent of primary health centers in India are understaffed. According to WHO statistics there are over 250 medical colleges in the modern system of medicines and over 400 in the Indian system of medicine and homeopathy.

India produces over 250,000 doctors annually in the modern system of medicine and the similar number of homeopathy practitioners, nurses and para professionals. India faces a huge need gap in

terms of availability of number of hospital beds per 1000 population. With a world average of 3.96 hospital beds per 1000 population India stands just a little over 0.7 hospital beds per 1000 population.

Moreover, India faces a shortage of doctors, nurses and paramedics that are needed to propel the growing health care industry. However, Under the Minimum Needs Programme, Government has started developing the rural health infrastructure. In rural areas service are provided through integrated health and family welfare delivery system.

3.5   Central and state Government Role:

It was introduced with a view to providing medical and health care facilities to the Central Government employees and expensive reimbursement of medical expenses under Central Services (Medical Attendance) Rules, 1944. This scheme was started in Delhi/New Delhi. Critics say that the national policy lacks specific measures to achieve broad stated goals. Particular problems include the failure to integrate health services with wider economic and social development, the lack of nutritional support and sanitation, and the poor participatory involvement at the local level. Central government efforts at influencing public health have focused on the five-year plans, on coordinated planning with the states, and on sponsoring major health programmes.

Government expenditures are jointly shared by the central and state governments. Goals and strategies are set through central-state government consultations of the Central Council of Health and Family welfare. Central government efforts are administered by the Ministry of Health and Family Welfare, which provides both administrative and technical services and manages medical education. States provide public services and health education. The 1983 National Health Policy is committed to providing health services to all by 2000.

In 1983 health care expenditure varied greatly among the states and union territories, from 13 per capita in Bihar to Rs 60 per capita in Himachal Pradesh, and Indian per capita expenditure was low when compared with other Asian countries outside of South Asia. Although government health care spending progressively grew throughout the 1980s, such spending as a percentage of the gross national product (GNP) remained fairly constant. In the meantime, health care spending as a share of total government spending decreased. During the same period, private sector spending on health care was about 1.5 times as much as government spending.

> **Expenditure:**
In the mid-1990s, health spending amounted to 6% of GDP, one of the highest levels among developing nations. The established per capita spending is around Rs 320 per year with the major input from private households (75%). State governments contribute 15.2%, the central government 5.2%, third-party insurance and employers 3.3%, and municipal government and foreign donors about 1.3, according to a 1995 World Bank study.

Of these proportions, 58.7% goes towards primary health care (*curative, preventive, and promotive*) and 38.8% is spent on secondary and tertiary inpatient care. The rest goes for nonservice costs. The fifth and sixth five year plans (FY 1974-78 and FY 1980-84, respectively). Included programmes to assist delivery of preventive medicine and improve the health status of the rural population. Supplemental nutrition programmes and increasing the supply of safe drinking water were high priorities.

The sixth plan aimed at training more community health workers and increasing efforts to control communicable diseases. There were also efforts to improve regional imbalances in the distribution of health care resources. The Seventh Five year plan (FY 1985-89) budgeted Rs 33.9 billion for health; an amount roughly doubled the outlay of the sixth plan.

Health spending as a portion of total plan outlays, however, had declined over the years since the first plan in 1951, from a high of 3.3% of the total plan spending in FY 1951-55 to 1.9% of the total for the seventh plan. Mid-way through the Eighth Five-Year Plan (FY 1992-96), however, health and family welfare was budgeted at Rs 20 billon, or 4.3% of the total plan spending for FY 1994, with an additional Rs 3.6 billion in the nonplan budget.

➢ **Primary Services:**

Health care facilities and personnel increased substantially between the early 1950s and early 1980s, but because of fast population growth, the number of licensed medical practitioners per 10,000 individuals had fallen by the late 1980s to three per 10,000 from the 1981 level of four per 10,000. In 1991 there were approximately ten hospital beds per 10,000 individuals. Primary health centers are the corner stone of rural health care system. By 1991, India had about 22,400 Primary health centers, 11,200 hospitals, and 27,400 clinics.

These facilities are part of a tiered health care system that funnels more difficult cases into urban hospitals while attempting to provide routine medical care to the vast majority in the countryside. Primary health centers and sub centers rely on trained paramedics to meet most of their needs. The main problem affecting the success of Primary health centers are the predominance of clinical and curative concerns over the indented emphasis on preventive work and the reluctance of staff to work in rural areas.

In addition, the integration of health services with family planning programmes often causes the local population to perceive the Primary health centers as hostile to their traditional preference for large families. Therefore, Primary health centers often play an adversarial role in local efforts to implement national health policies. According to data provided in 1989 by the Ministry of Health and Family welfare, the total number of civilian hospitals for all states and union territories combined was 10,157. However, various studies have shown that in both urban and rural areas people preferred to pay and seek the more sophisticated services provided by private physicians rather than use free treatment at public health centers.

➢ **Emergency Medical Relief:**

Disaster management is the responsibility of State governments, but the Directorate General of Health Service, Ministry of Health and Family Welfare, Government of India provide technical assistance to the states. The responsibility is discharged by the Emergency Relief Division of the Directorate, which requires constant communication with the state governments.

> ### Drugs:

The Drugs and Cosmetics Act, 1940, as amended from time to time, regulates import, manufacture, sale and distribution of drugs and cosmetics in the country. Under the Act, import, manufacture and sale of sub-standard, spurious, adulterated/misbranded drugs are prohibited.

> ### Vaccine Production:

India is self-sufficient in the production of all vaccines, including measles required for the National Immunization Programme, except Polio. Polio vaccine which is imported in bulk, is blended at the Haffkine Bio-Pharmaceuticals Corporation Ltd. (Mumbai), Bharat Immunologicals and Biologicals Corporation Ltd. (Bulandshahar, UP), Radicura Pharma (Delhi) and Bromed Pvt. Ltd. (Ghaziabad, UP).

> ### Nutrition:

Major nutritional problems in India are Protein Energy Malnutrition (PEM), Iodine Deficiency Disorder (IDD), Vitamin-A deficiency and anaemia. To combat these problems arising from nutritional deficiencies, Government has initiated various programmes.

> ### Medical Education and Research:

The Indian Council of Medical Research (ICMR) was established in 1911, as the apex body in India for the formulation, coordination and promotion of biomedical research.

> ### Medical Council of India:

It was established as a statutory body under the provisions of the Indian Medical Council Act, 1933, which was later repealed by the Indian Medical Council Act, 1956, with minor amendments in 1958. A major amendment in the IMC Act, 1956 was made in 1993 to stop the mushroom growth of medical colleges/increase of seats/starting of new courses without prior approval of the Ministry of Health and Family Welfare.

> ### Dental Council of India:

It was established under the Dentists Act, 1948 with the prime objective of regulating dental education, profession and its ethics in the country.

> ### Pharmacy Council of India:

The Pharmacy council of India is a statutory body constituted under the Pharmacy Act, 1948. It is responsible for regulation and maintenance of uniform standard of training of pharmacists.

➢ **National Academy of Medical Sciences:**

It was established as a registered society with the objective of promoting growth of medical sciences. To keep the -medical professionals abreast with new problems and update their knowledge in those fields for the required delivery of health care, a programme of Continuing Medical Education (CME) is being implemented by the Academy since 1982. Nursing Education

➢ **National Illness Assistance Fund:**

It has been set up in the Ministry of Health and Family Welfare with an initial contribution of Rs. 5 crore in 1997. The Fund will provide necessary financial assistance to patients livings below poverty line, suffering from life- threatening diseases, to receive medical treatment at any of the super specialty hospitals/institution or other government/private hospitals.

All the States/UTs administration has been advised to set up an Illness Assistance Fund in the respective States/UTs.

3.6 Concept of Integrated health service:

➢ **Integrated Approach to Healthcare:**

Essential to countries such as India is an ***integrated health system***, which addresses both the response and preventive aspects of health. A good response system must allow for early detection of health conditions. It must also provide high quality infrastructure, focused on those in need, for the identification of a disease trend and containment of infection. The system must enable rapid dissemination of information, provide for emergency response and empower patients and their families to take charge. A preventive system meanwhile must allow detection and diagnosis besides providing information to create awareness. Empowerment of such systems is required along with the availability of other support systems such as vaccines, drugs and rehabilitation therapy for containment of infection, through community action. An integrated health system must also ensure skills refresh for clinical staff and health workers, while addressing their issues related to geographical spread. Clearly, high-quality data is central. Focus must shift to stitching together all the information residing in several silos, to help people interact and work together closely. The availability of Information and Communications Technology (ICT) infrastructure and tools makes it easy for such collaboration to become a reality.

In many parts of the world access to healthcare is denied to large groups of people for several reasons including physical, financial and social causes. While on the one hand the global population of youth is increasing, so is the number of the elderly, creating new dimensions to the kind of health issues faced. As people migrate to urban areas the pressure on urban systems increases. Overcrowding often

leads to infections and incidence of new diseases. New ways of working and living also give rise to new forms of illnesses. All of the above increase the need for better healthcare delivery even as countries face a shortage of clinicians, healthcare workers and infrastructure, when required and where required. Outdated and outmoded healthcare systems are still prevalent, posing a severe challenge to governments and communities. Better health outcomes call for addressing several other related issues such as water, sanitation, nutrition, pollution, awareness, education, occupation and economic well-being. As care becomes more complex, it requires a specialized workforce to deliver services often across geographically dispersed areas. This means healthcare managers need to communicate and collaborate in better ways without increasing costs or reducing the effectiveness of human interaction. While advances in research, treatment, and processes have strengthened the healthcare system, accessing them requires interaction between multiple sites. This creates new challenges and increases pressure to improve operational efficiency. Therefore the medical fraternity requires constant updating of skills, learning and education, which is in sync with changing technology.

The health ecosystem as it exists today, is immensely complex encompassing primary, secondary and tertiary care providers, suppliers of drugs and other products, social workers, patients and their families, not for profit organizations, insurance agencies and the government. Unless this ecosystem works in close synchrony, the health needs of the society and various communities cannot be met.

> **High quality communication is critical:**

Poor communication among various healthcare workers impacts productivity and patient safety. It also has cost implications. Problems in communication stem from the fact that healthcare industry still clings to outdated methods of communication. Reasons why communication fails also include necessary personnel not being identified, located or not available to respond in a timely manner.

Many types of communications take place among clinicians, and between clinicians and patients. Technology can be applied to facilitate all these communications in a highly collaborative and mobile environment. While collaboration as a way of working is not new to the health system, it is becoming more of an imperative as the priorities of the industry and customers change. Better efficiencies and effectiveness could be achieved through closer collaboration within the ecosystem. Technology can be applied to facilitate all these communications in a highly collaborative and mobile environment.

> **Connected healthcare:**

Today, a 'connected' approach is required to be applied to the healthcare sector as organisations align technology and operational needs to support and streamline information flows. With increasing emphasis being placed on prevention and health, there will have to be a radical change in processes so as to optimize delivery of services, reduce medical errors and control spending. These processes must be

centered on patients, who play an active role in deciding the most appropriate course of treatment for them.

Ongoing education will have to be an integral part of the agenda for the medical workforce. Healthcare organizations will need an integrated network to help various departments to collaborate, learn and communicate effectively.

Across the globe, governments and healthcare systems have initiated broad healthcare improvement programmes, which require a secure, reliable, and increasingly interactive infrastructure to automate transactions and expedite the flow of healthcare data. This paves the way for a future in which all healthcare stakeholders can respond to patients more efficiently, expand preventive healthcare initiatives, and boost the overall health of communities. Several technology solutions exist for the many mechanisms that may be used to deliver collaborative care. However, the ability to combine or integrate all of them in a manner that is relevant to the specific situation and issues to be addressed, would determine their successful adoption.

3.7   Integrated Child Development Services in India:

Integrated Child Development Services (ICDS), Government of India sponsored programme, is India's primary social welfare scheme to tackle malnutrition and health problems in children below 6 years of age and their mothers. The main beneficiaries of the programme were aimed to be the children below 6 years of age, pregnant and lactating mothers, and adolescent girls. The gender promotion of the girl child by trying to bring her at par with the male child is a key component of the scheme.

Majority of children in India have underprivileged childhoods starting from birth. The infant mortality rate of Indian children is 44 and the under-five mortality rate is 93 and 25% of newborn children are underweight among other nutritional, immunization and educational deficiencies of children in India. Figures for India are substantially worse than the developing country average.

Given such a daunting challenge, ICDS was first launched in 1975 in accordance to the National Policy for Children in India. Over the years it has grown into one of the largest integrated family and community welfare schemes in the world. Given its effectiveness over the last few decades, Government of India has committed towards ensuring universal availability of the programme.

➢ **Objectives:**

The predefined objectives of ICDS are:

✓ To raise the health and nutritional level of poor Indian children below 6 years of age
✓ To create a base for proper mental, physical and social development of children in India
✓ To reduce instances of mortality, malnutrition and school dropouts among Indian Children

- ✓ To coordinate activities of policy formulation and implementation among all departments of various ministries involved in the different government programmes and schemes aimed at child development across India.
- ✓ To provide health and nutritional information and education to mothers of young children to enhance child rearing capabilities of mothers in country of India
- ✓ To provide nutritional food to the mothers of young children & also at the time of pregnancy period.

➢ **Scope of Services:**

The following services are sponsored under ICDS to help achieve its objectives:

- ✓ Immunization
- ✓ Supplementary nutrition
- ✓ Health checkup
- ✓ Referral services
- ✓ Pre-school non formal education
- ✓ Nutrition and Health information

➢ **Implementation:**

- o For nutritional purposes ICDS provides 300 calories (with 8-10 grams of protein) every day to every child below 6 years of age. For adolescent girls it is up to 500 calories with up to 25 grams of protein every day.

- o Delivery of services under ICDS scheme is managed in an integrated manner through Anganwadi centres, its workers and helpers. The services of Immunization, Health Check-up and Referral Services delivered through Public Health Infrastructure under the Ministry of Health and Family Welfare. UNICEF has provided essential supplies for the ICDS scheme since 1975. World Bank has also assisted with the financial and technical support for the programme. The cost of ICDS programme averages $10–$22 per child a year. The scheme is Centrally sponsored with the state governments contributing up to 1.00 (1.7¢ US) per day per child.

- o Furthermore, in 2008, the GOI adopted the World Health Organization (WHO) standards for measuring and monitoring the child growth and development, both for the ICDS and the National Rural Health Mission (NRHM). These standards were developed by WHO through an intensive study of six developing countries since 1997.

They are known as New WHO Child Growth Standard and measure of physical growth, nutritional status and motor development of children from birth to 5 years age.

- ➢ **Funding Pattern:**

    ICDS is a Centrally-sponsored Scheme implemented through the State Governments/UT Administrations. Prior to 2005-06, 100% financial assistance for inputs other than supplementary nutrition, which the States were to provide out of their own resources, was being provided by the Government of India. Since many States were not providing adequately for supplementary nutrition in view of resource constraints, it was decided in 2005-06 to support to States up to 50% of the financial norms or to support 50% of expenditure incurred by them on supplementary nutrition, whichever is less.

    From the financial year 2009-10, Government of India has modified the funding pattern of ICDS between Centre and States. The sharing pattern of supplementary nutrition in respect of North-eastern States between Centre and States has been changed from 50:50 to 90:10 ratio. So far as other States and UTs, the existing sharing pattern of 50:50 continues. However, for all other components of ICDS, the ratio has been modified to 90:10(100% Central Assistance earlier).

- ➢ **The ICDS team**:

    The ICDS team comprises the Anganwadi Workers, Anganwadi Helpers, Supervisors, Child Development Project Officers (CDPOs) and District Programme Officers (DPOs). Anganwadi Worker, a lady selected from the local community, is a community based frontline honorary worker of the ICDS Programme. She is also an agent of social change, mobilizing community support for better care of young children, girls and women. Besides, the medical officers, Auxiliary Nurse Midwife (ANM) and Accredited Social Health Activist (ASHA) form a team with the ICDS functionaries to achieve convergence of different services.

- ➢ **Role & responsibilities of AWW, ANM and ASHA:**

    Role and responsibilities of AWW, ANM & ASHA have been clearly delineated and circulated to States/UTs under the joint signature of Secretary, MWCD and Secretary, MHFW, vide D.O. No. R. 14011/9/2005-NRHM –I (pt) dated 20 January 2006.

- ➢ **Status of anganwadi workers and helpers**:

    Anganwadi Workers (AWWs) & Anganwadi Helpers (AWHs), being honorary workers, are paid a monthly honoraria as decided by the Government from time to time. Government of India has enhanced the honoraria of these Workers, w.e.f. 1.4.2008 by Rs.500 above the last honorarium drawn by Anganwadi Workers (AWWs) and by Rs.250 of the last honorarium drawn by Helpers of AWCs and Workers of Mini-AWCs. Prior to enhancement, AWWs were being paid a monthly honoraria ranging from Rs. 938/ to Rs. 1063/- per month depending on their

educational qualifications and experience. Similarly, AWHs were being paid monthly honoraria of Rs. 500/- In addition to the honoraria paid by the Government of India, many States/UTs are also giving monetary incentives to these workers out of their own resources for additional functions assigned under other Schemes.

- ➢ **ICDS Training Programme:**
  Training and capacity building is the most crucial element in the ICDS Scheme, as the achievement of the programme goals largely depends upon the effectiveness of frontline workers in improving service delivery under the programme. Since inception of the ICDS scheme, the Government of India has formulated a comprehensive training strategy for the ICDS functionaries. Training under ICDS scheme is a continuous programme and is implemented through 35 States/UTs and National Institute of Public Cooperation and Child Development (NIPCCD) and its four regional centres.

  During the 11th Five Year Plan, the Government of India has laid much emphasis on strengthening the training component of ICDS in order to improve the service delivery mechanism and accelerate better programme outcomes. An allocation of Rs. 500 crore has been kept for the ICDS Training Programme during the 11th Five Year Plan.

Financial norms relating to training of various ICDS functionaries and trainers have been revised upwardly with effect from 1 April 2009.

- ➢ **Existing Monitoring System under ICDS Scheme:**

  - **Central Level:**
    Ministry of Women and Child Development (MWCD) has the overall responsibility of monitoring the ICDS scheme. There exists a Central Level ICDS Monitoring Unit in the Ministry which is responsible for collection and analysis of the periodic work reports received from the States in the prescribed formats

  - **State Level:**
    Various quantitative inputs captured through CDPO's MPR/ HPR are compiled at the State level for all Projects in the State. No technical staff has been sanctioned for the state for programme monitoring. CDPO's MPR capture information on number of beneficiaries for supplementary nutrition, pre-school education, field visit to AWCs by ICDS functionaries like Supervisors, CDPO/ ACDPO etc., information on number of meeting on nutrition and health education (NHED) and vacancy position of ICDS functionaries etc.

- **Block Level:**

  At block level, Child Development Project Officer (CDPO) is the in-charge of an ICDS Project. CDPO's MPR and HPR have been prescribed at block level. These CDPO's MPR/ HPR formats have one-to-one correspondence with AWW's MPR/ HPR. CDPO's MPR consists vacancy position of ICDS functionaries at block and AWC levels. At block level, no technical post of officials has been sanctioned under the scheme for monitoring. However, one post of statistical Assistant./ Assistant is sanctioned at block level to consolidate the MPR/ HPR data. In between CDPO and AWW, there exist a supervisor who is required to supervise 25 AWC on an average. CDPO is required to send the Monthly Progress Report (MPR) by 7th day of the following month to State Government. Similarly, CDPO is required to send Half-yearly Progress Report (HPR) to State by 7th April and 7th October every year.

- **Village Level (Anganwadi Level):**

  At the grass-root level, delivery of various services to target groups is given at the Anganwadi Centre (AWC). An AWC is managed by an honorary Anganwadi Worker (AWW) and an honorary Anganwadi Helper (AWH).

  In the existing Management Information System, records and registers are prescribed at the Anganwadi level i.e. at village level. The Monthly and Half-yearly Progress Reports of Anganwadi Worker have also been prescribed. The monthly progress report of AWW capture information on population details, births and deaths of children, maternal deaths, no. of children attended AWC for supplementary nutrition and pre-school education, nutritional status of children by weight for age, information on nutrition and health education and home visits by AWW. Similarly, AWW's Half yearly Progress Report capture data on literacy standard of AWW, training details of AWW, increase/ decrease in weight of children, details on space for storing ration at AWC, availability of health cards, availability of registers, availability of growth charts etc.

  AWW is required to send this Monthly Progress Report (MPR) by 5th day of following month to CDPO' In-charge of an ICDS Project. Similarly, AWW is required to send Half-yearly Progress Report (HPR) to CDPO by 5th April and 5th October every year.

➢ **Impact:**

- By end of 2014, the programme was claimed to reach 80.6 lakh expectant and lactating mothers along with 3.93 crore children (under 6 years of age).There are 6,719 operational projects with 1,241,749 operational Aanganwadi centres. Several positive benefits of the programme have been documented and reported.

- A study in states of Tamil Nadu, Andhra Pradesh and Karnataka demonstrated significant improvement in the mental and social development of all children irrespective of their gender.
- A 1992 study of National Institute of Public Cooperation and Child Development confirmed improvements in birth-weight and infant mortality of Indian children along with improved immunization and nutrition.

➢ **Introduction of WHO growth standard in ICDS:**

The World Health Organization (WHO) based on the results of an intensive study initiated in 1997 in six countries including India has developed New International Standards for assessing the physical growth, nutritional status and motor development of children from birth to 5 years age. The Ministry of Women and Child Development and Ministry of Health have adopted the New WHO Child Growth Standard in India on 15th of August, 2008 for monitoring the Growth of Children through ICDS and NRHM.

➢ **Drawback:**

However, World Bank has also highlighted certain key shortcomings of the programme including inability to target the girl child improvements, participation of wealthier children more than the poorer children and lowest level of funding for the poorest and the most undernourished states of India.

3.8. Summary:

- Community health, a field of public health, is a discipline which concerns itself with the study and improvement of the health characteristics of biological communities. Community health tends to focus on geographical areas rather than people with shared characteristics.

- Community health may be studied within three broad categories: **Primary healthcare, Secondary healthcare, and Secondary healthcare.**

- Primary healthcare refers to interventions that focus on the individual or family such as hand-washing, immunization, circumcision. Secondary healthcare refers to those activities which focus on the environment such as draining puddles of water near the house, clearing bushes and spraying insecticides to control vectors like mosquitoes. Tertiary healthcare refers to those interventions that take place in a hospital setting such as intravenous rehydration or surgery.

- Community Health Center is staffed with a Medical Specialist, a child specialist, a gynecologist, a surgeon and a lady doctor along with around 25 other paramedical and support staff. A Primary Health Centre (PHC) is staffed with a medical officer, a pharmacist, a staff nurse, block extension educator/ health educator, lab technician, one male and one female health worker and 4-5 other support staff.

- Population health is an approach to health that aims to improve the health of an entire human population. The main aim is to reduce health inequities or disparities among different population group due to the social determinants of health, SDOH.

- The SDOH include all the factors: social, environmental, cultural and physical the different populations are born into, grow up and function with throughout their lifetimes which potentially have a measurable impact on the health of human populations.

- The Population Health concept represents a change in the focus from the individual-level, characteristic of most mainstream medicine. It also seeks to complement the classic efforts of public health agencies by addressing a broader range of factors shown to impact the health of different populations.

- Public health takes a population health approach, which places a greater emphasis on community health including: the population as a whole, the role of the community, health promotion and preventative care and the need to involve a range of professionals.

- A population health approach also takes into account all factors that determine a Person's health and wellbeing, which include: Peace, shelter and food, education and sufficient income, a stable eco-system, sustainable resource use, social justice and equity, etc.

- There has been increasing interest from epidemiologists on the subject of economic inequality and its relation to the health of populations. There is a very robust correlation between socioeconomic status and health. Despite the reality of the SES Gradient, there is debate as to its cause. A number of researchers see a definite link between economic status and mortality due to the greater economic resources of the better-off, but they find little correlation due to social status differences.

- Most famous for linking social status with health are the Whitehall studies—a series of studies conducted on civil servants in London. The studies found that, despite the fact that all civil servants in England have the same access to health care, there was a strong correlation between social status and health. The studies found that this relationship stayed strong even when controlling for health-affecting habits such as exercise, smoking and drinking.

- Furthermore the concept of psychosocial stress attempts to explain how psychosocial phenomenon such as status and social stratification can lead to the many diseases associated with the SES gradient. Higher levels of economic inequality tend to intensify social hierarchies and generally degrade the quality of social relations—leading to greater levels of stress and stress related diseases.

- Public health is about keeping people healthy and improving the health of populations rather than treating diseases, disorders and disabilities in individuals. Public health, particularly health promotion, has an important role in re-orienting the health sector towards a population health approach.

- India has a universal health care system run by the constituent states and territories of India. The Constitution charges every state with raising the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties.
- The National Health Policy was endorsed by the Parliament of India in 1983 and updated in 2002. Parallel to the public health sector, and indeed more popular than it, is the private medical sector in India.

- The long term objective of Twelfth Five Year plan (2012-2017) strategy was to establish a system of Universal Health Coverage (UHC) in the country.

- Major strategies of the 12th plan are Substantial expansion and strengthening of public sector health care system, the expenditure on health should increase to 2.5 per cent of GDP by the end of Twelfth Five Year Plan, Coordinated delivery of services within and across sectors, delegation matched with accountability, fostering a spirit of innovation, Increasing the cooperation between private and public sector health care providers to achieve health goals, entire Below Poverty Line (BPL) population will be covered through RSBY scheme.

- The quality of Indian healthcare is varied. In major urban areas, healthcare is of adequate quality, approaching and occasionally meeting Western standards but quality medical care is limited or unavailable in most rural areas.

- There are numerous health problems in India like malnutrition, high infant mortality, poor sanitation, problem of safe drinking water, kala azar, high maternal Mortality, malaria, HIV aids etc.

- Half of all residents of rural areas live below the poverty line, struggling for better and easy access to health care and services. Health issues confronted by rural people are many and diverse – from severe malaria to uncontrolled diabetes, from a badly infected wound to cancer. Postpartum maternal illness is a serious problem in resource-poor settings and contributes to maternal mortality, particularly in rural India.

- There are numbers of schemes and plans for major community health problems in India like Kala-azar control was being provided by the Government of India out of the National Malaria Eradication Programme (NMEP), until 1990-91. During the Ninth Plan, the focus was on ensuring effective implementation of the programme so as to prevent outbreaks and eventually to control infection. DDT continued to be the mainstay for insecticide spray as the vector (phlebotomus argentites) is still susceptible to DDT. National Anti-Malaria Programme was started in 1958. **National Filaria Control Programme** was launched in 1955. **National Tuberculosis Control Programme** was initiated in 1962. The Revised National Tuberculosis Programme (RNTCP) was launched in the country on March 1, 1997, and is proposed to be implemented in a phased manner in 102 districts of the country, covering a population of 271 million, with the assistance of World Bank. The National Leprosy Eradication Programme (NLEP) was launched in 1983 as hundred percent centrally sponsored schemes with the availability of Multi Drug Therapy (MDT). The National Blindness Control Programme started in 1976 as 100 per cent centrally sponsored programme with the objective of providing comprehensive eye care services at primary, secondary and tertiary health care level and achieving substantial reduction in the prevalence of eye disease in general and blindness in particular. Control of Sexually Transmitted Disease (STDs) was introduced as a national control programme by the Government of India during the Fourth Five Year Plan (1967). The Government of India launched a National AIDS Control Programme in 1987. In 1992, National AIDS Control Organization was established and a 5 year strategic plan was implemented with a US $ 84 million soft loan from the World Bank and another US $ 1.5 million in the form of technical assistance from the World Health Organization. The National Goitre Control Programme was initiated in 1962 as a 100 per cent centrally funded, centre sector programme with the objective of conducting goitre survey, and supplying good quality iodized salt to areas having high IDD, health education and resurvey after five years. The National Mental Health Programme was started in 1982. The Cancer Control Programme was initiated in 1975- 76 as 100 per cent centrally funded centre sector project. It was renamed as National Cancer Control Programme in 1985. The National Diabetes Control Programme has included a pilot programme in Seventh Five Year Plan. It was initiated in

Tamilnadu and in one district in J and K. In 1983-84, India became the first country to launch an eradication programme against the disease, which had been causing great human suffering where safe drinking water is not available. The programme was implemented through existing primary health care infrastructure along with Ministry of Rural Development and the State public health engineering departments.

- Public health system in India suffers from many problems which includes insufficient funding, shortage of facilities leading to overcrowding severe shortage of trained health personnel. There is also lack of accountability in the public health delivery mechanisms.

- Inspite of so many government schemes and efforts most public health facilities lack efficiency, are understaffed and have poorly maintained or outdated medical equipment. Approximately one millon people, mostly women and children, die in India each year due to inadequate health care. 700 million people have no access to specialist care and 80% of specialists live in urban areas. In addition to poor infrastructure India faces a shortage of trained medical personal especially in rural areas where access to care is altogether limited.

- In the mid-1990s, health spending amounted to 6% of GDP, one of the highest levels among developing nations. The established per capita spending is around Rs 320 per year with the major input from private households (75%). State governments contribute 15.2%, the central government 5.2%, third-party insurance and employers 3.3%, and municipal government and foreign donors about 1.3, according to a 1995 World Bank study. Of these proportions, 58.7% goes towards primary health care (*curative, preventive, and promotive*) and 38.8% is spent on secondary and tertiary inpatient care. The rest goes for nonservice costs.

- *Integrated health system* addresses both the response and preventive aspects of health. A good response system must allow for early detection of health conditions. It must also provide high quality infrastructure, focused on those in need, for the identification of a disease trend and containment of infection. A preventive system meanwhile must allow detection and diagnosis besides providing information to create awareness. Empowerment of such systems is required along with the availability of other support systems such as vaccines, drugs and rehabilitation therapy for containment of infection, through community action.

- An integrated health system must also ensure skills refresh for clinical staff and health workers, while addressing their issues related to geographical spread. Clearly, high-quality data is central. Focus must shift to stitching together all the information residing in several silos, to help people interact and work together closely. The availability of Information and Communications Technology (ICT) infrastructure and tools makes it easy for such collaboration to become a reality.

- Integrated Child Development Services (ICDS), Government of India sponsored programme, is India's primary social welfare scheme to tackle malnutrition and health problems in children below 6 years of age and their mothers. The main beneficiaries of the programme were aimed to be the children below 6 years of age, pregnant and lactating mothers, and adolescent girls.

- The main objectives of ICDS are to raise the health and nutritional level of poor Indian children below 6 years of age,to create a base for proper mental, physical and social development of children in India, to reduce instances of mortality, malnutrition and school dropouts among Indian Children,to coordinate activities of policy formulation and implementation among all departments of various ministries involved in the different government programmes and schemes aimed at child development across India, to provide health and nutritional information and education to mothers of young children to enhance child rearing capabilities of mothers in country of India and to provide nutritional food to the mothers of young children & also at the time of pregnancy period.

- ICDS Scheme works in four levels, Central Level, State Level, Block Level and Village Level (Anganwadi Level). Ministry of Women and Child Development (MWCD) has the overall responsibility of monitoring the ICDS scheme. Various quantitative inputs captured through CDPO's MPR/ HPR are compiled at the State level for all Projects in the State. At block level, Child Development Project Officer (CDPO) is the in-charge of an ICDS Project. CDPO's MPR and HPR have been prescribed at block level. At the grass-root level, delivery of various services to target groups is given at the Anganwadi Centre (AWC). An AWC is managed by an honorary Anganwadi Worker (AWW) and an honorary Anganwadi Helper (AWH).

3.9.Key Words

Community - a human population living within a geographical area and carrying on a common interdependent life.

Health marketing - an approach to public health that applies traditional marketing principles and theories alongside science-based strategies to prevention, health promotion and health protection

Health care- is the diagnosis, treatment, and prevention of disease, illness, injury, and other physical and mental impairments in human beings.

Primary healthcare - an essential health care based on practical, scientifically sound and socially acceptable methods and technology

Secondary healthcare - the health care services provided by medical specialists and other health professionals who generally do not have first contact with patients, for example, cardiologists, urologists and dermatologists.

Tertiary healthcare - specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary referral hospital.

Population health - the health outcomes of a group of individuals, including the distribution of such outcomes within the group

Social determinants of health - are the economic and social conditions – and their distribution among the population – that influence individual and group differences in health status.

Healthy People 2020 - a web site sponsored by the US Department of Health and Human Services, representing the cumulative effort of 34 years of interest by the Surgeon General's office.

Public health - all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole.

Health care systems - are organizations established to meet the health needs of target populations.

High Level Expert Group - The High-Level Expert Group (HLEG) on Universal Health Coverage (UHC) was constituted by the Planning Commission of India in October 2010, under the chairmanship of Prof. K. Srinath Reddy, with the mandate of developing a framework for providing easily accessible and affordable health care to all Indians which submitted its report in October, 2010

Malnutrition - lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat.

Infant mortality - the death of children under the age of one year.

Maternal Mortality - represents deaths to women that occur during the reproductive process, meaning during pregnancy, childbirth, or within 2 months of after the birth of termination of a pregnancy.

Rural health - the interdisciplinary study of health and health care delivery in rural environments

Sexually Transmitted Disease - also referred to as sexually transmitted infections (STI) and venereal diseases (VD) are illnesses that have a significant probability of transmission between humans by means of sexual behavior

Mental Health - a person's condition with regard to their psychological and emotional well-being.

Integrated health service - coordinated care or the process of managing all of a patient's needs across providers and settings.

Connected healthcare - a model for healthcare delivery that uses technology to provide healthcare remotely. It aims to maximize healthcare resources and provide increased, flexible opportunities for consumers to engage with clinicians and better self-manage their care.

ICDS - Integrated Child Development Services (ICDS), Government of India sponsored programme, is India's primary social welfare scheme to tackle malnutrition and health problems in children below 6 years of age and their mothers.

Immunization - the process by which an individual's immune system becomes fortified against an agent (known as the immunogen).

Health checkup - the general medical examination is a common form of preventive medicine involving visits to a general practitioner by asymptomatic adults on a regular basis

Referral services - an online auto buying service that refers customers to brick-and-mortar dealerships where the actual purchase is made.

Non formal education - is any organized educational activity that takes place outside the formal educational system. Usually it is flexible, learner-centered, contextualized and uses a participatory approach.

3.10.Further Readings:

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Unit-IV: Health services in five year plans, Health for All- Alma Ata to current and Health policy of Govt. of India

Unit-IV

4.0.Objectives of the Unit
4.1 Health services in five year plans:

      4.1.1 Five year plan at a glance:

4.2 Alma Ata Declaration and the goal of "Health for all":

      4.2.1 What is the Alma-Ata Declaration:

      4.2.2 International conference on primary health care:

4.3 Introduction of "health for all":

4.4 Relevance of Alma- Ata to the primary health care system:

      4.4.1 Characteristics of primary health care from Alma Ata declaration:

      4.4.2 Essential components of effective primary health care:

      4.4.3 Progress and context

      4.4.4 Four Assaults on Primary Health Care:

      4.4.5 Corporate rule as a threat to world health.
      4.4.6 Primary health care: 36 years since Alma-Ata:

4.5 Alma Ata and the primary health care in India:

      4.5.1 Challenges for Primary Healthcare System in India with few suggested remedies:

4.6 Role of government in public health: Current scenario in India:

      4.6.1 Challenges confronting public health in India:

      4.6.2 Role of Govt. in addressing Public health in India:

4.7   Role of government within the health sector with few suggested majors:

   4.7.1   Scenario around 1950s and onwards:

   4.7.2   Pilot Projects:

   4.7.3.   Regulation and enforcement in public health:

   4.7.4   Health promotion:

   4.7.5   Human resource development and capacity building:

   4.7.6   Public health policy:

   4.7.7   Role of government in enabling intersectoral coordination towards public health issues:

4.8   Conclusion:

4.9.Summary:

4.10.Key Words

4.11.Further Readings

4.0. Objectives of the Unit

The main objective of this unit is to inform the students about the role of government towards development of health system in India. After the completion of studying this unit the students will gain some fundamental knowledge on the following topics:

- ❖ Details of Five-year plans of government of India and special provision for health if any.
- ❖ The concept of Alma Ata, its origin, evolution, development and setbacks.
- ❖ The concept of "Health for all".
- ❖ Alma Ata and the primary health care system in India
- ❖ Role of government towards realization of Alma Ata

4.1 Health services in five year plans:

4.1.1 Five year plan at a glance:

Since Independence, the Indian economy has been premised on the concept of planning. This has been carried through the Five-Year Plans, developed, executed, and monitored by the Planning Commission. With the Prime Minister as the ex-officio Chairman, the commission has a nominated Deputy Chairman, who holds the rank of a Cabinet Minister. The Eleventh Plan completed its term in March 2012 and the Twelfth Plan is currently underway.

> **History**

Five-Year Plans (FYPs) are centralized and integrated national economic programs. Joseph Stalin implemented the first FYP in the Soviet Union in the late 1920s. Most communist states and several capitalist countries subsequently have adopted them. China and India both continue to use FYPs, although China renamed its Eleventh FYP, from 2006 to 2010, a guideline (guihua), rather than a plan (jihua), to signify the central government's more hands-off approach to development. India launched its First FYP in 1951, immediately after independence under socialist influence of first Prime Minister Jawaharlal Nehru.

The First Five-Year Plan was one of the most important because it had a great role in the launching of Indian development after the Independence. Thus, it strongly supported agriculture production and it also launched the industrialization of the country. It built a particular system of mixed economy, with a great role for the public sector (with an emerging welfare state), as well as a growing private sector (represented by some personalities as those who published the Bombay Plan).

➤ **First Plan (1951-1956)**

The first Indian Prime Minister, Pandit Jawaharlal Nehru presented the First Five-Year Plan to the Parliament of India and needed urgent attention. The First Five-year Plan was launched in 1951 which mainly focused in development of the agricultural sector. The First Five-Year Plan was based on the Harrod–Domar model.

The total planned budget of Rs.2069 crore was allocated to seven broad areas: irrigation and energy (27.2%), agriculture and community development (17.4%), transport and communications (24%), industry (8.4%), social services (16.64%), land rehabilitation (4.1%), and for other sectors and services (2.5%). The most important feature of this phase was active role of state in all economic sectors. Such a role was justified at that time because immediately after independence, India was facing basic problems—deficiency of capital and low capacity to save.

The target growth rate was 2.1% annual gross domestic product (GDP) growth; the achieved growth rate was 3.6% the net domestic product went up by 15%. The monsoon was good and there were relatively high crop yields, boosting exchange reserves and the per capita income, which increased by 8%. National income increased more than the per capita income due to rapid population growth. Many irrigation projects were initiated during this period, including the Bhakra Dam and Hirakud Dam. The World Health Organization (WHO), with the Indian government, addressed children's health and reduced infant mortality, indirectly contributing to population growth.

At the end of the plan period in 1956, five Indian Institutes of Technology (IITs) were started as major technical institutions. The University Grant Commission (UGC) was set up to take care of funding and take measures to strengthen the higher education in the country. Contracts were signed to start five steel plants, which came into existence in the middle of the Second Five-Year Plan. The plan was quasi successful for the government.

➤ **Second Plan (1956-1961)**

The Second Plan, particularly in the development of the public sector. The plan followed the Mahalanobis model, an economic development model developed by the Indian statistician Prasanta Chandra Mahalanobis in 1953. The plan attempted to determine the optimal allocation of investment between productive sectors in order to maximize long-run economic growth. It used the prevalent state of art techniques of operations research and optimization as well as the novel applications of statistical models developed at the Indian Statistical Institute. The plan assumed a closed economy in which the main trading activity would be centered on importing capital goods.

Hydroelectric power projects and five steel plants at Bhilai, Durgapur, and Rourkela were established. Coal production was increased. More railway lines were added in the north east. The Tata Institute of Fundamental Research was established as a research institute. In 1957 a talent search and scholarship program was begun to find talented young students to train for work in nuclear power.

The total amount allocated under the Second Five-Year Plan in India was Rs.48 billion. This amount was allocated among various sectors: power and irrigation, social services, communications and transport, and miscellaneous.

The target growth rate was 4.5% and the actual growth rate was 4.27%.[6] 1956-industrial policy

➢ **Third Plan (1961–1966)**

The Third Five-year Plan stressed agriculture and improvement in the production of wheat, but the brief Sino-Indian War of 1962 exposed weaknesses in the economy and shifted the focus towards the defence industry and the Indian Army. In 1965–1966, India fought a War with Pakistan. There was also a severe drought in 1965. The war led to inflation and the priority was shifted to price stabilization. The construction of dams continued. Many cement and fertilizer plants were also built. Punjab began producing an abundance of wheat.

Many primary schools were started in rural areas. In an effort to bring democracy to the grass-root level, Panchayat elections were started and the states were given more development responsibilities.

State electricity boards and state secondary education boards were formed. States were made responsible for secondary and higher education. State road transportation corporations were formed and local road building became a state responsibility.

The target growth rate was 5.6%, but the actual growth rate was 2.4%.[6]

Due to miserable failure of the Third Plan the government was forced to declare "plan holidays" (from 1966–67, 1967–68, and 1968–69). Three annual plans were drawn during this intervening period. During 1966-67 there was again the problem of drought. Equal priority was given to agriculture, its allied activities, and industrial sector. The main reasons for plan holidays were the war, lack of resources, and increase in inflation.

➢ **Fourth Plan (1969–1974)**

At this time Indira Gandhi was the Prime Minister. The Indira Gandhi government nationalised 14 major Indian banks and the Green Revolution in India advanced agriculture. In addition, the situation in East Pakistan (now Bangladesh) was becoming dire as the Indo-Pakistan War of 1971 and Bangladesh Liberation War took funds earmarked for industrial development. India also performed the Smiling Buddha underground nuclear test in 1974, partially in response to the United States deployment of the Seventh Fleet in the Bay of Bengal. The fleet had been deployed to warn India against attacking West Pakistan and extending the war.

The target growth rate was 5.6%, but the actual growth rate was 3.3%.

➢ **Fifth Plan (1974–1979)**

The Fifth Five-Year Plan laid stress on employment, poverty alleviation (Garibi Hatao), and justice. The plan also focused on self-reliance in agricultural production and defence. In 1978 the newly elected Morarji Desai government rejected the plan. The Electricity Supply Act was amended in 1975, which enabled the central government to enter into power generation and transmission.

The Indian national highway system was introduced and many roads were widened to accommodate the increasing traffic. Tourism also expanded. It was followed from 1974 to 1979. It was mainly followed in Tamil Nadu by a protester Dhanya, who was a girl just studying 8th now had made the citizens of India to follow it and made all of them to know our rights.

The target growth rate was 4.4% and the actual growth rate was 5.0%.

➢ **Rolling Plan (1978–1980)**

The Janata Party government rejected the Fifth Five-Year Plan and introduced a new Sixth Five-Year Plan (1978-1983). This plan was again rejected by the Indian National Congress government in 1980 and a new Sixth Plan was made.

➢ **Sixth Plan (1980–1985)**

The Sixth Five-Year Plan marked the beginning of economic liberalisation. Price controls were eliminated and ration shops were closed. This led to an increase in food prices and an increase in the cost of living. This was the end of Nehruvian socialism.

Family planning was also expanded in order to prevent overpopulation. In contrast to China's strict and binding one-child policy, Indian policy did not rely on the threat of force. More prosperous areas of India adopted family planning more rapidly than less prosperous areas, which continued to have a high birth rate.

The Sixth Five-Year Plan was a great success to the Indian economy. The target growth rate was 5.2% and the actual growth rate was 5.4%. The only Five-Year Plan which was done twice.

➢ **Seventh Plan (1985–1990)**

The Seventh Five-Year Plan marked the comeback of the Congress Party to power. The plan laid stress on improving the productivity level of industries by upgrading of technology.

The main objectives of the Seventh Five-Year Plan were to establish growth in areas of increasing economic productivity, production of food grains, and generating employment.

As an outcome of the Sixth Five-Year Plan, there had been steady growth in agriculture, controls on the rate of inflation, and favourable balance of payments which had provided a strong base for the Seventh Five-Year Plan to build on the need for further economic growth. The Seventh Plan had strived towards socialism and energy production at large. The thrust areas of the Seventh Five-Year Plan were:

social justice, removal of oppression of the weak, using modern technology, agricultural development, anti-poverty programs, full supply of food, clothing, and shelter, increasing productivity of small- and large-scale farmers, and making India an independent economy.

Based on a 15-year period of striving towards steady growth, the Seventh Plan was focused on achieving the prerequisites of self-sustaining growth by the year 2000. The plan expected the labour force to grow by 39 million people and employment was expected to grow at the rate of 4% per year.

Some of the expected outcomes of the Seventh Five-Year Plan India are given below:

Balance of payments (estimates): Export – 330 billion (US$5.5 billion), Imports – (-) 540 billion (US$9.0 billion), Trade Balance – (-)210 billion (US$3.5 billion)

Merchandise exports (estimates): 606.53 billion (US$10.1 billion)

Merchandise imports (estimates): 954.37 billion (US$15.8 billion)

Projections for balance of payments: Export – 607 billion (US$10.1 billion), Imports – (-) 954 billion (US$15.8 billion), Trade Balance- (-) 347 billion (US$5.8 billion)

Under the Seventh Five-Year Plan, India strove to bring about a self-sustained economy in the country with valuable contributions from voluntary agencies and the general populace.

The target growth rate was 5.0% and the actual growth rate was 6.01%.

➢ **Annual Plans (1990-1992)**

The Eighth Plan could not take off in 1990 due to the fast changing political situation at the centre and the years 1990-91 and 1991-92 were treated as Annual Plans. The Eighth Plan was finally launched in 1992 after the initiation of structural adjustment policies.

➢ **Eighth Plan (1992–1997)**

1989–91 was a period of economic instability in India and hence no five-year plan was implemented. Between 1990 and 1992, there were only Annual Plans. In 1991, India faced a crisis in foreign exchange (forex) reserves, left with reserves of only about US$1 billion. Thus, under pressure, the country took the risk of reforming the socialist economy. P.V. Narasimha Rao was the ninth Prime Minister of the Republic of India and head of Congress Party, and led one of the most important administrations in India's modern history, overseeing a major economic transformation and several incidents affecting national security. At that time Dr. Manmohan Singh (former Prime Minister of India) launched India's free market reforms that brought the nearly bankrupt nation back from the edge. It was the beginning of privatisation and liberalisation in India.

Modernization of industries was a major highlight of the Eighth Plan. Under this plan, the gradual opening of the Indian economy was undertaken to correct the burgeoning deficit and foreign debt. Meanwhile India became a member of the World Trade Organization on 1 January 1995. This plan

can be termed as, the Rao and Manmohan model of economic development. The major objectives included, controlling population growth, poverty reduction, employment generation, strengthening the infrastructure, institutional building, tourism management, human resource development, involvement of Panchayati rajs, Nagar Palikas, NGOs, decentralisation and people's participation.

Energy was given priority with 26.6% of the outlay. An average annual growth rate of 6.78% against the target 5.6%[6] was achieved.

To achieve the target of an average of 5.6% per annum, investment of 23.2% of the gross domestic product was required. The incremental capital ratio is 4.1. The saving for investment was to come from domestic sources and foreign sources, with the rate of domestic saving at 21.6% of gross domestic production and of foreign saving at 1.6% of gross domestic production.

➢ Ninth Plan (1997-2002)

The Ninth Five-Year Plan came after 50 years of Indian Independence. Atal Bihari Vajpayee was the Prime Minister of India during the Ninth Five-Year Plan. The Ninth Five-Year Plan tried primarily to use the latent and unexplored economic potential of the country to promote economic and social growth. It offered strong support to the social spheres of the country in an effort to achieve the complete elimination of poverty. The satisfactory implementation of the Eighth Five-Year Plan also ensured the states' ability to proceed on the path of faster development. The Ninth Five-Year Plan also saw joint efforts from the public and the private sectors in ensuring economic development of the country. In addition, the Ninth Five-Year Plan saw contributions towards development from the general public as well as governmental agencies in both the rural and urban areas of the country. New implementation measures in the form of Special Action Plans (SAPs) were evolved during the Ninth Five-Year Plan to fulfill targets within the stipulated time with adequate resources. The SAPs covered the areas of social infrastructure, agriculture, information technology and Water policy.

Budget

The Ninth Five-Year Plan had a total public sector plan outlay of Rs 8,59,200 crores. The Ninth Five-Year Plan also saw a hike of 48% in terms of plan expenditure and 33% in terms of the plan outlay in comparison to that of the Eighth Five-Year Plan. In the total outlay, the share of the centre was approximately 57% while it was 43% for the states and the union territories.

The Ninth Five-Year Plan focused on the relationship between the rapid economic growth and the quality of life for the people of the country. The prime focus of this plan was to increase growth in the country with an emphasis on social justice and equity. The Ninth Five-Year Plan placed considerable importance on combining growth oriented policies with the mission of achieving the desired objective of improving policies which would work towards the improvement of the poor in the country. The Ninth Five-Year Plan also aimed at correcting the historical inequalities which were still prevalent in the society.

Objectives

The main objective of the Ninth Five-Year Plan was to correct historical inequalities and increase the economic growth in the country. Other aspects which constituted the Ninth Five-Year Plan were:

- Population control.
- Generating employment by giving priority to agriculture and rural development.
- Reduction of poverty.
- Ensuring proper availability of food and water for the poor.
- ***Availability of primary health care facilities and other basic necessities.***
- Primary education to all children in the country.
- Empowering the socially disadvantaged classes like Scheduled castes, Scheduled tribes and other backward classes.
- Developing self-reliance in terms of agriculture.
- Acceleration in the growth rate of the economy with the help of stable prices.

Strategies

- Structural transformations and developments in the Indian economy.
- New initiatives and initiation of corrective steps to meet the challenges in the economy of the country.
- Efficient use of scarce resources to ensure rapid growth.
- Combination of public and private support to increase employment.
- Enhancing high rates of export to achieve self-reliance.
- Providing services like electricity, telecommunication, railways etc.
- Special plans to empower the socially disadvantaged classes of the country.
- Involvement and participation of Panchayati Raj institutions/bodies and Nagar Palikas in the development process.

Performance

- The Ninth Five-Year Plan achieved a GDP growth rate of 5.4% against a target of 6.5%
- The agriculture industry grew at a rate of 2.1% against the target of 4.2%
- The industrial growth in the country was 4.5% which was higher than that of the target of 3%
- The service industry had a growth rate of 7.8%.
- An average annual growth rate of 6.7% was reached.

The Ninth Five-Year Plan looks through the past weaknesses in order to frame the new measures for the overall socio-economic development of the country. However, for a well-planned economy of any country, there should be a combined participation of the governmental agencies along with the general population of that nation. A combined effort of public, private, and all levels of government is essential for ensuring the growth of India's economy.

The target growth was 7.1% and the actual growth was 6.8%.

➢ **Tenth Plan (2002–2007)**

The main objectives of the Tenth Five-Year Plan were:

- Attain 8% GDP growth per year.
- Reduction of poverty rate by 5% by 2007.
- Providing gainful and high-quality employment at least to the addition to the labour force.
- Reduction in gender gaps in literacy and wage rates by at least 50% by 2007.
- 20-point program was introduced.
- Target growth: 8.1% - growth achieved: 7.7%
- Expenditure of Rs 43,825 crores for tenth five years

➢ **Eleventh Plan (2007-2012)**
- Rapid and inclusive growth.
- Emphasis on social sector and delivery of service therein.
- Empowerment through education and skill development.
- Reduction of gender inequality.
- Environmental sustainability.
- To increase the growth rate in agriculture, industry and services to 4%,10% and 9% respectively.

➢ **Twelfth Plan (2012–2017)**

The Twelfth Five-Year Plan of the Government of India has decided for the growth rate at 8.2% but the National Development Council (NDC) on 27 Dec 2012 approved 8% growth rate for 12th five-year plan.

Based on the recommendation of HLEG (High Level Expert Group) Report and other stakeholder consultations, the key elements of Twelfth Five Year plan strategy was outlined. The long term objective of this strategy was to establish a system of Universal Health Coverage (UHC) in the country. Following are the 12th plan period strategy: Substantial expansion and strengthening of public sector health care system, freeing the vulnerable population from dependence on high cost and often unreachable private sector health care system.

✓ Health sector expenditure by central government and state government, both plan and non-plan will have to be substantially increased by the twelfth five year plan. It was increased from 0.94 per cent of GDP in tenth plan to 1.04 per cent in eleventh plan. The provision of clean drinking water and sanitation as one of the principal factors in control of diseases is well established from the history of industrialized countries and it should have high priority in health related resource allocation. The expenditure on health should increase to 2.5 per cent of GDP by the end of Twelfth Five Year Plan.

- ✓ Financial and managerial system will be redesigned to ensure efficient utilization of available resources and achieve better health outcome. Coordinated delivery of services within and across sectors, delegation matched with accountability, fostering a spirit of innovation are some of the measures proposed.

- ✓ Increasing the cooperation between private and public sector health care providers to achieve health goals. This will include contracting in of services for gap filling, and various forms of effectively regulated and managed Public-Private Partnership, while also ensuring that there is no compromise in terms of standards of delivery and that the incentive structure does not undermine health care objectives.

- ✓ The present Rashtriya Swasthya Bhima Yojana (RSBY) which provides cash less in-patient treatment through an insurance based system should be reformed to enable access to a continuum of comprehensive primary, secondary and tertiary care. In twelfth plan period entire Below Poverty Line(BPL) population will be covered through RSBY scheme. In planning health care structure for the future, it is desirable to move from a 'fee-for-service' mechanism, to address the issue of fragmentation of services that works to the detriment of preventive and primary care and also to reduce the scope of fraud and induced demand.

- ✓ In order to increase the availability of skilled human resources, a large expansion of medical schools, nursing colleges, and so on, is therefore is necessary and public sector medical schools must play a major role in the process. Special effort will be made to expand medical education in states which are under-served. In addition, a massive effort will be made to recruit and train paramedical and community level health workers.

- ✓ The multiplicity of Central sector or Centrally Sponsored Schemes has constrained the flexibility of states to make need based plans or deploy their resources in the most efficient manner. The way forward is to focus on strengthening the pillars of the health system, so that it can prevent, detect and manage each of the unique challenges that different parts of the country face.

- ✓ A series of prescription drugs reforms, promotion of essential, generic medicine and making these universally available free of cost to all patients in public facilities as a part of the Essential Health Package will be a priority.

- ✓ Effective regulation in medical practice, public health, food and drugs is essential to safeguard people against risks and unethical practices. This is especially so given the information gaps in the health sector which make it difficult for individual to make reasoned choices.

✓ The health system in the Twelfth Plan will continue to have a mix of public and private service providers. The public sector health services need to be strengthened to deliver both public health related and clinical services. The public and private sectors also need to coordinate for the delivery of a continuum of care. A strong regulatory system would supervise the quality of services delivered. Standard treatment guidelines should form the basis of clinical care across public and private sectors, with the adequate monitoring by the regulatory bodies to improve the quality and control the cost of care.

4.2 Alma Ata Declaration and the goal of "Health for all":

Health systems are part of the fabric of social and civic life. They both signal and enforce societal norms and values through the personal experiences of providers and users. The declaration of Alma Ata helped to entrench the idea of health care as a human right.

The **Declaration of Alma-Ata** was adopted at the International Conference on Primary Health Care (PHC), Almaty (formerly Alma-Ata), Kazakhstan (formerly Kazakh Soviet Socialist Republic), 6-12 September 1978. It expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all people. It was the first international declaration underlining the importance of primary health care. The primary health care approach has since then been accepted by member countries of the World Health Organization (WHO) as the key to achieving the goal of "Health For All" but only in third world countries at first. This applied to all other countries five years later.

➢ **Evolution of the Alma Ata declaration:**

Overthrow of colonial rule and rising aspirations of the liberated people, starting of democratic forms of government in some of the newly independent countries, initiation of the cold war and information of the Non Aligned Movement (NAM), have been some of the major factors which contributed to creation of conditions which tended to impel the new rules in these countries and the newly formed international organizations to pay attention to some of the urgently needed problem facing them. International organizations such as WHO and UNICEF bilateral agencies came forward to contribute to improvement of health status of the people in the needy countries. Availability of the so called silver bullets tempted these organization to launch special 'vertical' or 'categorical' programmes against some of the major scourges such as malaria (DDT and synthetic antimalarials), tuberculosis (BCG vaccination), leprosy (dapsone), filaraisis (hetrazan) and trachoma (aureomycin). It took them quite some time to realize that these vertical programmes were not only very expensive but they also failed to provide the expected results. These programme also hindered the growth of integrated health services. This impelled them to advocate integration of health services, then promotion of basic health services, then going to individual countries to promote country health planning and later, country health programming. In the mid – 1970s WHO got together with the World Bank to link activities with poverty reduction programmes. A World Health Assembly resolution in 1977 (6), aiming for a programme of Health for All through PHC by 2000 AD (HFA 2000/PHC), set the stage for the calling of the International Conference for PHC at Alma Ata in 1978.

4.2.1 What is the Alma-Ata Declaration:

In September 1978, the International Conference on Primary Health Care was held in Alma-Ata, USSR (now Almaty, Kazakhstan). The Declaration of Alma-Ata, co-sponsored by the World Health Organization (WHO), is a brief document that expresses "the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world." It was the first international declaration stating the importance of primary health care and outlining the world governments' role and responsibilities to the health of the world's citizens.

The Declaration of Alma-Ata begins by stating that health, "which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal . . . " It goes on to call for all governments, regardless of politics and conflicts, to work together toward global health. These are still some of the fundamental tenets that guide the work of the WHO today.

Those who ratified the Declaration of Alma-Ata hoped that it would be the first step toward achieving health for all by the year 2000. Although that goal was not achieved, the Declaration of Alma-Ata still stands as an outline for the future of international healthcare.

4.2.2   International conference on primary health care:

The Alma-Ata Declaration of 1978 emerged as a major milestone of the twentieth century in the field of public health, and it identified primary health care as the key to the attainment of the goal of Health for All. The following are excerpts from the Declaration:

Declaration:

I
The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II
The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III
Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better

quality of life and to world peace. IV The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V
Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI
Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of selfreliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII
Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII
All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX
All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X
An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share. The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

4.3   Introduction of "health for all":

- By the mid-1970s international health agencies and experts began to examine alternative approaches to health improvement in developing countries.

- The impressive health gains in China as a result of its community-based health programs and similar approaches elsewhere stood in contrast to the poor results of disease-focused programs.

- Soon this bottom-up approach that emphasized prevention and managed health problems in their social contexts emerged as an attractive alternative to the top-down, high-tech approach and raised optimism about the feasibility of tackling inequity to improve global health.

- Thus, *"health for all"* was introduced to global health planners and practitioners by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) at the International Conference on Primary Health Care in Alma Ata, Kazakhstan, in 1978.

- The declaration was intended to revolutionize and reform previous health policies and plans used in developing countries, and it reaffirmed WHO's definition of health in 1946: "a state of complete physical, mental, and social well being, and not merely the absence of disease or infirmity."

- The conference declared that health is a fundamental human right and that attainment of the highest possible level of health was an important worldwide social goal.

- To achieve the goal of *health for all*, global health agencies pledged to work toward meeting people's basic health needs through a comprehensive approach called primary health care.

- Primary health care as envisioned at Alma Ata had strong sociopolitical implications. It explicitly outlined a strategy that would respond more equitably, appropriately, and effectively to basic health needs and also address the underlying social, economic, and political causes of poor health.

- It was to be underpinned by universal accessibility and coverage on the basis of need, with emphasis on disease prevention and health promotion, community participation, self-reliance, and intersectoral collaboration.

- It acknowledged that poverty, social unrest and instability, the environment, and lack of basic resources contribute to poor health status.
- It outlined *eight elements* that future interventions would use to fulfill the goal of health improvement: education concerning prevailing health problems and methods of preventing and controlling them; *promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care,*

including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

4.4   Relevance of Alma- Ata to the primary health care system:

WHO has highlighted the importance of primary health care in tackling health inequality in every country but after years of relative neglect; the World Health Organization has recently given strategic prominence to the development of primary health care. This year sees the 36th anniversary of the declaration of Alma Ata. Convened by WHO and the United Nations Children's Fund (Unicef), the Alma Ata conference drew representatives from 134 countries, 67 international organisations, and many non-governmental organisations. (China was notably absent.) Primary health care "based on practical, scientifically sound and socially acceptable methods and technology made universally accessible through people's full participation and at a cost that the community and country can afford" was to be the key to delivering health for all by the year 2000.Primary health care in this context includes both primary medical care and activities tackling determinants of ill health.

4.4.1   Characteristics of primary health care from Alma Ata declaration:

- Evolves from the economic conditions and socio-cultural and political characteristics of a country and its communities
- Is based on the application of social, biomedical, and health services research and public health experience
- Tackles the main health problems in the community—providing promotion, preventive, curative, and rehabilitative services as appropriate
- Includes education on prevailing health problems; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against the main infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs
- Involves all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, and industry
- Requires maximum community and individual self-reliance and participation in the planning, organisation, operation, and control of services
- Develops the ability of communities to participate through education
- Should be sustained by integrated, functional, and mutually supportive referral systems, leading to better comprehensive health care for all, giving priority to those most in need
- Relies on health workers, including physicians, nurses, midwives, auxiliaries, and community workers as well as traditional practitioners, trained to work as a team and respond to community's expressed health needs.

4.4.2   Essential components of effective primary health care:

- Well trained, multidisciplinary workforce
- Properly equipped and maintained premises
- Appropriate technology, including essential drugs

- Capacity to offer comprehensive preventive and curative services at community level
- Institutionalised systems of quality assurance
- Sound management and governance systems
- Sustainable funding streams aiming at universal coverage
- Functional information management and technology
- Community participation in the planning and evaluation of services provided
- Collaboration across different sectors—for example, education, agriculture
- Continuity of care
- Equitable distribution of resources

4.4.3   Progress and context

In 2008, the 30th Anniversary of Alma-Ata, primary health care (PHC) was reaffirmed as the key global strategy for attaining optimal health. Celebratory meetings were held under the auspices of the World Health Organization (WHO) in all its regions. The WHO World Health Report 2008 (WHR08) was devoted to PHC (WHO 2008). In 2008 *The Lancet* produced a themed issue on PHC. Notwithstanding these activities and publications there remains confusion, disagreement, and controversy around PHC in terms of its content, emphasis and application.

In the thirty years since the Alma-Ata Declaration there has been significant progress in global health with an overall increase in life expectancy. However, rapidly widening inequalities in health experience between and within countries – and even reversals in Africa and the former Soviet bloc countries – have led to a re-examination of the current context and content of health policies and why the Alma-Ata Declaration failed to lead to health for all (Commission on Social Determinants of Health 2008). The key question is whether PHC, as originally elaborated at Alma-Ata, remains a feasible option. This re-examination shows that a series of reform projects, with some key common features, driven by vested interests and short-sightedness, have perpetuated or aggravated the conditions that underpin ill-health and undermined the ability of health systems to function appropriately. Key among these are selective PHC, health sector reform, and the global health partnerships. These have depoliticized health and undermined the spirit of PHC.

4.4.4   Four Assaults on Primary Health Care:

1. **Selective Primary Health Care** – introduced in the late 70's. The comprehensive approach to PHC with its emphasis on equity and its call for a model of socioeconomic development conducive to *Health for All,* was quickly undermined by experts at John Hopkins School of Public Health, who claimed it was too complex and too costly. Instead, they advocated Selective Primary Health Care, focusing on a few "cost effective", top-down technological fixes "targeting" high risk groups. UNICEF quickly adopted this selective approach, which in practice focused mainly on oral rehydration therapy and immunization. While these so-called "twin engines" of the Child Survival Revolution did succeed in somewhat reducing child mortality, they did discouragingly little to reduce poverty, hunger, or children's quality of life. For this, a comprehensive approach is needed that confronts the root causes. While progress in implementing the PHC strategy in most low and middle income countries (LMICs) has been greatest in respect of certain of its more medically-related elements, the narrow and technicist focus characterizing what has been termed the 'selective PHC' approach (Walsh and Warren 1979) has at best delayed, and at worst undermined, the implementation of the comprehensive strategy codified at Alma-Ata. The

latter insisted on the integration of rehabilitative, therapeutic, preventive and promotive interventions with an emphasis on the latter two components. Selective PHC (SPHC) took the form in many LMICs of certain selected medical – mostly therapeutic and personal preventive – interventions, such as growth monitoring, oral rehydration therapy (ORT), breastfeeding and immunisation (GOBI). These constituted the centrepiece of UNICEF's 1980s Child Survival Revolution, which, it was argued, would be the 'leading edge' of PHC, ushering in a more comprehensive approach at a later stage (Werner and Sanders 1997). The relative neglect of the other PHC programme elements and the shift of emphasis away from equitable social and economic development, inter-sectoral collaboration, community participation and the need to set up sustainable district level structures suited the prevailing conservative winds of the 1980s (Rifkin and Walt 1986). It gave donors and governments a way of avoiding the fuzzier and more radical challenges of tackling inequalities and the underlying causes of ill-health. Some components of comprehensive PHC, especially the promotive interventions, have remained marginalised ever since Alma-Ata. These require for their operationalisation the implementation of such core principles of PHC as 'intersectoral action' and 'community involvement', and, increasingly with economic globalisation, intersectoral policies to address the social determinants of health (SDH) (Sanders et al. 2009). PHC has been defined (even in the Alma-Ata Declaration) as both a 'level of care' and an 'approach'. These two different meanings have persisted and perpetuated divergent perceptions and approaches. Thus, in some rich countries and sectors, PHC became synonymous with first line or primary medical care provided by general doctors, and simultaneously PHC has been viewed by many as a cheap, low technology option for poor people in LMICs. The Alma-Ata Declaration was one of the last expressions of the development thinking of the 1970s where the non-aligned movement declared its commitment to a 'New International Economic Order' (Cox 1997) and a 'Basic Needs Approach' to development. These visionary policies were buried in the 1970s debt crisis, stagflation, and the dominance of global economic policy by neoliberal thinking. This, together with rising unemployment and changes in the labour market, changes in demographic and social trends, and rapid technological advances with major cost implications for health services, has, over the past two decades, driven a process of 'health sector reform' in industrialized countries and LMICs.

2. Structural Adjustment Programs – introduces in the early 1980s. In the 1960s and 70s the governments and banks of the North loaned a vast amount of money to poor countries in the South to promote a model of development that replaced rural peasants and urban workers with fossil fuel consuming machines. This brought large profits for foreign investors and massive joblessness and increased poverty for the many. When poor countries began to default on their loans, the World Bank and IMF stepped in with bailout loans. There were tied to structural adjustment programs (SAPs). These required debt-burdened countries to reduce public spending, including that for health and education, to free up money to keep servicing their debts to the Northern Banks. Whereas the Alma Ata Declaration has called for increased government spending on health, SAP's pressured the poor countries to reduce and privatize public services. "Cost recovery" schemes (with introduction of "user fees") placed health services out of reach for many poor families. As a result in some countries child mortality, sexually transmitted diseases and rates of tuberculosis drastically increased. In terms of the pursuit of Health for All, this was a giant step backwards.

3. World Bank's takeover of Third World Health Policy – in the 1990s. Prior to the 1990s the World Bank invested almost nothing in health. But in the 1990s the Bank discovered that poor health reduces worker productivity, thus impeding economic growth (of big industry). So over a few years the Bank increased its investment in health to where, by the late 1990s, it was spending on the health sector three times as much as the entire WHO Budget. In terms of guiding Third World health policy, this has

relegated WHO to second place, not only because of the Bank's greater spending, but because it can tie its health reform "recommendations" to urgently needed (or strongly desired) loans. In its 1993 World Development Report, titled Investing in Health, the Bank spells out its health policy recommendations. These are essentially a free market version of selective health care. Governments should determine which health interventions to support according to their cost effectiveness in terms of keeping workers on the ob. Persons who cannot contribute to the economy – such as elderly and severely disabled persons – are ranked as of lower "value" and therefore merit little or no public assistance. Another dehumanizing step backwards in terms of Health for All!

4. The Mcdonaldization of WHO and UNICEF – in the 2000's. Partly because of shortage of funds, and partly because of influence of corporate gifts, in the last few years both WHO and UNICEF have entered into an increasing number of "partnerships" with transnational corporations, including drug and junk food companies. An example is UNICEF's recent plan with fast – food giant, Mcdonalds. On its promotion McDonalds will include UNICEF public helth messages and boost sales of Big Macs by announcing that part of the purchase price goes to UNICEF. In Nigeria UNICEF has made a similar agreement with Coca Cola. Such compromises with industries that promote conducive to obesity, heart diseases, stroke and diabetes are not conducive for Health for ALL. Partnerships with other pre-packaged mass-produced food with endorsement by WHO or UNICEF. Even if these costly foods have improved nutritional content, they are still a threat to health. If poor families spend their limited money to buy them rather than cheaper staple foods (like Maize and beans), the end result is more undernourished children. The Alma Ata declaration called for combating the underlying social and structural causes of poor health. To the contrary, these new partnerships by UNICEF and WHO with transnational corporations further entrenches and legitimizes the forces that put healthy profits before people.

4.4.5 Corporate rule as a threat to world health.

All of these four "assaults" on Primary Health Care as conceived in Alma Ata are manifestations of the dominant "free market" paradigm of development. As undemocratic as it is unsustainable, it promotes economic growth of the rich regardless of the human and environmental cost. That the current model of economic development driven by a deregulated market system is dangerous to health is evident when we consider the impact of its biggest industries. In economic terms, the world's three biggest industries are:

1) Military/arms.

2) Illicit drugs, and

3) Oil.

All three of these colossal industries poses far-reaching dangers to the sustainable well being of humanity and the planet. Yet because the money proffered by these industries strongly influences who gets elected to public office, it undermines democratic process. It impedes humanity from taking decisive steps to rein in the biggest emerging global threats to human health such as global warming, the pending Third World War, the deepening poverty of one third of humanity, the global pandemic of

crime and violence and the disempowerment that leads to terrorism. Rather than confront the underlying causes of these globalized threats to health, the world's chieftains – with their ties to the arms, drugs and the oil industries – use the current crises as a pretext to systematic role-back of civil rights, public services and rein in on corporate greed. In sum, far from progressing toward *Health for All*, humanity may currently be on a collision course toward Health for no one. It is time to collectively wake up and change course.

4.4.6   Primary health care: 36 years since Alma-Ata:

- The 1978 Declaration of Alma-Ata was groundbreaking because it linked the rights-based approach to health to a viable strategy for attaining it. The outcome document of the International Conference on Primary Health Care, the declaration identified primary health care as the key to reducing health inequalities between and within countries and thereby to achieving the ambitious but unrealized goal of "Health for All" by 2000.

- Primary health care was defined by the document as "essential health care" services, based on scientifically proven interventions. These services were to be universally accessible to individuals and families at a cost that communities and nations as a whole could afford. At a minimum, primary health care comprised eight elements: health education, adequate nutrition, maternal and child health care, basic sanitation and safe water, control of major infectious diseases through immunization, prevention and control of locally endemic diseases, treatment of common diseases and injuries, and the provision of essential drugs.

- The declaration urged governments to formulate national policies to incorporate primary health care into their national health systems. It argued that attention be given to the importance of community-based care that reflects a country's political and economic realities.

- This model would bring "health care as close as possible to where people live and work" by enabling them to seek treatment, as appropriate, from trained community health workers, nurses and doctors.

- It would also foster a spirit of self-reliance among individuals within a community and encourage their participation in the planning and execution of health-care programmes. Referral systems would complete the spectrum of care by providing more comprehensive services to those who needed them most – the poorest and the most marginalized.
- Alma-Ata grew out of the same movement for social justice that led to the 1974 Declaration on the Establishment of a New International Economic Order. Both stressed the interdependence of the global economy and encouraged transfers of aid and knowledge to reverse the widening economic and technological divides between industrialized countries and developing countries, whose growth had, in many cases, been stymied by colonization.

- Examples of community-based innovations in poorer countries after World War II also provided inspiration. Nigeria's under-five clinics, China's barefoot doctors and the Cuban and Vietnamese health systems demonstrated that advances in health could occur without the infrastructure available in industrialized countries.

- The International Conference on Primary Health Care was itself a milestone. At the time, it was the largest conference ever held devoted to a single topic in international health and development, with 134 countries and 67 non-governmental organizations in attendance.

- *Yet there were obstacles to fulfilling its promise. For one thing, the declaration was non-binding.*

- *Furthermore, conceptual disagreements over how to define fundamental terms such as 'universal access', which persist today, were present from the beginning. In the context of the cold war, these terms revealed the sharp ideological differences between the capitalist and communist worlds, discord perhaps heightened by the fact that the Alma-Ata conference took place in what was then the Union of Soviet Socialist Republics.*

- *As the 1970s gave way to a new decade, a tumultuous economic environment contributed to a diversion away from primary health care in favour of the more affordable model of selective health care, which targeted specific diseases and conditions.*

- *Insufficient progress towards the Millennium Development Goals, coupled with the threats posed to global health and human security by climate change, pandemic influenza and the global food crisis, have led to renewed interest in comprehensive primary health care.*

- *Yet the many challenges that prevented Alma-Ata's implementation have evolved and must be confronted to achieve its goals now. Drawing on the growing body of evidence about cost-effective initiatives that integrate household and community care with outreach and facility-based services – such as those for maternal and child health.*

4.5   Alma Ata and the primary health care in India:

- The primary healthcare approach was described as "essential care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation

and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination".

- The Alma-Ata Declaration also emphasizes that everyone should have access to primary healthcare, and everyone should be involved in it. The primary healthcare approach encompasses the following key components: Equity, community involvement/participation, intersectorality, appropriateness of technology and affordable costs.

- Primary healthcare is a vital strategy that remains the backbone of health service delivery.

- India was one of the first countries to recognize the merits of primary healthcare approach. Long before the Declaration of Alma-Ata, India adopted a primary healthcare model based on the principle that inability to pay should not prevent people from accessing health services.

- Derived from the recommendations of the Health Survey and Development Committee Report 1946, under the chairmanship of Sir Joseph Bhore, the Indian Government resolved to concentrate services on rural people. This committee report laid emphasis on social orientation of medical practice and high level of public participation.

- With beginning of health planning in India and first five year plan formulation (1951-1955) Community Development Programme was launched in 1952.

- It was envisaged as a multipurpose program covering health and sanitation through establishment of primary health centers (PHCs) and subcenters.

- By the close of second five year plan (1956-1961) Health Survey and Planning Committee (Mudaliar Committee) was appointed by Government of India to review the progress made in health sector after submission of Bhore Committee report. The major recommendations of this committee report was to limit the population served by the PHCs with the improvement in the quality of the services provided and provision of one basic health worker per 10,000 population.

- The Jungalwalla Committee in 1967 gave importance to integration of health services. The committee recommended the integration from the highest to lowest level in services, organization, and personnel.

- The Kartar Singh Committee on multipurpose workers in 1973 laid down the norms about health workers.

- Shrivastav Committee (1975) suggested creation of bands of para-professionals and semi-professional worker from within the community like school teachers and post masters. It also recommended the development of referral complex by establishing linkage between PHCs and high level referral and service centers.

- Rural Health Scheme was launched in 1977, wherein training of community health, reorientation training of multipurpose workers, and linking medical colleges to rural health was initiated. Also to initiate community participation, the community health volunteer "Village Health Guide" scheme was launched.

- The Alma-Ata Declaration of 1978 launched the concept of health for all by year 2000. The declaration advocated the provision of first contact services and basic medical care within the framework of an integrated health services.

- Several critical efforts outlined Government of India's commitment to provide health for all of its citizens after Alma-Ata declaration. The report of study group on "Health for All: An Alternative Strategy" commissioned by Indian Council for Social Science Research (ICSSR) and Indian Council for Medical Research (ICMR) (1980) argued that most of health problems of a majority of India's population were amenable to being solved at the primary healthcare level through community participation and ownership.

- Alma-Ata declaration led to formulation of India's first National Health Policy in 1983. The major goal of policy was to provide universal, comprehensive primary health services. Nearly 20 years after the first policy, the second National Health Policy was presented in 2002.

- The National Health Policy, 2002 set out a new framework to achieve public health goals in socioeconomic circumstances currently prevailing in the country. It sets out an increased sectoral share of allocation out of total health spending to primary healthcare.

- Recognizing the importance of health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has launched the National Rural Health Mission in 2005 to carry out necessary

architectural correction in the basic healthcare delivery system. The goal of the mission is to improve the availability of and access to quality healthcare by people, especially for those residing in rural areas, the poor, women, and children.

4.5.1 Challenges for Primary Healthcare System in India with few suggested remedies:

- Delivering quality primary care to large populations is always challenging, and that is certainly the case in India. In India, communicable diseases, maternal, perinatal, and nutritional deficiencies continue to be important causes of deaths. Non-communicable diseases like diabetes, cardiovascular diseases, respiratory disorders, cancers, and injuries are showing the rising trends.

- Mental health disorders are also on the rise also taking a substantial toll of human lives.

- The health issues related to elderly population are common due to increase in life expectancy. Within the next few decades, we will see an extraordinary increase in the number of older people worldwide. The public health benefit of preventive medicine in old age comes from the compression of the time spent in dependency to a minimum. The rising morbidities clearly showed that a regular, complete health checkup of the elderly should be embedded in the essential elements of the primary healthcare.

- India has been witnessing rapid urbanization particularly in recent decades. Currently one-fourth of the urban population lives in slums with severely compromised health and sanitary conditions.

- It has been observed that there is poor level of client satisfaction in rural as well as urban areas of India regarding primary healthcare services.

- Client satisfaction is an important measure of the quality of healthcare and needs to be addressed in order to improve the utilization of primary healthcare services. Patients often complain of rude and abrupt health workers that discriminate against women and minorities from scheduled castes or tribes.

- The current primary healthcare infrastructure and manpower is also deficient. According to Rural Health Survey (RHS) 2011, as on March 2011 there are 148,124 subcenters; 23,887 PHCs; and 4,809 community health centers (CHCs) functioning in India.

- The norms set for the population coverage for subcenter, PHC, and CHC for plane areas are 5,000; 30,000; and 120,000; respectively. As per RHS, 2011 the average population covered by a subcenter, PHC, and CHC was 5,624; 34,876; and 173,235; respectively. As on March, 2011 the overall shortfall in the posts of health worker (female (F))/auxiliary nurse midwife was 3.8% of the total requirement. For allopathic doctors at PHCs, there was a shortfall of 12.0% of the total requirement for existing infrastructure as compared to manpower in position. Similarly, in case of health worker (male (M)), there was a shortfall of 64.7% of the requirement. In case of health assistant (female)/lady health visitor, the shortfall was 38% and that of health assistant (male) was 43.3%. For allopathic doctors at PHC, there was a shortfall of 12.0% of the total requirement. As compared to requirement for existing CHC infrastructure, there was a shortfall of 75% of surgeons, 65.9% of obstetricians and gynecologists, 80.1% of physicians, and 74.4% of pediatricians. Overall, there was a shortfall of 63.9% specialists at the CHCs as compared to the requirement for existing CHCs.

- As per 2011 census, India's population is more than 121 crores. 83.3 crores (68.84%) of Indians live in rural areas. Considering the population norms for PHC of 30,000 in plane areas (here the population norms for PHC of 20,000 for tribal and hilly areas is not considered), India requires more than 27,700 PHCs. So when compared with RHS, 2011; India requires 3,800 more PHCs.

- There is urgent need to address inadequate infrastructure as well as manpower for better service and delivery of primary healthcare. Only after addressing these issues we can think of applying Indian Public Health Standards to all healthcare infrastructures.

- The current primary healthcare structure is extremely rigid, making it unable to respond effectively to local realities and needs. The lack of resources, which is acute in some states, is certainly a contributing factor to the poor performance of the primary healthcare system.

- There is a need to explore and understand the reasons that prompt people to visit health facilities and the reasons driving them away from free government care.

- Ubiquitous absenteeism, low client-provider interaction, poor referral systems, and a low perceived quality of care could emerge as possible reasons for this situation.

- Large diversity in India calls for local adaptation of the basic healthcare package and its delivery mechanism.

- The question confronting health systems in India is how best to reform, revitalize, and resource primary health systems to deliver different levels of service aligned to local realities, ensuring universal coverage, equitable access, efficiency and effectiveness, through an empowered cadre of health personnel.

- To encourage accountability, access should be monitored at district level by an independent agency.

- There is growing need of research in improving the service delivery of primary healthcare.

- Qualitative research into this area could yield lessons for the delivery of future services. Research into factors influencing service utilization could lead us to developing a public health marketing strategy for care access.

- A conjoint effort by the state and the institutes can thus be used to reinvent primary healthcare and bring it to the forefront.

- Several opportunities can be explored within the facilitating atmosphere of National Rural Health Mission (NRHM).

- Thus, it is evident that the success of health systems exists in tapping the existing potential and making appropriate structural changes.

- The role of primary care should not be defined in isolation but in relation to the constituents of the health system.
- The Millennium Development Goals (MDGs) which include eight goals were framed to address the world's major development challenges with health and its related areas as the prime focus. In India, considerable progress has been made in the field of basic universal education, gender equality in education, and global economic growth. However, there is slow progress in the improvement of health indicators related to mortality, morbidity, and various environmental factors contributing to poor health conditions.

- As rightly mentioned by Nath, even though the government has implemented a wide array of programs, policies, and various schemes to combat these health challenges,

further intensification of efforts and redesigning of outreach strategies is needed to give momentum to the progress toward achievement of the MDGs.

- India's progress towards achieving MDGs is slow and it is evident that role of primary healthcare is essential in the progress towards achieving them. To conclude, the primary healthcare system in India has evolved in due course of time but the challenges of future are needed to be addressed effectively to achieve the MDGs.

4.6 Role of government in public health: Current scenario in India:

The new agenda for Public Health in India includes the

- **epidemiological transition**
- **demographical transition**
- **environmental changes and**
- **social determinants of health**

Based on the principles outlined at Alma-Ata in 1978, there is an urgent call for revitalizing primary health care in order to meet these challenges. The role of the government in influencing population health is not limited within the health sector but also by various sectors outside the health systems. Health system strengthening, human resource development and capacity building and regulation in public health are important areas within the health sector. Contribution to health of a population also derives from social determinants of health like living conditions, nutrition, safe drinking water, sanitation, education, early child development and social security measures. Population stabilization, gender mainstreaming and empowerment, reducing the impact of climate change and disasters on health, improving community participation and governance issues are other important areas for action. Making public health a shared value across the various sectors is a politically challenging strategy, but such collective action is crucial.

4.6.1 Challenges confronting public health in India:

The practice of public health has been dynamic in India, and has witnessed many hurdles in its attempt to affect the lives of the people of this country. Since independence, major public health problems like malaria, tuberculosis, leprosy, high maternal and child mortality and lately, human immunodeficiency virus (HIV) have been addressed through a concerted action of the government. Social development coupled with scientific advances and health care has led to a decrease in the mortality rates and birth rates.

- The new agenda for Public Health in India includes the epidemiological transition (rising burden of chronic non-communicable diseases), demographic transition (increasing elderly population) and environmental changes.

- The unfinished agenda of maternal and child mortality, HIV/AIDS pandemic and other communicable diseases still exerts immense strain on the overstretched health systems.

- Silent epidemics: In India, the tobacco-attributable deaths range from 800,000 to 900,000/year, leading to huge social and economic losses. Mental, neurological and substance use disorders also cause a large burden of disease and disability. The rising toll of road deaths and injuries (2—5 million hospitalizations, over 100,000 deaths in 2005) makes it next in the list of silent epidemics. Behind these stark figures lies human suffering.

- Health systems are grappling with the effects of existing communicable and non-communicable diseases and also with the increasing burden of emerging and re-emerging diseases (drug-resistant TB, malaria, SARS, avian flu and the current H1N1 pandemic).

- Inadequate financial resources for the health sector and inefficient utilization result in inequalities in health. As issues such as Trade-Related aspects of Intellectual Property Rights continue to be debated in international forums, the health systems will face new pressures.

- The causes of health inequalities lie in the social, economic and political mechanisms that lead to social stratification according to income, education, occupation, gender and race or ethnicity.

- Lack of adequate progress on these underlying social determinants of health has been acknowledged as a glaring failure of public health.

- In the era of globalization, numerous political, economic and social events worldwide influence the food and fuel prices of all countries; we are yet to recover from the far-reaching consequences of the global recession of 2008.

4.6.2   Role of Govt. in addressing Public health in India:

To meet the formidable challenges described earlier, there is an urgent call for revitalizing primary health care based on the principles outlined at Alma-Ata in 1978: Universal access and coverage, equity, community participation in defining and implementing health agendas and intersectoral approaches to health. These principles remain valid, but must be reinterpreted in light of the dramatic changes in the health field during the past 36years. Attempts to achieve "Health For All" have been carried forward in the form of "Millenium Development Goals."

Public health is concerned with disease prevention and control at the population level, through organized efforts and informed choices of society, organizations, public and private communities and individuals. However, the role of government is crucial for addressing these challenges and achieving health equity. The Ministry of Health and Family Welfare (MOHFW) plays a key role in guiding India's public health system.

Contribution to health of a population derives from systems outside the formal health care system, and this potential of intersectoral contributions to the health of communities is increasingly recognized worldwide. Thus, the role of government in influencing population health is not limited within the health sector but also by various sectors outside the health systems.

4.7   Role of government within the health sector with few suggested majors:

Health forms a major criteria in the evaluation of the developmental status of a country. The Constitution of India envisages the establishment of a new social order based on equality, justice and dignity of the individual. The Preamble, Directive Principles of State Policy and Fundamental Rights in the Constitution of India stand testimony to the commitment of the State to its people in this regard. The commitment made by the nation has found expression in the various developmental activities undertaken by the Government since independence.

Various government departments are contributing to the well being and healthy development of the people, either directly or indirectly. While the Ministry of Health & Family Welfare is the nerve center of all health related activities, other Ministries like Human Resource Development, Rural Development, Agriculture, Food and Civil Supplies and Urban Affairs also contribute substantially.

Ministry of Health & Family Welfare has the constitutional obligation to guide, regulate, assist and finance State Governments in the area of population control, family planning, medical education, adulteration of food, drugs and poisons, medical profession, vital statistics and mental deficiency, leaving the other areas of public health, sanitation and nutrition to the State Governments' exclusive jurisdiction. The central Government evolves broad policies and plans through Central Council of Health & Family Welfare for implementing various health programme in the country.

4.7.1   Scenario around 1950s and onwards:

- At the time of independence the health situation in the country was dismal with millions of people succumbing to the scourge of Malaria, Plague, Influenza, Pneumonia, Tetanus, and Tuberculosis. Added to this misery was the frequent occurrence of droughts.

- With the inception of planning in the country, the Government took concerted measures to control/eradicate communicable and non- communicable diseases through various National Health Programmes. These are being implemented as centrally sponsored schemes aimed mainly at reduction of mortality and morbidity caused by major diseases.

- The major health schemes include the National programmes for Eradication/Control of Malaria, Blindness, Leprosy, Tuberculosis, AIDS including Blood safety measures and STD control, Cancer control, Iodine Deficiency Disorders Control, Mental Health and Guineaworm Eradication programme.

- The National Rural Health Mission (NRHM) launched by the Government of India is a leap forward in establishing effective integration and convergence of health services and affecting architectural correction in the health care delivery system in India.

- India is a signatory to the Alma-Ata declaration of Health for All by 2000 A.D. through primary health care approach. In 1983, the National health Policy was adopted to give effect to this commitment. It laid stress on the provision of preventive, promotive and rehabilitative health services to the people representing a shift from medical care to health care, and from urban to rural population.

- To achieve this a huge network of rural health infrastructure comprising of 1,36,339 sub-centres, 22,010 Primary health Centres and 2,622 community health centres have been set up throughout the country. The Common Minimum Programmes of the Government also attaches importance to primary health care and envisages to provide 100% coverage both in the rural and urban areas. Health Care Institutions.

- Over the years the country has expanded the health care delivery system and has adequate availability of health manpower and training institutes. At present there are about 489189 allopathic doctors, 11,300 Dental Surgeons and 5,59,896 Nurses in the country. Every year about 18,000 medical graduates and post graduates are passing out of nearly 164 medical colleges and other institutions.
- India has many premier educational and research institutes like AIIMS, New Delhi; PGI, Chandigarh, JIPMER, Pondicherry, NIMHANS, Bangalore, ICMR, New Delhi; NTI, Bangalore; NICD New Delhi; CLTRI Changalpattu; NBE, New Delhi and All India Institute of Hygiene and Public Health, Calcutta, attached to the Ministry of health & Family Welfare.

- India has attained self-sufficiency in the manufacture of many drugs and vaccines and a chain of laboratories are working in this area. Many institutes of Department of Science &

Technology like Centre for Cellular & Molecular Biology, Hyderabad; National Institute of Immunology, New Delhi and DRDO, Bangalore have been contributing usefully towards health sector.

4.7.2 Pilot Projects:

To strengthen the secondary health care development system, Government has started State Health Systems Development projects in Andhra Pradesh, Karnataka, West Bengal, Orissa and it is being extended to six more States with World Bank's assistance.

To strengthen disease surveillance system in the country, especially at District and State level a pilot project has been started. Two districts each in Madhya Pradesh, Gujarat, Maharashtra, Bihar, Andhra Pradesh, Rajasthan, karnataka, Haryana, Uttar Pradesh, Kerala and Delhi have been selected under this project. Pilot projects have also been initiated on Cancer, Oral health, Diabetes and Micro-nutrients. Realising the importance of Information, Education and Communication (IEC) strategy in India, Government has taken measures to utilise all forms of media to propagate and advocate health messages.

4.7.3. Regulation and enforcement in public health:

A good system of regulation is fundamental to successful public health outcomes. It reduces exposure to disease through enforcement of sanitary codes, e.g., water quality monitoring, slaughterhouse hygiene and food safety. Wide gaps exist in the enforcement, monitoring and evaluation, resulting in a weak public health system. This is partly due to poor financing for public health, lack of leadership and commitment of public health functionaries and lack of community involvement. Revival of public health regulation through concerted efforts by the government is possible through updation and implementation of public health laws, consulting stakeholders and increasing public awareness of existing laws and their enforcement procedures.

4.7.4 Health promotion:

Stopping the spread of STDs and HIV/AIDS, helping youth recognize the dangers of tobacco smoking and promoting physical activity. These are a few examples of behavior change communication that focus on ways that encourage people to make healthy choices. Development of community-wide education programs and other health promotion activities need to be strengthened. Much can be done to improve the effectiveness of health promotion by extending it to rural areas as well; observing days like "Diabetes day" and "Heart day" even in villages will help create awareness at the grass root level.

4.7.5 Human resource development and capacity building:

There are several shortfalls that need to be addressed in the development of human resources for public health services. There is a dire need to establish training facilities for public health specialists along with identifying the scope for their contribution in the field. The Public Health Foundation of India

is a positive step to redress the limited institutional capacity in India by strengthening training, research and policy development in public health. Preservice training is essential to train the medical workforce in public health leadership and to impart skills required for the practice of public health. Changes in the undergraduate curriculum are vital for capacity building in emerging issues like geriatric care, adolescent health and mental health. In-service training for medical officers is essential for imparting management skills and leadership qualities. Equally important is the need to increase the number of paramedical workers and training institutes in India.

4.7.6 Public health policy:

Identification of health objectives and targets is one of the more visible strategies to direct the activities of the health sector, e.g. in the United States, the "Healthy People 2010" offers a simple but powerful idea by providing health objectives in a format that enables diverse groups to combine their efforts and work as a team. Similarly, in India, we need a road map to "better health for all" that can be used by states, communities, professional organizations and all sectors. It will also facilitate changes in resource allocation for public health interventions and a platform for concerted intersectoral action, thereby enabling policy coherence.

4.7.7 Role of government in enabling intersectoral coordination towards public health issues:

The Ministry of Health needs to form stronger partnerships with other agents involved in public health, because many factors influencing the health outcomes are outside their direct jurisdiction. Making public health a shared value across the various sectors is a politically challenging strategy, but such collective action is crucial.

➢ **Social determinants of health**

Kerala is often quoted as an example in international forums for achieving a good status of public health by addressing the fundamental determinants of health: Investments in basic education, public health and primary care.

- *Living conditions*

Safe drinking water and sanitation are critical determinants of health, which would directly contribute to 70-80% reduction in the burden of communicable diseases. Full coverage of drinking water supply and sanitation through existing programs, in both rural and urban areas, is achievable and affordable.

- *Urban planning*

Provision of urban basic services like water supply, sewerage and solid waste management needs special attention. The Jawaharlal Nehru National Urban Renewal Mission in 35 cities works to develop financially sustainable cities in line with the Millenium Development Goals, which needs to be expanded to cover the entire country.Other issues to be addressed are housing and urban poverty alleviation.

- *Revival of rural infrastructure and livelihood*

Action is required in the following areas: Promotion of agricultural mechanization, improving efficiency of investments, rationalizing subsidies and diversifying and providing better access to land, credit and skills.

- *Education*

Elementary education has received a major push through the Sarva Siksha Abhayan. In order to consolidate the gains achieved, a mission for secondary education is essential. "Right of children to Free and Compulsory education Bill 2009" seeks to provide education to children aged between 6 and 14 years, and is a right step forward in improving the literacy of the Indian population.

- *Nutrition and early child development*

Recent innovations like universalization of Integrated Child Development Services (ICDS) and setting up of mini-Anganwadi centers in deprived areas are examples of inclusive growth under the eleventh 5-year plan. The government needs to strengthen ICDS in poor-performing states based on experiences from other successful models, e.g., Tamil Nadu (upgrading kitchens with LPG connection, stove and pressure cooker and electrification; use of iron-fortified salt to address the burden of anemia). Micronutrient deficiency control measures like dietary diversification, horticultural intervention, food fortification, nutritional supplementation and other public health measures need intersectoral coordination with various departments, e.g., Women and Child Development, Health, Agriculture, Rural and Urban development.

- *Social security measures*

The social and economic spinoff of the Mahatma Gandhi Rural Employment Guarantee Scheme (MREGS) has the potential to change the complexion of rural India. It differs from other poverty-alleviation projects in the concept of citizenship and entitlement.[9] However, employment opportunities and wages have taken the center stage, while development of infrastructure and community assets is neglected. This scheme has the necessary manpower to implement intersectoral projects, e.g., laying roads, water pipelines, social forestry, horticulture, anti-erosion projects and rain water harvesting. The unlimited potential of social capital has to be effectively tapped by the government.

- *Food security measures*

Innovations are required to strengthen the public distribution system to curb the inclusion and exclusion errors and increase the range of commodities for people living in very poor conditions. It is essential that the government puts forth action plans to increase domestic food grain production, raise consumer incomes to buy food and make agriculture remunerative.

- *Other social assistance programs*

The Rashtriya Swasthiya Bima Yojana and Aam Admi Bhima Yojana are social security measures for the unorganized sector (91% of India's workforce). The National Old Age Pension scheme has provided social and income security to the growing elderly population in India.

➢ **Population stabilization**

There is all round realization that population stabilization is a must for ensuring quality of life for all citizens. Formulation of a National Policy and setting up of a National Commission on Population and Janasankhya Sthiratha Kosh reflect the deep commitment of the government. However, parallel developments in women empowerment, increasing institutional deliveries and strengthening health services and infrastructure hold the key to population control in the future.

➢ **Gender mainstreaming and empowerment**

Women-specific interventions in all policies, programs and systems need to be launched. The government should take steps to sensitize service providers in various departments to issues of women. The Department of Women and Child Development must take necessary steps to implement the provisions of "Protection of Women from Domestic Violence Act, 2005." Training for protection officers, establishment of counseling centers for women affected by violence and creating awareness in the community are vital steps. Poverty eradication programs and microcredit schemes need to be strengthened for economic and social empowerment of women.

➢ **Reducing the impact of climate change and disasters on health**

Thermal extremes and weather disasters, spread of vector-borne, food-borne and water-borne infections, food security and malnutrition and air quality with associated human health risks are the public health risks associated with climate change. Depletion of non-renewable sources of energy and water, deterioration of soil and water quality and the potential extinction of innumerable habitats and species are other effects. India's "National Action Plan on Climate Change" identifies eight core "national missions" through various ministries, focused on understanding climate change, energy efficiency, renewable energy and natural resource conservation. Although there are several issues concerning India's position under UNFCCC, it has agreed not to allow its per capita Greenhouse gas emissions to exceed the average per capita emissions of the developed countries, even as it pursues its social and economic development objectives.

The Ministry of Health, in coordination with other ministries, provides technical assistance in implementing disaster management and emergency preparedness measures. Deficient areas include carrying out rapid needs assessment, disseminating health information, food safety and environmental health after disasters and ensuring transparency and efficiency in the administration of aid after disasters. Implementation of Disaster Management Act, 2005 is essential for establishing institutional mechanisms for disaster management, ensuring an intersectoral approach to mitigation and undertaking holistic, coordinated and prompt response to disaster situations.

➢ **Community participation**

Community participation builds public support for policies and programs, generates compliance with regulations and helps alter personal health behaviors. One of the major strategic interventions under NRHM is the system of ensuring accountability and transparency through people's participation – the Rogi Kalyan Samitis. The Ministry of Health needs to define a clear policy on social participation and operational methods in facilitating community health projects. Potential areas of community participation could be in lifestyle modification in chronic diseases through physical activity and diet modification, and primary prevention of alcohol dependence through active community-based methods like awareness creation and behavioral interventions.

> **Private sectors, civil societies and global partnerships**

Effective addressing of public health challenges necessitates new forms of cooperation with private sectors (public-private partnership), civil societies, national health leaders, health workers, communities, other relevant sectors and international health agencies (WHO, UNICEF, Bill and Melinda Gates foundation, World Bank).

> **Governance issues**

In order to ensure that the benefits of social security measures reach the intended sections of society, enumeration of Below Poverty Line families and other eligible sections is vital. Check mechanisms to stop pilferage of government funds and vigilance measures to stop corruption are governance issues that need to be attended. The government should take strict action in cases of diversion of funds and goods from social security schemes through law enforcement, community awareness and speedy redressal mechanisms. Social audits in MREGS through the Directorate of Social Audit in Andhra Pradesh and Rajasthan are early steps in bringing governance issues to the fore. This process needs strengthening through separate budgets, provisions for hosting audit results and powers for taking corrective action. Similar social auditing schemes can be emulated in other states and government programs like ICDS, which will improve accountability and community participation, leading to effective service delivery.

4.8   Conclusion:

In this changing world, with unique challenges that threaten the health and well-being of the population, it is imperative that the government and community collectively rise to the occasion and face these challenges simultaneously, inclusively and sustainably. Social determinants of health and economic issues must be dealt with a consensus on ethical principles – universalism, justice, dignity, security and human rights. This approach will be of valuable service to humanity in realizing the dream of Right to Health. The ultimate yardstick for success would be if every Indian, from a remote hamlet in Bihar to the city of Mumbai, experiences the change.

It is true that a lot has been achieved in the past: The milestones in the history of public health that have had a telling effect on millions of lives – launch of Expanded Program of Immunisation in 1974, Primary Health Care enunciated at Alma Ata 1978, eradication of Smallpox in 1979, launch of polio eradication in 1988, FCTC ratification in 2004 and COTPA Act of 2005, to name a few. It was a glorious past, but the future of a healthy India lies in mainstreaming the public health agenda in the framework

of sustainable development. The ultimate goal of great nation would be one where the rural and urban divide has reduced to a thin line, with adequate access to clean energy and safe water, where the best of health care is available to all, where the governance is responsive, transparent and corruption free, where poverty and illiteracy have been eradicated and crimes against women and children are removed – a healthy nation that is one of the best places to live in.

4.9.Summary:

- Five-Year Plans (FYPs) are centralized and integrated national economic programs. It is central government's more hands-off approach to development. India launched its First FYP in 1951, immediately after independence under socialist influence of first Prime Minister Jawaharlal Nehru.

- The First Five-Year Plan was one of the most important, because it had a great role in the launching of Indian development after the Independence. Thus, it strongly supported agriculture production and it also launched the industrialization of the country. It built a particular system of mixed economy, with a great role for the public sector as well as a growing private sector.

- The Second Plan (1956-1961) devoted particularly in the development of the public sector and attempted to determine the optimal allocation of investment between productive sectors in order to maximize long-run economic growth.

- The Third Five-year Plan (1961-1966) stressed agriculture and improvement in the production of wheat.

- At the time of Indira Gandhi forth five year plan (1969-1974) was implemented. During this plan 14 major Indian banks were nationalized and the Green Revolution in India advanced agriculture.

- The Fifth Five-Year Plan (1974-1979) laid stress on employment, poverty alleviation (Garibi Hatao), and justice. The plan also focused on self-reliance in agricultural production and defence.

- The Sixth Five-Year Plan (1980-1985) marked the beginning of economic liberalisation. An dwith this there was the end of Nehruvian socialism.

- The main objectives of the Seventh Five-Year Plan (1985- 1990) were to establish growth in areas of increasing economic productivity, production of food grains, and generating employment.

- Modernization of industries was a major highlight of the Eighth Plan (1992-1997).

- The Ninth Five-Year Plan (1997-2002) tried primarily to use the latent and unexplored economic potential of the country to promote economic and social growth. For the first time health system has been given attention in this plan. The ninth five year plan focused on the ***availability of primary health care facilities and other basic necessities***.

- The main objectives of the Tenth Five-Year Plan (2002-2007) was Providing gainful and high-quality employment at least to the addition to the labour force.

- The main objectives of the Eleventh Five-Year Plan (2007-2012) was to increase the growth rate in agriculture, industry and services, Environmental sustainability, Reduction of gender inequality, Empowerment through education and skill development, Rapid and inclusive growth.

- The Twelfth Five-Year Plan (2012-2017) of the Government of India has decided for the growth rate at 8.2% but the National Development Council (NDC) on 27 Dec 2012 approved 8% growth rate for 12th five-year plan.

- The declaration of Alma Ata defined primary health care 36 years ago at the International Conference on Primary Health Care (PHC), Almaty (formerly Alma-Ata), Kazakhstan (formerly Kazakh Soviet Socialist Republic), 6-12 September 1978.

- The Declaration of Alma-Ata, co-sponsored by the World Health Organization (WHO), is a brief document that expresses **"the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world."**

- Thus, *"health for all"* was introduced to global health planners and practitioners by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) at the International Conference on Primary Health Care in Alma Ata, Kazakhstan, in 1978.

- Primary health care was defined by the document as "essential health care" services, based on scientifically proven interventions. These services were to be universally accessible to individuals and families at a cost that communities and nations as a whole could afford.

- Primary health care comprised eight elements: health education, adequate nutrition, maternal and child health care, basic sanitation and safe water, control of major infectious diseases through immunization, prevention and control of locally endemic diseases, treatment of common diseases and injuries, and the provision of essential drugs.

- India was one of the first countries to recognize the merits of primary healthcare approach. Long before the Declaration of Alma-Ata, India adopted a primary healthcare model based on the principle that inability to pay should not prevent people from accessing health services

- By the close of second five year plan (1956-1961) Health Survey and Planning Committee (Mudaliar Committee) was appointed by Government of India to review the progress made in health sector after submission of Bhore Committee report. The major recommendations of this committee report was to limit the population served by the PHCs with the improvement in the quality of the services provided and provision of one basic health worker per 10,000 population.

- Alma-Ata declaration led to formulation of India's first National Health Policy in 1983. The major goal of policy was to provide universal, comprehensive primary health services. Nearly 20 years after the first policy, the second National Health Policy was presented in 2002.

- There are Four Assaults on Primary Health Care: Selective Primary Health Care, Structural adjustment Programs, World Bank's takeover of third World Health Policy and the Mcdonaldization of WHO and UNICEF.

- Although it had huge symbolic importance, its effect in practice was more limited.

- Delivering quality primary care to large populations is always challenging, and that is certainly the case in India. In India, communicable diseases, maternal, perinatal, and nutritional deficiencies continue to be important causes of deaths. Non-communicable diseases like diabetes, cardiovascular diseases, respiratory disorders, cancers, and injuries are showing the rising trends.

- The current primary healthcare infrastructure and manpower is also deficient. According to Rural Health Survey (RHS) 2011, as on March 2011 there are 148,124 subcenters; 23,887 PHCs; and 4,809 community health centers (CHCs) functioning in India.

- There is urgent need to address inadequate infrastructure as well as manpower for better service and delivery of primary healthcare. Only after addressing these issues we can think of applying Indian Public Health Standards to all healthcare infrastructures.

- The current primary healthcare structure is extremely rigid, making it unable to respond effectively to local realities and needs. The lack of resources, which is acute in some states, is certainly a contributing factor to the poor performance of the primary healthcare system.

- To meet the formidable challenges described earlier, there is an urgent call for revitalizing primary health care based on the principles outlined at Alma-Ata in 1978: Universal access and coverage, equity, community participation in defining and implementing health agendas and intersectoral approaches to health. These principles remain valid, but must be reinterpreted in light of the dramatic changes in the health field during the past 36years.

- Health forms a major criteria in the evaluation of the developmental status of a country. The Constitution of India envisages the establishment of a new social order based on equality, justice and dignity of the individual. The Preamble, Directive Principles of State Policy and Fundamental Rights in the Constitution of India stand testimony to the commitment of the State to its people in this regard. The commitment made by the nation has found expression in the various developmental activities undertaken by the Government since independence.

- Various government departments are contributing to the well being and healthy development of the people, either directly or indirectly. While the Ministry of Health & Family Welfare is the nerve center of all health related activities, other Ministries like Human Resource Development, Rural Development, Agriculture, Food and Civil Supplies and Urban Affairs also contribute substantially.

- India is a signatory to the Alma-Ata declaration of Health for All by 2000 A.D. through primary health care approach. In 1983, the National health Policy was adopted to give effect to this commitment. It laid stress on the provision of preventive, promotive and rehabilitative health services to the people representing a shift from medical care to health care, and from urban to rural population.

- To strengthen the secondary health care development system, Government has started State Health Systems Development projects in Andhra Pradesh, Karnataka, West Bengal, Orissa and it is being extended to six more States with World Bank's assistance.

- To strengthen disease surveillance system in the country, especially at District and State level a pilot project has been started. Two districts each in Madhya Pradesh, Gujarat, Maharashtra, Bihar, Andhra Pradesh, Rajasthan, karnataka, Haryana, Uttar Pradesh, Kerala and Delhi have been selected under this project. Pilot projects have also been initiated on Cancer, Oral health, Diabetes and Micro-nutrients. Realising the importance of Information, Education and Communication (IEC) strategy in India, Government has taken measures to utilise all forms of media to propagate and advocate health messages.

- The Ministry of Health needs to form stronger partnerships with other agents involved in public health, because many factors influencing the health outcomes are outside their direct jurisdiction. Making public health a shared value across the various sectors is a politically challenging strategy, but such collective action is crucial like social determinants of health, population stabilization, gender mainstreaming and empowerment, reducing impact of climate change and disaster, community participation, private sectors, civil societies and global partners and other governance issues.

4.10. Key Words

Health services - all services dealing with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health.

Health system - the organization of people, institutions, and resources that deliver health care.

Primary healthcare - an essential health care based on practical, scientifically sound and socially acceptable methods and technology

Health care - is the diagnosis, treatment, and prevention of disease, illness, injury, and other physical and mental impairments in human beings.

Alma-Ata - a major milestone of the twentieth century in the field of public health and primary health care.

Evolution - any process of formation or growth; development.

Health for all - a programming goal of the World Health Organization, which envisions securing the health and well being of people around the world.

Public health - all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole.

Epidemiological transition - a phase of development witnessed by a sudden and stark increase in population growth rates brought about by medical innovation in disease or sickness therapy and treatment.

Demographical transition - a model that describes population change over time.

Environmental changes - a change or disturbance of the environment caused by human influences or natural ecological processes.

Social determinants of health - are the economic and social conditions – and their distribution among the population – that influence individual and group differences in health status.

Health sector - the medical and healthcare goods and services category of stocks.

Role of government - government's obligation to provide services, or to see that they are provided properly.

Pilot Projects - project which is designed as a test or trial to demonstrate the effectiveness of a full program.

Health promotion - the process of enabling people to increase control over, and to improve, their health.

Human resource development - a framework for the expansion of human capital within an organization through the development of both the organization and the individual to achieve performance improvement.

Capacity building - transforming community approaches to social and environmental problems by assisting them in being competent around skills through education and training.

Intersectional coordination - the promotion and co-ordination of the activities of different sectors

Gender mainstreaming - perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies.

4.11.Further Readings:

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