SYLLABUS

HEALTH, MEDICINE AND SOCIETY (MEDICAL SOCIOLOGY)

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Unit – I

Introduction: Concepts and perspectives on health, medicine, illness, sickness, disease and society

Unit – II

Theoretical perspectives on health and medicine within sociology

Unit – III

Health, health care and social institutions: state, market, community and family in health and medicine, Philosophical and historical debates on provision of health care and medicine: Health and Development: Current Challenges

Unit – IV

Sociology and Health –Areas of Concerns, Social behavior sciences, Factors involved in Social class differences health, Family in Health & Diseases, Hospital Sociology, Social Cultural factors in Health and diseases, Etiology & Health care, Environmental Sanitation, Mother and Child health and Social aspects, Hygiene in Society, Sex age and marriage

Unit – V

Health, health care and social institutions: state, market, community and family in health and medicine, Philosophical and historical debates on provision of health care and medicine: The sociology of health in India: Disparities in health indices: Historical Development of health services system in India; the sociology of medical knowledge and medical systems in India Health and Development: Current Challenges: The sociology of health in India: Disparities in health indices: Historical Development of health services system in India; the sociology of medical knowledge and medical systems in India.

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UNIT – I

INTRODUCTION

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STRUCTURE

1.1 LEARNING OBJECTIVES

After studying the chapter, students will be able to :

- State the concept of life span development;
- Explain principles of growth and development;
- Discuss the various satges of life span development;
- Describe the role of various factors in human growth and development.

1.2 INTRODUCTION

Sociology can relate to health and illness in two different ways. On the one hand, a sociological perspective can be applied to the experience and social distribution of health and health disorders and to the institutions through which care and cure are provided. In this sense, medical sociology can have an applied orientation to understanding and improving health, and can be seen as one of many disciplines that might appropriately be studied by providers of health care. On the other hand, the sociological study of health, illness and institutions of health care can stand alongside analysis of other significant social experiences

and institutions, as a means of understanding the society under study. Thus, medical sociology is also a theoretically orientated field, committed to explaining large-scale social transformations and their implications, as well as interactions in everyday settings, as these are expressed in health and illness.

These two aspects of medical sociology have, in a well-worn phrase, been characterized as sociology in medicine and sociology of medicine. This double-edged character is, in our view, one of the reasons why medical sociology is such an exciting, challenging and rewarding field to work in. This unit helps guide students through some of the complexities of the field, encouraging further study and equipping the reader with knowledge to understand health and illness.

Medical Sociology is an important substantive area within the general field of Sociology. Sociology itself is an academic discipline that is concerned with the function, structure and roles of social institutions and social processes. It is also concerned with the social behaviour of groups. It logically follows to say that Medical Sociology is concerned with the social facets of health and illness, the social functions of health institutions and organization, as well as the relationship of systems of healthcare delivery to other social systems, and the social behaviour of health personnel and all those who are consumers of health.

Medical Sociology is a relatively new specialty in Sociology in particular and behavioural sciences generally. Some scholars define it as a new speciality that is concerned with social as opposed to biological factors in the causation of diseases.

The sociology of medicine on the other hand, deals with such factors as the organization, role relationships, norms, values and beliefs of medical practice as a form of human behaviour. The emphasis is upon the social processes that occur in the medical setting and how these help our understanding of medical sociology in particular and social life generally.

1.3 DEFINITION OF SOCIOLOGY AND HOW IT IS RELATED TO MEDICINE

Sociology is a major discipline in the social sciences founded by Auguste Comte, a French philosopher and Herbert Spencer an Englishman in the mid-1800s. These founding fathers were worried about the political instability of their time and they attempted to analyze society and highlight the various strategies by which social order could be restored to the fabric of society. This was the beginning of the study of sociology as an academic discipline.

Sociology therefore focuses on social order and the analyses of social groups in particular and society in general. Sociology is interested in analyzing how human beings interact with one another and the forces that determine social order or harmony in human interactions. Sociology studies behavioural patterns, be they

rational, non-rational or irrational. In its quest for understanding human behaviour, sociology employs scientific methodology.

Sociology is related to medicine in several ways. First, the incidence of illness is to a large extent determined by social and cultural factors. As a result of this, knowledge of these factors in the aetiology of illness cannot be overemphasized. Besides, success in therapeutic efforts may be limited, except physicians and other health workers can show some appreciation of forces that are not entirely "medical".

Sociology is also related to medicine because it helps us to understand and appreciate the various actors in the treatment settings, such as physicians, pharmacists, laboratory technologists, nurses etc. Sociology indeed equips us with the knowledge of understanding such attitudes that may constrain or facilitate the treatment process. Sociology provides a careful study of all those who are relevant in providing support during the post-treatment phase. The study of these issues and many more definitely brings into focus the relationship between sociology and medicine.

Definition of Medical Sociology

Medical Sociology is a branch of sociology, which addresses a wide range of key issues and especially the interplay between social factors and health.

The field of medical sociology is a sub-discipline of sociology, which attempts to analyze social action and social factors in illness and illness-related situations with a view to making it possible for all involved in the illness situation to appreciate the meaning and implication of any illness episode.

In the 1950s, medical sociological studies were limited in scope as they concerned the social aspects of mental disorders and their consequences. Today, the field of health sociology, as it is more appropriately called, is concerned with virtually all aspects of health and medical care. Areas of coverage in medical sociology include the aetiology of disease and illness, illness behaviour, health-seeking behaviour and the delivery of health services and access to them. Others are: patterns of disease and mortality, medicine as a profession, ethical, political and organizational issues in relation to health.

1.4 MAJOR APPROACHES AND CONCERNS IN MEDICAL SOCIOLOGY

Medical Sociology overlaps with Social Epidemiology, Health Services Research, Behavioural Medicine, Social Psychiatry and Medical Anthropology. There are two major approaches to the study of medical sociology. The first approach sees medicine as a social institution which one should study and test using sociological hypotheses.

The other approach sees medicine as an applied enterprise seeking to reduce the suffering of humans and to improve the quality of life.

Major Concerns of Medical Sociology

Medical Sociology is concerned with the following perspectives :

i Looking at how diseases in the population are located among social groupings.

ii. Explaining how people respond to diseases with a view to defining them in predictable ways from the perspective of their culture and their social class within a particular culture.

iii. Describing how society prescribes means of treating diseases.

iv. Investigating how social institutions give their support to the medical organizations in their bid to treat the sick.

1.5 WHAT MEDICAL SOCIOLOGY ENTAILS

Medical sociology basically attempts to investigate social factors in illness and illness related situations. Medical sociology is concerned with almost every aspect of health and medical care. The discipline is specifically interested in knowing those social factors in the etiology of disease and illness. It examines the delivery of health services and access to them while probing into the ethical, political issues in relation to health.

Today, works by medical sociologists permeate both physical and psychological medicine and most of these works are devoted to the interplay between social factors and health. Medical sociology is being discountenanced in favour of *health sociology* because sociologists working in the area are not of the view that health is much more than the domain of medicine and so it is better to adopt a more relevant title.

1.6 WHAT SOCIAL MEDICINE ENTAILS

Social medicine is concerned with what is real with man by virtue of his being part of society or group life. Social medicine is concerned with two broad aspects :

(a) Descriptive science

(b) Normative science

As a descriptive science, social medicine attempts to investigate those social and medical conditions that exist between specific groups. It also seeks to establish causal connections between these conditions. As a normative science, social medicine is involved in setting up standards for various groups that are being studied with a view to achieving the standards that are socially desired.

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1.7 RELATIONSHIP BETWEEN MEDICAL SOCIOLOGY AND SOCIAL MEDICINE

Both medical sociology and social medicine are related in that the thrust of medical sociology tends to overlap with the field of social medicine. Both of them deal with the role of social factors in the aetiology, course and management of illnesses.

Differences between Medical Sociology and Social Medicine

Medical sociology can be distinguished from social medicine on the basis of the following :

i. Medical sociology engages in research work with different disciplinary contexts, while social medicine operates mainly within the context of bio-medical scientists.

ii. The academic background and expertise in these two areas vary because, their objectives are not identical.

iii. The theoretical perspectives in terms of research work in the two fields are not the same. This is because the practitioners in the two fields have different academic background.

iv. Whereas social medicine is practised in the departments of community health and social epidemiologists by formally trained physicians, medical sociology, on the other hand is undertaken by sociologists who embark on research work within the department of sociology in universities.

v. Social medicine helps to describe problems, analyze their nature and suggest or prescribe solutions to them; medical sociology however, is pre-occupied with finding insight into health problems as well as making contributions to theoretical formulations.

1.8 MEDICAL SOCIOLOGY AS A DISCIPLINE

Medical sociology is a branch of sociology based on analyzing the field of medicine as a whole, particularly as it relates to the availability of medical care and to the social impacts of medical professions.

The field of medical sociology is based on the work of many different fields, ranging from public health to statistics. It is also a very diverse group in terms of specific ideology, approach, and focus. One group may study the social nature of a specific group of health care institutions, while another may focus on the social impact of disease. The significant variance in focus has led some to believe that medical sociology should be considered a loosely connected group of disciplines instead of a single unified field.

Generally speaking, an education in medical sociology comes as a part of a general sociology or public health programme. Some such programes offer concentrations or specializations in medicine-related subjects. Medical sociologists may find employment in many different fields, ranging from academia to social work to health policy. Their training and interest gives them the ability to look beyond doctor-patient interactions and to seek social explanations for trends in medical fields. They are also well-equipped to seek explanations and solutions for differences between the levels of health care received by different social groups.

The multifaceted nature of medical sociology tends to lead students through a wide variety of coursework. A student of medical sociology tends to begin his education with classes on general sociology and psychology. After gaining familiarity with general social and psychological problems and methods, students generally move on to more specific coursework based on their particular interests. This may include such topics as the sociology of aging or of mental health. Students of medical sociology may also study the history, philosophy, and social issues associated with medicine.

Politics and economics are often of particular interest in medical sociology, as they tend to have a tremendous effect on social structure. Different socioeconomic groups, for example, often receive significantly different levels of health care. The effects of capitalism are often called into question during an analysis of the social and political effects on medicine. Some claim that capitalism leads to significant inequalities in wealth that result in significant inequalities in healthcare. Others claim that capitalism is the driving force that leads to rapid advancement in health care and that, even though a division may exist, everyone is better off because of the advancements made through capitalism.

Several key concepts in sociology relate to its role in public health. Foremost is the emphasis on society rather than the individual. The individual is viewed as an actor within larger social processes. This distinguishes the field from psychology. The emphasis is on units of analysis at the collective level, such as the family, the group, the neighborhood, the city, the organization, the state, and the world. Of key importance is how the social fabric, or social structure, is maintained, and how social processes, such as conflict and resolution, relate to the maintenance and change of social structures. A sociologist studies processes that create, maintain, and sustain a social system, such as a health care system in a particular country. The scientific component of this study would be the concern with the processes regulating and shaping the health care system. Sociology assumes that social structure and social processes are very complex. Therefore its methodology is appropriately complex and often, particularly in American sociology, dominated by multivariate statistical methods of analysis. The advent of the computer in the

second half of the twentieth century presented the field with the opportunity to work with very large bodies of data and complex variables.

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Earlier social theorists, such as those noted above, did write on subjects of concern to medicine, health, and illness, but medical sociology, as a subdiscipline of sociology, developed in the post-World War II period. Early debates in medical sociology were concerned with the role of sociology as it relates to medicine: Should the field be critical and analytical, concerning itself with the sociology of medicine (i.e., examining how medicine works); or should it be largely applied, focusing on sociology as a handmaiden for medicine? Like many such formative debates, there could be no conclusive answer. However, the field has developed into two groups: those (largely within academic settings) which focus on the sociology of medicine; and those (primarily in schools of public health and governmental institutions) which focus on the application of sociology to medicine. Later debates related to whether the focus should be on health sociology or medical sociology. This debate has moved the field to a broader, more ecological, view of medicine and health.

1.9 THE DEVELOPMENT OF MEDICAL SOCIOLOGY

Thirty-five years ago, medical sociology was a scarcely known subfield of the then controversial but expanding discipline of sociology. Those who called themselves medical sociologists were few and far between. Moreover, they were usually working on applied projects related to public health and social aspects of medicine, often located in medical schools. In doing this, sociologists were continuing a long, diverse tradition of research into the relationship between social factors and health in Europe and North. However, as academic departments of sociology grew in the 1960s, and developed a strongly theoretical orientation, the study of health and illness was sometimes regarded with disdain as being 'an applied activity...lacking in theoretical substance'. Yet today, medical sociology is the largest specialist professional study group within both British and North American sociology, and thrives in many other parts of the world, notably Australia and New Zealand and the Nordic countries. Sometimes, it will be found under alternative designations, such as the 'sociology of health and illness': the term 'medical' being regarded by some as evoking too strong an association with one particular health care profession and with pathology, rather than health.

As a result, medical sociology can no longer be regarded as an isolated and applied specialism within its parent discipline. In recent years, there has been increasing rapprochement between long-standing analytical concerns of medical sociology and new issues in sociological theory, most notably in the growing theoretical interest in sociological aspects of embodiment (for example, Nettleton and Watson, 1998; Williams and Bendelow, 1998), emotions (for example, James

and Gabe, 1996) and risk (for example, Gabe, 1995; Green, 1997). At the same time, medical sociologists have been increasingly, and successfully, working across the boundaries with other sociological or interdisciplinary fields, for example, criminology (Timmermans and Gabe, 2003) and social studies of science and technology (Elston, 1997).

A further area of growing medical sociology research that crosses disciplinary borderlands has been that concerned with studying the organization of health care and health policy. The accessibility and quality of health care are significant issues for citizens of any country and, at least in affluent countries, health care (public and/or private) is a major component of the domestic economy and one of the largest employers of labour. Moreover, almost all affluent and many less affluent countries, have experienced major reforms to their health care systems since the 1970s. Sociological analysis of these changes and their significance has brought new vigour to the academic study of health policy (for example, Green and Thorogood, 1998).

So, medical sociology has now established a secure and prominent place in the social science academe. But this has not been at the expense of its applied institutional roots. In the 1960s and early 1970s, although medical sociologists were mainly to be found in medical schools, their position there was generally a marginal one. Three decades later, the place of social science is far more central in radically revised medical curricula. Sociology textbooks for medical students are now well established and undergo regular revision (for example, Armstrong, 2003; Scambler, 2003). And, with the increasing incorporation of professional education for nurses and professions allied to medicine within universities, new medical sociology courses for a wider range of health care students have been burgeoning, as have those for qualified professionals, for example through the distance learning programmes of institutions such as the Open University in the United Kingdom and India.

Thus, at the start of a new millennium, medical sociology is a subject studied by a wide range of students : some intent on pursuing a career in one of the health professions, some, at the other end of the spectrum, with strong theoretical interests in post-modernist social theory.

1.10 THE SOCIAL PERSPECTIVE OF HEALTH, ILLNESS AND MEDICINE

To say that health and illness have a social basis may at first seem to be an example of sociological arrogance, claiming for 'the social' more than can be credibly accepted. 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 neurophysiological 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 such as Glaxo-Wellcome, Zeneca and Merck. 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.

This application of 'rational medicine' has also reduced reliance on patients' own accounts of their illness (Stacey, 1989). Unlike in the eighteenth and nineteenth

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centuries, doctors rarely rely on descriptions by or the demeanour of the patient for diagnosis. Instead, clinical instruments – ranging from the stethoscope to NMR (nuclear magnetic resonance imaging) – are used to expose deep-seated disease. This distancing from the patient is part of the rationality of medical practice, as well as an important device for cultivating a mystique of professional expertise. It also means that – by means of patients' records, X-rays, scans and chromosomal profiles – cases can be handled by teams of doctors, many of whom may never meet the patient in the flesh.

Beck (1992) points out that the improved capacity to diagnose illnesses has not necessarily been accompanied by 'the presence or even the prospect of any effective measures to treat them'. Distinguishing between acute (short-term) and chronic (longterm) illnesses, he points out ***(ibid., pp. 204–5)*** that :

> "At the start of this century, 40 out of 100 patients died of acute illnesses. In 1980 these constituted only 1% of the causes of mortality. The proportion of those who die of chronic illnesses, on the other hand, rose in the same period from 46 to over 80%. ... A cure in the original sense of medicine becomes more and more the exception. ... Yet this is not the expression solely of a failure. Because of its *successes* medicine also discharges people into illness, which it is able to diagnose with its high technology."

Moreover, the growing technical sophistication of medicine exposes patients to an array of equipment and therapeutic techniques that have to be used frequently to justify their expense, and, as Richman (1987, p. 87) notes, 'the criteria of referral are continuously being adjusted to keep specialists in work'.

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 institutionalised 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, socialisation 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) Alternative or

complementary remedies for ill-health often take a holistic approach to understanding the cause of illness and its remedy. Studies in the US have shown that patients present themselves to 'the medical gaze' more rarely than doctors would expect or like.

In short, people's perception of health and illness is culturally variable, highly context-specific, dynamic and subject to change. Crucially, there is no clear-cut relationship between the existence of a physical or emotional feeling and the judgement that this indicates illness (that it is a 'symptom'), requiring consultation with a doctor and becoming a patient.

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 shapes the perception and experience of disease.

1.11 SOCIOLOGY IN PUBLIC HEALTH

Public health has been and remains a very applied field. It is also characterized by a population-based approach to health, and statistical methods are deemed the appropriate underlying method for the field. It is viewed as a science that seeks to intervene, control, and prevent large-scale processes that negatively affect the public's health. By these criteria, there is a strong logical fit of sociological principles and practices within public health. Nonetheless, sociology has not been the key social science discipline in public health. That position has gone to psychology, where the emphasis on individual behaviour resonates more with a biomedical model.

Despite this, many of the primary concerns of present-day public health, with large-scale variables such as social capital, social inequality, social status, and health care organization and financing, remain topics best suited to the sociological perspective and methodology. The emphasis in public health is thus shifting toward a sociological perspective.

Sociological Concepts in Public Health

Sociology in public health is reflected in the myriad of sociological concepts that pervade the practice of public health. More than any other social science, sociology has the discussion of socioeconomic status at its very core. Social-class variation within society is the key explanatory variable in sociology—for everything from variation in social structure to differential life experiences of health and illness. Indeed, there appears to be overwhelming evidence that Western industrialized societies that have little variation in social class experience have far better health outcomes than societies characterized by wide social-class dispersion. In short, inequalities in health are directly related to social and economic inequalities. Much of later-twentieth-century public health is devoted to the reduction of these inequalities.

Sociological Methods in Public Health

Methodological concerns are critical to sociological research. The great debate in sociology has been on the relative merits and role of quantitative versus qualitative approaches. Both approaches are widely used and play a critical role for public health. Sociology has long recognized that the social world comprises both an objective and a subjective reality. For example, the objective reality of having cancer is accompanied by the subjective reality of the experience of cancer by the patient, and the patient's family and friends. Both realities are relevant to the sociological approach. The subjective, qualitative approach is generally discussed in the theory and methods concerned with illness behaviour, but qualitative approaches are equally applicable to the understanding of social policy, world systems, and areas of sociology where statistical measurement is difficult or less relevant.

Within public health, surveillance is seen as a key approach to describing the distribution and dynamics of disease. In sociological approaches to public health, the role of social and behavioral factors in health and illness is central. Survey methodology has occupied a central place in sociological research since the middle of the twentieth century. The concern has been with the collection, management, analysis, interpretation, and use of large quantities of data obtained by direct interview with respondents. Social surveys are characterized by large random samples, complicated questionnaires, and the use of multivariate statistics for analysis. By their very nature, most sociological variables are complex to measure and to analyze. For example, the assessment of socioeconomic status of an individual requires the accurate measurement of several variables that sit within a larger social context. Socioeconomic status (SES) is regarded as a product of several components, including income, residence, education, and occupation. Determining the relative weight of each of these components is a major analytical

problem. Thus, when considering the role of socioeconomic status on health care outcomes, there is no easy answer to what mechanism actually works to determine the observed relationship between SES and health.

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1.12 SOCIOLOGY AND EVALUATION IN PUBLIC HEALTH

Because many sociological variables are at the so called macro level, there is limited opportunity to intervene rapidly, directly, or simply. For example, the SES of a group is affected by complex components, such as education and occupation, that are part of the total life course of individuals within the group. Thus, to change the SES of a group would require significant redistribution of resources of the larger social structure. A significant period of time and concerted effort is needed to change such macro variables. This is, however, not dissimilar to many other challenges in public health, such as the long-term and time-consuming effort to change lifestyles and reduce behavioral risk factors related to chronic diseases.

The chief role of sociology in public health remains its evaluation of those macro components of society that affect public health at the population level. Such evaluations provide an understanding of why inequalities in health exist, and they help elaborate upon the mechanisms and processes that sustain these inequalities. This relates to the long-standing theoretical concern with social structure among sociologists. Further, sociology reveals the mechanisms for long-term changes that may lead to a reduction in health inequalities. The product of sociological thinking in public health is not immediate nor easily understood by those who seek quick and easy solutions to the suffering of humanity. Nonetheless, the long-term role of sociology in public health is to change and improve the public health.

Some have argued that medical sociology should be thought of as a loosely connected network of disparate subgroups rather than as a single discipline. Many medical sociologists tend to argue against certain axioms in the biomedical model of health and illness. They reject the reductivist approach of biomedicine, which claims that health and disease are natural phenomena that exist in the individual body rather than in the interaction of the individual and the social world; they reject the doctrine of specific etiology, the vision that disease can be induced by introducing a single specific factor into a healthy animal; and they reject biomedicine's claim to scientific neutrality. Like sociology in general, subgroups within medical sociology vary according to dichotomies such as human agency versus social structure, conflict versus consensus, and idealism versus realism. Subgroups also vary according to subject matter, thus the sociology of medicine can be distinguished from the sociology of health and illness, the sociology of

healers, and the sociology of the health care system. Medical sociologists also distinguish between the sociology of health, the study of health, illness, and health care to further sociological theory; and sociology in health, the use of sociological insights to complement biomedicine's objectives and priorities. There are four often interrelated areas of research in medical sociology: the social production of health and illness, the social construction of health and illness, postmodern perspectives on health and illness, and the study of the health care system and its constituent parts.

Research in the social production of health and illness tends to explore variations in biomedical indicators of health such as self-reported health status and morbidity or mortality statistics. Social epidemiology shows that the distribution of disease is related to the structure of social inequalities (i.e., to occupational class, socioeconomic status, gender, marital status, age, ethnicity, area of residence, housing, family structure, and employment status), although it does little to explain these microlevel relationships.

The political economy perspective incorporates a broader political and economic framework, arguing that relations of domination within patriarchal capitalism create conditions of deprivation within which some people must struggle to maintain health.

It claims that there is a contradiction between the pursuit of health and the pursuit of profit. It notes the large differentials in health found among social classes, sometimes pointing to unhealthy work environments of the lower classes as an explanation, and also notes the strong relationship found among Western countries between aggregate health and degree of income inequality. This perspective has been criticized, however, for failing to recognize the substantial health gains that have accompanied capitalist development and for proposing a scenario with little opportunity for intervention or change.

Social relations (such as social support for individuals and social capital or social cohesion for communities) have been investigated as determinants of the health of individuals and communities. There is also strong empirical support for the importance of lifestyle practices and behaviours embedded in social environments and cultural contexts. On a global scale, some authors argue that capitalist imperialism influences the presence and distribution of illness in developing nations, through the transfer of modern medicine, industry, and technology from the West, which is motivated in part by profit-driven pharmaceutical companies, for example. Finally, some authors investigate the role of Western medicine in creating as well as preventing illness. They argue that improvements in health have come mainly from nonmedical factors, and that

medicine reproduces the legitimacy of the dominant social order by serving as a means of social control.

Social construction research views illness behaviours and the experience of health and illness as social states. Interactionist theory argues that people bestow meaning on their interactions with others—that selves are emergent and socially constructed. An early sociological contribution was the distinction between disease (an objective state), illness (the subjective experience of disorder), and sickness (the social state associated with being ill).

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Talcott Parsons's sick role, a social role with certain rights and obligations for those so labeled, shows the power of medicine to define illness and shows that illness is a form of social deviance. Subsequent work has introduced core sociological concepts such as deviance, labeling, career, medicalization, socialization, self, and identity to the field. Interactionist approaches have been criticized for neglecting the hard realities of power and politics and for their cognitivist bias, sharply separating the mind and body.

Post-modernist thought rejects binary oppositions, instead focusing on a shifting reality with multiple truths. Foucauldian social constructionism of claims that diseases are fabrications of powerful discourses wherein individuals explore the boundaries of their self-identity, engaging in the endless task of self-transformation.

Others argue that the body is a liquid commodity, an object of circulating capital, in a new world of hyperreality filled with new forms of technology. The sociology of the body stresses the re-entrance of the physical body within sociological discourse, exploring how socially structured physiology affects social behaviour and vice versa. These perspectives are criticized for their lack of an ethic, extreme relativism and abstraction, and lack of attention to the greater political context.

Some micro-level concerns when studying the health care system are entry into and experience with the health care system and patient-practitioner relationships, which have shifted focus from the provider's interest in compliance to a power-based perspective. Some argue that medicalization (providers defining needs) impinges on patient autonomy and acts as a form of social control directing deviance into controllable channels. Others explore the behaviours of providers, the management of uncertainty in practice, and implicit theories of professional knowledge.

A prevailing theme at the meso-level, the interactional region between the face-to-face encounter and the wider social structure, is medical dominance, the power of medicine to define matters in its own interests, applied to the study of

professions, occupations, hospitals, and medical schools, for example. Some have studied the adoption of a cloak of competence in the socialization of medical students. Community involvement in planning and decision making—the democratization of medical care—received attention in the late 1990s. Finally, some macro-level concerns are the role of multinational pharmaceutical companies in shaping the nature of health care and the reasons for and historical development of health insurance.

1.13 SUMMARY

- sociology focuses on social order and the analyses of social groups in particular and society in general;
- sociology is related to medicine in several ways: the incidence of illness in particular is to a large extent determined by social and cultural factors;
- Medical Sociology is a sub-discipline of sociology, which attempts to analyze social action and social factors in illness and illness-related situations;
- The study, Medical Sociology, has two approaches :
  a. It sees medicine as a social institution which one should study through sociological hypotheses; and
  b. It sees medicine as an applied enterprise that seeks to reduce the health burdens of humans.
- medical sociology and social medicine are intertwined;
- medical sociology, however among others, is different in methodology and theoretical formulations from social medicine;
- the academic background and expertise in medical sociology and social medicine are quite different;
- medical sociology and social medicine are both involved in the study of the role of social factors in aetiology, course and management of illnesses and diseases; and
- health sociology is a more appropriate title than medical sociology because the thrust of the work of sociologists working in this area go beyond what is "medical."

1.14 REVIEW QUESTIONS

1. Define medical sociology.
2. What is the scope of medical sociology as a discipline?
3. What are the major concerns of medical sociology?

4. Discuss the sociological perspective of health, illness and medicine.
5. Explain the important aspects of sociology of public health.
6. What is the relationship between medical sociology and social medicine?

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1.15 FURTHER READINGS

- G Stanley, Jaya Kumar and P Siva Kumar, ***Medical Sociology : Grooming Social Scientists in Medical Field***, Sonali Publications, 2007.
- Hannah Bradby, ***Medical Sociology : An Introduction***, Sage Publications.
- Dr. Kavin White, ***An Introduction to Sociology of Health and Illness***, Sage Publications, 2nd edition, 2009.
- Rose Weitz, ***The Sociology of Health, Illness and Health Care : A Critical Approach***, Wardsworth Publising, 5th edition, 2009.

UNIT – II

THEORETICAL PERSPECTIVES IN MEDICAL SOCIOLOGY

STRUCTURE

2.1 LEARNING OBJECTIVES

After studying this unit, students will be able to :

- Appreciate the role of theories in health studies;
- Distinguish between major theoretical frameworks in health sociology;
- Show the strength of some of the theories in respect of health matters;
- Predict the future of theoretical formulations in the comparative analyses of healthcare delivery systems in different contexts;
- Appreciate the need for theorizing in medical sociology;
- Highlight and explain the different theories of disease in medical sociology;

2.2 INTRODUCTION

Theories are relevant to sociologists in every field of study. This helps them to understand and analyze complex aspects of social life much more objectively. Health sociologists in particular theorize so as to appreciate the complex illness episodes within the framework of a dynamic social system.

This study unit contains material on the role of theories in health studies. The major differences and similarities between medical sociology theories are

highlighted. The problems and prospects of theoretical formulation in the study of illness and health relations also form part of this unit.

2.3 MEDICAL SOCIOLOGY AND THEORIZING

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Medical sociologists like other sociologists in other disciplines theorize on the basis that health issues are complex and cannot be understood or analyzed by subjective standards. The need for theories in sociology arose from the burden of earliest sociologists like Talcot Parsons (1978) who believed that sick role behaviour for instance cannot be understood without taking into cognizance certain theoretical perspectives within the context of the relationship between units (*i.e.,* individual) and social system (*i.e.,* the family unit).

Types of Theories in Medical Sociology

Theories in health sociology generally may be divided into four major types. These are: Structural functionalism/Social System and the Marxist Theory. Others are Middle-range Theories and Sandwiched Theories.

System/Structural Functional Theory

The structural/functionalist or systems theoretical perspectives may be compared with an analogy between a biological organism and society. This perspective has led some health sociologists to argue that sickness, health and health institutions can be analyzed within the framework of a dynamic social system.

For example, the illness of a particular member of a given family unit may be traced to poverty. Whatever may be the cause of the illness, the sick member's illness behaviour has implication not only for himself but also for other members of the family, his peer group and larger society.

Marxian Paradigm (Theory)

The Marxian theoretical perspective or paradigm sees contradictions within the power relations and different aspects of the social structure, which can result into illness. This perspective also emphasizes the role of power ideologies and economic system in healthcare in this regard. Proponent of this theory believe that the power structure or ideology or the economic system of any society cannot be divorced from the nature of its healthcare delivery.

Middle-range Theories

This paradigm is represented by the view of Goffman (1971), which believes that social situations have wider implications for human behaviour whether in sickness or in illness. For instance, scarcity of fuel in the city at any given point in time may account for morbidity and mortality that is unprecedented in the population.

Other Theories Sandwiched between one or two above

There are other theories that do not appear to belong either here or there. They sometimes combine one or more theories to take a seemingly blended theoretical perspective.

Apart from these sociological theories outlined above, there are other theories within the confines of medical sociology, which are very useful in the study of health issues. Prominent among these has been the Health Belief Model propounded first by Rosenstock (1966). This theory places emphasis on the role of norms and values and culture generally as major determinants of health behaviour. The future of theories in medical sociology depends on the extent to which sociology generally can continue to use scientifically objective criteria to measure symptomatic and non-symptomatic phenomena.

2.4 THEORETICAL PERSPECTIVES OF HEALTH AND MEDICINE WITHIN SOCIOLOGY

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

- *Parsonsian functionalism* looks at the role the sick person plays in society. The focus is on how being ill is given a specific form in human societies so that the social system's stability and cohesion can be maintained.
- *Symbolic interactionism* is 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.
- *Marxist theory* is concerned with the relationship between health and illness and capitalist social organisation. 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.
- *Feminist theory* 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.
- *Foucauldian theory* 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.

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PARSONSIAN FUNCTIONALISM AND 'THE SICK ROLE'

Although Parsons (1951) was interested in several aspects of the management of illness, he is best remembered for his emphasis on the social importance of the sick role. Parsons stressed the motivation involved in being sick and getting better. That is, people have to decide that they are sick and in need of treatment. Since being sick means choosing to withdraw from the normal patterns of social behaviour, 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.

As for the role of doctors, in return for the trust placed in them, doctors are obliged to act in the best interests of their patients, applying their skill and expertise according to professional codes of conduct. Conformity to these codes gives doctors unusual rights – the right of authority over their patients' health, the right to examine their patients' bodies, and the right to obtain personal details from their patients.

There have been a number of criticisms of Parsons' model. First, it assumes that recovery is always possible, but during the twentieth century, there was a growth in chronic rather than acute conditions. Second, a number of researchers have pointed out that arrival at the doctor's surgery is often the last stage in the construction of sickness. For example, according to Scambler (1991), the majority of patients consult widely with lay (non-medical) contacts before deciding to visit the doctor. Thus, it is perfectly possible to be a sick person without becoming a patient. For this reason epidemiological statistics on the distribution of illnesses, which derive from doctor–patient consultations, should be treated with caution. The sociological question here is why it is that some sick people and their illness

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remain under-reported or are dealt with primarily within the lay arena, while others are not.

Third, Parsons assumes that patients will be sufficiently knowledgeable about and sensitive to their condition to know that they should consult a doctor, but will be naive and compliant once inside the surgery. In return, doctors are expected to treat all patients equally, but research shows that the class, age, gender and ethnicity of patients can have a considerable bearing on the kind of treatment provided. For instance, higher social classes are given more consultation time and a more comprehensive explanation of their illness than are lower classes. There is also a tendency to treat female patients' problems as 'typical' feminine neuroses and complaints, while similar problems among male patients are viewed as the product of work-related stress (MacIntyre and Oldham, 1977). Doctors in UK casualty wards have a private language for classifying newly arrived patients, including the acronym 'T. F. Bundy' ('Totally fucked, but unfortunately not dead yet'). These are just a few examples of the variation in practice among doctors.

Despite these criticisms, Parsons' notion of the sick role enabled exploration of the construction and career or 'occupation' of being ill (Herzlich, 1973; Pollock, 1988). Many patients cope with illness by defining it as a 'job', to be successfully managed by hard work, cooperation with others (doctors and kin) and sharing information about the state of the illness. According to Pollock (1998), for people suffering from chronic forms of mental illness such as schizophrenia, this 'illness as a job' option is not available, as they are seen by others as having no control over their illness: the notion of positive coping is not seen as credible in their case. This example tells us much about the interactive nature of illness and the social accounting processes surrounding it, which has prompted sociologists from the symbolic interactionist school to look more closely at the interaction between doctor and patient.

Symbolic Interactionism and the Social Construction of Illness

According to the symbolic interactionism thesis, identity is created through interaction with others. Learning to become a social being means learning to achieve control over this process by managing the impressions others have of us.

This creative capacity is evident when we play the role of patient in our encounters with health-care practitioners. Practitioners also attempt to create impressions of themselves for us. Given this interpretive element of the social encounter, doctor–patient interactions do not follow the script laid out by Parsons (1951). Instead, we should expect a considerable variation in the interactive play.

Byrne and Long (1976) present a continuum of interactions, with exclusively patient-centred communication at the one extreme and exclusively doctor-centred communication at the other. Most studies show that the power element in doctor

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patient relations is significant, with doctor-centred interactions being the most common. Stewart and Roter (1989) have constructed a similar classification, contrasting the situation where the patient dominates (as a consumer of medicine, especially in private, market-based health care) with that where the doctor dominates, exercising a strong paternalism over subordinate clients. Morgan (1997, p. 53) suggests that the relationship between practitioner and patient moves between these two states during the various stages of an illness: 'At an acute stage of illness it may be necessary or desirable for the doctor to be dominant, whereas at later stages it may be beneficial for patients to be more actively involved, as they are responsible for the everyday management of their condition.'

The power element in doctor–patient relations is particularly significant when a patient is obliged to enter hospital. Following the classic analysis of institutionalisation by Erving Goffman (1968), interactionist research into hospital life often focuses on the claim that the hospital regime is designed to restrict the opportunity of patients to fashion their own identities. Hospital life mirrors life in other total institutions such as prisons, mental hospitals, convents and so on. Patients' power to control their identity is reduced as much as possible, a process that starts as soon as they are admitted.

Most patients are compliant, but some do resist and attempt to maintain their personal autonomy and identity, for example, by refusing to comply rigidly with the ward rules, whereupon they become 'difficult patients'. This shows the potential for conflict between medical practitioners and patients. Conflict also arises from the power of others to impose their definition of 'being ill' on the patient. That is, there is a labelling component in illness, whether through medical diagnosis or through the way in which a sick person's friends, relatives and others treat him or her. For example, a cancer patient may be labelled a cancer patient above all else, no matter how the sufferer tries to persuade others that he or she is still a friend, a lover or a mother who just happens to have cancer. Interactionist analysis draws attention to the often overwhelming influence of the stigmatic label. Indeed, the illness to which the label is attached may even be interpreted as a sign of personal weakness or culpability (Sontag, 1979). Rosenhan *et al.* (1973) have shown how difficult it is to resist the imposition of a label for those defined as mentally ill. Likewise, Horwitz (1977) has shown that the greater the social gap in terms of class and status between the labeller and the labelled, the more difficult it is for the latter to resist the illness stigma. Lemert (1974) asserts that the imposition of a stigmatic label – especially that of being 'mentally ill' – is a serious assault on a person's sense of self. Such people are effectively being told that their (mental) capacity for selfknowledge is damaged and their feelings about themselves are probably delusory. The end result is that the patient, whether mentally ill or not, finds it impossible not to believe in the reality of the illness. It

is at this stage – of 'self-realisation' – that the labellers, especially the medical staff, start to feel hopeful about eventual recovery!

Labelling can work in other ways, too. For example, in the case of elderly people who are physically very fit, preconceived notions about the state of being elderly discount the way they really are.

In summary, the interactionist approach focuses on power relations in the construction and management of health and illness. It draws attention to the unequal distribution of the resources available to health practitioners and patients, whether in home visits, in the surgery, at the outpatient clinic or on hospital wards. However, interactionism offers neither a theory of power nor a theory of patterns of inequality. Rather, it explains power and inequality as functions of the relative strength of the personalities of the parties to the medical encounter. We have to turn to other approaches to provide a theoretical explanation of such inequality.

Marxist Theory

As we have seen elsewhere, 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. 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 specialised and hierarchical.
- Medicine now has an extensive wage-labour 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

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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 organised 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, subsidises 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 class disadvantages that are reproduced under capitalism. Patterns of mortality and ill-health (morbidity) are closely related to occupation, especially in the case of the industrial working class. For example, industrial carcinogens (asbestos, heavy metals, chemicals and so on) are responsible for over 10 per cent of all male cancers. While accidents at work may be regarded as the result of human error, research has shown that they also reflect pressure on workers to complete tasks at speed in risk-laden environments (Tombs, 1990; Wright, 1994). Legislation to control hazards in the workplace has been introduced over the years, and this has reduced the rate of death, injury and illness among workers. However, such legislation can only be fully effective if it is policed properly, and in the UK there has been considerable underpolicing of sweatshops and similar workplaces. Moreover, Health and Safety Executive reports show that it has been difficult to reduce injury levels below a certain threshold, suggesting that these statistical levels represent the structural – and not the accidental – character of occupational injury and mortality.

Navarro argues that medicine is in a state of crisis, in that its growth is matched by an increasing inability to meet society's needs. Despite more and more money being spent on health care, more and more people are experiencing the system as ineffective. The state's response has been to deflect attacks on the medical–industrial–state complex by declaring that health problems are the problem of the individual, and that any difficulty coping with this is not the fault of the system but of the individual. The individual must be taught to become a discerning consumer of medicine, to take out extensive (and expensive) private medical insurance, allowing the state to reduce the burdensome cost of universal medical provision. This latter strategy will cause problems for the medical industrial complex, since a reduced state budget will hit the secure drugs market

enjoyed by the pharmaceutical industry. According to the Marxist view, this is to be expected in medicine as elsewhere, since in late capitalism there is never complete coincidence between the interests of powerful corporations and those of the state. The danger for the state is that larger multinational corporations will seek secure markets and cheaper labour overseas, so reducing the overall contribution they make to the state's GNP.

Critics of the Marxist view of medicine focus more on its inadequacy than its practice of locating medicine firmly within capitalism. That is, it should pay more attention to the dynamics of the medical process, the experience of illness and the state of being a patient. In addition, as Turner (1987) argues, the Marxist ***political economy*** of health needs to address how the diversity of capitalist societies relates to medicine, health and illness. As he notes, 'there are major differences between the USA, the UK and Sweden, despite the fact that all three societies are quite distinctively capitalist' (ibid., p. 194). The welfare state, of which medical care is a key part, operates on a different basis in each of these countries. Moreover, Marxists are accused of underplaying the genuinely progressive features of the health sector under contemporary capitalism, arguing that the measures taken are ameliorative rather than solving people's health problems.

Navarro (1986) does acknowledge that medical practitioners play a useful role in delivering health care, but argues that their primary purpose is to regulate the working classes and the popular masses. Finally, the Marxist account is criticised for downplaying the gendering of health and medicine, that is, the professional process that has sub-ordinated women of all social class backgrounds to patriarchal medical control. This leads us to the feminist approach to health and illness.

Feminist Accounts

In general, feminist analyses of inequality have focused on the construction and maintenance of female subordination. It is not surprising that medicine, health and illness have been central to this analysis, as they concern the body, the site where most gendered interaction takes place. Nor is it surprising that feminists have paid great attention to birth and maternity, an area where patriarchy is acute and the links between sexuality and reproduction are biologically and socially intertwined. As Turner (1987) notes, the regulation of women's bodies by controlling their sexual expression and reproductive capacity is now conducted through medicine, whereas in the past religion played this role. For women, a healthy body is tied to healthy sexuality and reproduction within the confines of lawful marriage.

The feminist critique concentrates on the male-dominated medical profession and the way in which, over the past century, it has medicalised events

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that are natural to women, including menstruation, pregnancy and childbirth. Medical intervention in these areas – which in the past were handled by women themselves in conjunction with family and female friends – originally arose from the desire by the newly emerging medical profession to create a medical market. Not only was there little real benefit in having a physician in attendance at child birth, but there is also evidence to show that physicians had little idea about the birth process and that medical intervention often endangered both mother and child.

By the mid 1950s, pregnancy had become a fully medicalised condition (Oakley, 1984). Midwifery had gradually been excluded, in the US by state legislation. This removal from women of control over their bodies, both personally and professionally, means that the majority of obstetricians and gynaecologists are men – about 80 per cent in the US and about 85 per cent in the UK. Medical training, textbooks and journals perpetuate the patriarchal attitude towards women. For example, Jordanova (1989) has shown, through an examination of medical journals and magazines, and especially the advertisements, how the classification of illness by gender is commonplace. 'Depression, anxiety, sleeplessness and migraine are likely to be associated with women, while disorders that can inhibit full movement and strenuous sporting activities are associated, metaphorically, with masculinity' (ibid., p. 144).

The sexual division of labour in medicine reflects the subordination of women. Despite health matters being seen as closely tied to women's caring, nurturing role in a patriarchal society, this does not mean that women have a high position in the medical hierarchy. Thus, while many women work in medicine, the bulk of them are in paramedical or nursing jobs with poorer pay and occupational status. Feminists believe that the gradual increase in the proportion of female physicians, while welcome, will not bring about any major change, since at medical schools they are indoctrinated with the same patriarchal attitudes as their male colleagues.

Feminists argue that only by breaking with the malestream of orthodox medicine can women regain control over their bodies. Hence, there has emerged a feminist health movement (led by writers such as Ehrenreich, 1979) that is challenging the medical establishment and promoting a philosophy of self-care and healing by and for women. The relation between health, its definition, care and control and how this relates to the regulation of bodies and sexuality in wider society was also recognised by Foucault, whose theory we consider next.

Foucauldian Analysis

Foucault (1977a) insisted that in order to understand the role of medicine in society, we have to see it as part of a wider social requirement for the regulation

and surveillance of bodies. He used the term bodies both in the physical sense of individuals' bodies and in the more abstract sense of bodies of populations. According to Foucault, the demand for regulation grew as society became more complex – especially as it became urbanised and brought people together in one large mass. Urban areas have both public and private 'spaces' that dictate appropriate behaviour for the bodies that occupy them.

Medicine, and especially the medicine of the asylum, the clinic and everyday public hygiene, has to be understood within this broader context of public control. Foucault argued that medicine plays not merely a clinical but also a moral role, especially with regard to 'proper' forms of sexual expression, as he described in his *History of Sexuality* (1977b). This recounts the way in which medicine has played an increasingly important role in establishing a regimen of acceptable sexuality. Here the concept of 'discipline' is important. The emergence of 'rational' modern disciplines – such as economics, urban planning, penology and notably medicine – was central to the disciplining of people as public and private bodies. In their different ways, each of these disciplines legitimated forms of social control and regulation over people. They constituted powerful forms of social discourse.

Foucault's concept of discourse was central to his analysis. Discourses are ways of knowing about or of representing, and so giving some control over, reality and social behaviour. Medical discourse is one of the most powerful discourses, because it defines, organises and controls human bodies from the cradle to the grave.

This discourse first appeared during the nineteenth century: 'A medico-administrative knowledge begins to develop concerning society, its health and sickness, its conditions of life, housing and habits, which serve as the basic core for the "social economy" and the sociology of the 19th century' (Foucault, 1980, p. 176). For Foucault, medical discourse and the medical profession that sustained it had displaced the religious, clergy-based discourses that dominated in previous centuries. Scientific, secular medicine provided a powerful means of social discipline and control. As Turner (1987, pp. 37–8) suggests :

> "Put simply, the doctor has replaced the priest as the custodian of social values: the panoply of ecclesiastical institutions of regulation (the ritual order of sacraments, the places of vocational training, the hospice for pilgrims, places of worship and sanctuary) have been transferred through the evolution of scientific medicine to a panoptic collection of localised agencies of surveillance and control. Furthermore, the rise of preventive medicine, social medicine and community medicine has extended these agencies and regulation deeper and deeper into social life."

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Religious mortification and denial of the body have been replaced by health regimes, diets and exercise as the modern forms of self-regulation and public regulation of our bodies. The clerical gaze has been replaced by the clinical gaze.

Foucault's work on medicine requires us to relate analyses of medicine and the body to historical changes in the ways in which the regulation of bodies has been secured in society, at both the micro (individual) and the macro (population) level. Medicine cannot be seen merely as an activity associated with clinical healing; the medicalisation of the body has to be understood as a process of social control. Croft and Beresford (1998) have provided an example of this when looking at discourses on dying.

Combining Perspectives: Turner's Contribution

The sociological perspectives discussed above are based on distinct theoretical assumptions about how best to understand health, illness and medicine in society. Parsons (1951) suggests that illness and disease create structural and behavioural problems that society needs to resolve through normative, rule-governed role performances. In contrast, interactionists stress how the definitions of illness and the appropriate behaviours surrounding it are elastic and precarious because they are constructed through interaction. Marxists emphasise the political economy of health, in that there is considerable inequality in the ways in which health and illness are defined and managed, and this reflects the wider social structures of capitalism. Feminists insist that gender should be incorporated into the analysis of role relations and the definition of health and illness, and point to the institutionalised patriarchy that characterises the health care system. Foucauldian analysis ties the issue of medical control to the question of how the individual and the wider collective body are subject to bio-social surveillance and regulation.

It is possible to argue that these discrete traditions cannot be merged into a single theoretical model. However, Turner (1987) considers them to be reconcilable, as they focus on different aspects of the same phenomena. Each has something to contribute to the sociological analysis of health, illness and medicine. He begins by distinguishing between three levels of analysis – the individual, the social and the societal. At the level of the individual, we are interested in the experience of illness and disease. Here, interactionism plays a valuable role in drawing attention to the perceptions that people (and patients) have of their illness. Secondly, at the level of the social, we concentrate on institutional dynamics (for example, of hospitals and asylums) and the way in which professionals (doctors) define and regulate sickness and disease (whether physical or mental). Here, the Parsonsian and more institutionally oriented interactionist analyses (such as that by Goffman) are appropriate. Finally, at the societal level, we turn to the wider

macro or systemic structures that pattern health care systems. Here, feminist analysis, Marxist political economy and Foucault's exploration of power and discourse are important. Turner (1992, p. 237) describes the accommodation of these different perspectives within a single theory as a 'strategy of inclusion': 'Rather than being forced to choose between [these] particular competing paradigms, one could see them as addressing very different issues at rather different levels'.

Turner has built on these different traditions to produce an integrated theoretical approach. His strategy relies on tying the sociological analysis of medicine to the sociology of the body. He agrees with Foucault that we can distinguish between the body as an individual entity – as a person – and as a collective entity – as a population. The desires, demands and pathologies of the body at both these levels are regulated, especially those relating to sexuality. Turner is particularly interested in understanding the social and societal management of the HIV virus, where sexual and biological pathologies are explicitly interlinked. The personal and public hygiene that those in dominant positions demand for the regulation and checking of the virus has both a biological and a moral form: hence the homophobic term 'gay plague'.

2.5 SPECIALIZATIONS IN MEDICAL SOCIOLOGY

Medical sociology is a field of study that has assumed new dimensions and specialties in modern times. A few decades ago, medical sociology began to face greater challenges because of the increasingly complex dimensions of health issues. This factor compelled the founding fathers of the discipline to suggest all possible areas that are relevant for its study. These areas are today known as specializations in medical sociology.

The Need for Specializations in Medical Sociology

The increasingly widening scope of medical sociology has necessitatedthe need for specializations in the subject area. In the 1950s, studies inmedical sociology were limited to the social aspect of mental disordersand their consequences. Today the discipline now studies virtually all aspects of healthcare. This is because what constitutes disease is now known to be beyond the "germ theory" explanation alone.

Sociology in Medicine and Sociology of Medicine

Medical sociology in the 50s was divided by Robert Straus into two separate but interrelated areas : Sociology in Medicine and Sociology of Medicine.

Sociology in Medicine as earlier discussed in this module is a subset of medical sociology that helps the health personnel in studying the social factors

that are relevant to a particular health problem. However,sociology of medicine, studies the social processes that occur in the medical setting. The two, though analytically different, are however intertwined and interrelated in reality.

Modern specializations in Medical Sociology

Specializations in medical sociology today include the following major areas:

i. The concept of health, including theories of illness and disease.

ii. Research methods in health and elementary aspects of epidemiology.

iii. Health and illness behaviour.

iv. The professions and medicine.

v. Therapeutic relations and the factors affecting compliance with doctor's order.

vi. Types of medical practice.

vii. The organization of health services.

viii. Comparative analysis of healthcare delivery system in different contexts.

ix. State, politics and healthcare delivery otherwise referred to as the political economy of health.

2.6 THEORIES AND CONCEPT OF DISEASE

The need for theorizing in health sociology cannot be over stressed. Theories in medical sociology provide analytical tools and broader light for possibilities in research, cause, prescription, diagnosis and management of illness and diseases. Two classical sociological theories – structural functionalism and Marxist perspectives have both tried to explain illness, disease, healthcare institutions and the healthcare delivery system generally. While the former tends to argue that sickness, health and health sector can be analyzed within a framework of a dynamic social system, the latter (Marxist paradigm) argues that power, ideologies and economic institutions all play vital roles in healthcare delivery in all human societies.

However, there are other specific theories that try to explain disease within the context of medical sociology. These theories are: Psychological, Medical model, Sociocultural, etc.

This section contains material on the need for theorizing in medical sociology and the major theories of disease. The unit also contains material on the definitions of health and disease.

Definitions of Health and Disease

According to the World Health Organization (WHO), health is "a complete state of physical, social, mental well-being and not necessarily the absence of

infirmity or disease" (cited in Lewis 1953). Disease on the other hand has been defined as a form of deviation from normal functioning which has undesirable consequences because it produces personal discomfort or adversely affects the future health status of individuals (mechanic, as it's yet).

Health, according to biomedical science is not only the absence of disease or physical disability in individuals. Physicians are also quick to argue that disease connotes pathology and its state of disequilibrium.

The concepts of health, disease and illness, generally speaking, are amplified by the belief of a people.

Medical Model of Disease

This model argues that disease is a function of biological discontinuity, and such a discontinuity can be linked to the malfunctioning of a part of the human organism. Disequilibrium in a human organism can occur if a part of an organism fails to perform its function effectively and efficiently. There are several biomedical techniques for ascertaining which parts of a human organism may not be functioning effectively.

The medical model finds explanation for the etiology of many diseases like malaria, pneumonia and guineaworm infection. Others include sickle cell anaemia, tuberculosis, cancer, organic mental disorder, etc.

Psychological Theory of Disease

This theory is about an appraisal of the contribution of psychiatrists and psychologists in the understanding of the aetiology of mental disorder. Sigmund Freud (1914) was the psychoanalyst who propounded a theory to explain the role of psychology in the aetiology of mental diseases by analysing the unconscious drives in human-beings. Although the theory has generated a lot of controversies for many reasons, it has stimulated several other psychological explanations especially as it relates to mental illness.

Culture-Bound Theory of Disease

This theory highlights the interplay between culture and disease. Today it is known that many culture-bound syndromes and conditions can be managed more effectively through an informed knowledge of their cultural contexts and the patients' background.

It is reported that Lambo (1955) of Nigeria and Yap (1951) of Hong Kong did some tremendous works among their peoples on the cultural dimension of health and ill-health. According to the scholars health and disease are, to a great extent, determined by culture in Africa. The incidence of disease is therefore usually attributed to witch-craft, sorcery and mystical forces.

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Socio-environmental Theory of Disease

The social factors such as income, education, occupation and environmental cushions within which man lives and functions can, to a large extent, account for the aetiology of health and disease. Behavioural patterns can also determine health and illness.

2.7 SUMMARY

- theories are useful tools for understanding health problems;
- different theories are relevant to our understanding of illness and health behaviour;
- there is an overlap in the application of theoretical formulations to health matters; and
- the future of theories concerning illness and disease depends on the extent to which sociology can remain an unbiased science in a dynamic world.
- the need for theorizing in the understanding of health and disease;
- definitions of health and disease;
- the major theories of disease; and
- appreciating the integration of all the theories to grasp a clear understanding of health and disease.

2.8 REVIEW QUESTIONS

1. Discuss the important aspects of theories of medical sociology.
2. Explain the most important theoretical traditions of sociology of health and illness.
3. What is the need of specialization in medical sociology?
4. What is the culture-bound theory of disease?
5. Discuss the medical model of disease.

2.9 FURTHER READINGS

- G Stanley, Jaya Kumar and P Siva Kumar, ***Medical Sociology : Grooming Social Scientists in Medical Field***, Sonali Publications, 2007.
- Dr. Kavin White, ***An Introduction to Sociology of Health and Illness***, Sage Publications, 2nd edition, 2009.
- Erinosho, A.O. (1998). ***Health Sociology***, Ibadan: Bookman Educational and Communication Services.
- Jones, L and James S.P. (1975). ***Sociology in Medicine***, English: Ilorin Press, Land.
- Stacey, M. (1975). ***The Sociology of Health and Illness, Sociology***, Vol. 12.

UNIT – III

HEALTH, HEALTH CARE AND SOCIAL INSTITUTIONS

STRUCTURE

3.1 LEARNING OBJECTIVES

After studying the chapter, students will be able to :

- State the relationship between government and healthcare;
- Explain role of market in healthcare;
- Discuss the importance of primary healthcare;
- Understand the philosophy of healthcare;
- Describe the challenges faced by healthcare.

3.2 INTRODUCTION

Relationship between social institutions and healthcare is an essential field of medical sociology. Social institutions vary to one or other degree both in structure and functions across cultures; they include institutions like the government (State), market, community, family etc. These vary in scope, size and function. The levels of institutions are not the same but each of them to one degree or the other provides some form of support.

Health care systems are designed to meet the health care needs of target populations. There are a wide variety of health care systems around the world. In some countries, health care system planning is distributed among market

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participants, whereas in others planning is made more centrally among governments, trade unions, charities, religious, or other co-ordinated bodies to deliver planned health care services targeted to the populations they serve. However, health care planning has often been evolutionary rather than revolutionary.

Every aspect of government and the economy has the potential to affect health and health equity – finance, education, housing, employment, transport, and health, just to name six. While health may not be the main aim of policies in these sectors, they have strong bearing on health and health equity. A policy agenda that aims to address the social determinants of health and that is pro-equity therefore demands a relationship between health and other sectors at global, national, and local levels. In this unit, we will discuss the relationship of healthcare and social instituions. We will also focus on the philosophical aspects of the healthcare along with the cureent challenges faced by the healthcare sector.

3.3 STATE, GOVERNMENT AND HEALTHCARE

Governments, through ministries of health and other related ministries and agencies, play an important role in health development, through strengthening health systems and generation of human, financial and other resources. This allows health systems to achieve their goals of improving health, reducing health inequalities, securing equity in health care financing and responding to population needs. Improved health outcomes are not attributable to health systems alone, as evidence has shown, but to social, economic, cultural and environmental determinants also, as reflected in the WHO conceptual framework of Health For All.

The role of governments in health development is well documented worldwide and is illustrated by the impressive growth of health systems, initiated and supported by governments and pursued through partnership with the private sector, nongovernmental organizations and charitable institutions. Governments, which levy taxes and benefit from natural resources, have social obligations to provide security and to facilitate socioeconomic development, including education and health development.

The dramatic changes and challenges which took place during the last four decades of the 20th century have greatly affected, and led to a repositioning of, the role of governments in health as well as other social sectors. Moves towards democracy, decentralization and a more active role for civil society in governance, and the growing importance of the private sector in socioeconomic development, have been accompanied by policy changes reflecting more privatization, a more restricted role of government in policy development, strategic planning and management, and greater reliance on market forces.

However, the case of the health sector is distinctive from other sectors, as market forces fail to address properly the health needs of populations, for various reasons, leaving governments with special responsibilities in health development. As a consequence of market failures, governments have an obligation to intervene in order to improve both equity and efficiency, to carry out important public health functions and to produce vital public goods which have a lot of bearing on health development.

Moreover health is perceived in the Region and elsewhere, not merely as a market commodity, but as a basic human need and a social right, as stated in many constitutions and signed treaties. Such commitment entails significant roles and responsibilities for governments, despite changing political and social environments.

Evolution of the Role of Governments in Health Development

Human beings and communities throughout history have always strived to cater for their health needs by using indigenous medicines and the knowledge available from healers, either at home or in small facilities. Religious leaders have also played an important role in the provision of health care, the art of healing often being intertwined with religious belief. In ancient India, the doctor was a Saint. In Europe, hospitals and health facilities were often built by churches and charitable institutions and some of them still bear the names of priests and religious scholars. In early Islamic society religious leaders developed health care facilities and hospitals, including *bimaristans*, sponsored well known physicians and established medical schools to train health professionals. Local organizations, religious and endowment institutions contributed to the development of organized health care services during the colonial period, when coverage by the modern health system was limited to the rulers and to the privileged local elite in major cities. These services continue to be provided in some countries to supplement failing governmental facilities, focusing on the poor and deprived populations, particularly in slums and remote areas.

The need for self-help in case of disease or injury was behind the development of health insurance in Europe and in other parts of the world. Industrial workers developed the first sickness funds which later evolved into social health insurance under Bismarck in Germany, while tax-based health insurance was promoted by Lord Beveridge in the United Kingdom after the Second World War. In France, mutual aid and mutual societies evolved throughout the 19th and early 20th century into a social assistance system which covered only a limited population because of its voluntary nature.

The Beveridge Report influenced the development of a comprehensive social security system in France and in many Organisation for Economic Cooperation

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and Development (OECD) countries after the Second World War. In low-income countries, where the formal sector of the economy is weak and government coverage is usually limited, community health insurance schemes have been, and are still being initiated to provide social health protection. Sickness funds were developed to help workers in dealing with the social consequences of diseases and injuries for themselves and their families and to avoid catastrophic expenditures as a result of ill health. The efforts of individuals and communities to ensure they can access health care services now, as then, are justified by the unpredictable nature of diseases and injuries and their impact on life and well-being.

The evolution of modern health systems after the Second World War was facilitated by dramatic developments in biomedical technology and important discoveries, such as of antibiotics and other devices. The national government in France took control of religious hospitals, which became managed by local authorities as part of the policy of separation between the state and the Church. National governments played a crucial role in the development of health systems, as part of the sovereign functions including governance, health system infrastructure and training of the necessary health workforce in all fields of medicine and public health. In most OECD countries, with the exception of the United States of America, medical schools and major hospitals were developed by governments and health personnel education was, and still is, heavily subsidized by governments, whether central or local. This situation is also reflected in the structure of health expenditure in high income countries, where 70% or more of total health spending comes from public sources of financing. The high share of social and public health care financing is explained by the level of social protection which in many countries, apart from the United States of America, is almost universal.

The adoption of a market economy in many developed and developing economies has not been accompanied by a disengagement of governments from their social responsibilities in health development. Indeed, the role of health development in the formation of social capital and the protection of health as a human right have been accepted worldwide.

The global political developments following the First World War supported the move towards health as a human right. The Versailles treaty gave birth in 1919 to the International Labour Organisation (ILO) based on the principle of "peace through social justice" and promoting social security against various hazards, including sickness and injury.

The United Nations adopted its Universal Declaration of Human Rights in 1948, which states that "every one has the right to a standard of living for the health and well being for himself and his family, including food, clothing, housing

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and medical care and necessary services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control".

The WHO Constitution, adopted in its First World Health Assembly in 1948, established as its objective the "attainment by all peoples of the highest possible level of health" and stated that "Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures".

In 1968, the proclamation of Teheran provided for the protection of the family and children. In 1974, the Universal Declaration on the Eradication of Hunger and Malnutrition, called for the elimination everywhere of hunger and malnutrition. In 1975, the Declaration of the Rights of Disabled Persons affirmed the right of such persons to full rehabilitation. In 1978, the Alma-Ata Declaration affirmed that "health is ... a fundamental human right" and that "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".

These universal principles were supported by the United Nations Commissioner for Human Rights on many occasions. The former commissioner, Mary Robinson (1997–2002) stated that "A world of true security is only possible when the full range of human rights – civil and political, as well as economic, social and cultural – is guaranteed for all people. Governments from both the North and the South must expand their thinking and policies to encompass a broader understanding of security beyond the security of states." All these declarations and treaties have influenced the role of government in the field of health development and have helped shape health systems, particularly at the level of policymaking where political commitments made at national, regional and global levels are accommodated.

The landscape with respect to the role of government in developed economies is similar in many aspects to that of developing countries, particularly in the Eastern Mediterranean Region. In many countries that were formerly ruled by colonial powers, colonization has affected the development of health systems and has impacted on health development in several aspects, including organization of service delivery and training of human resources for health.

In the Eastern Mediterranean Region, health professionals were, and are still being, trained in different languages including English, French and Italian, affecting interpersonal communication between health care providers and served populations. The networks of hospitals and health facilities was tailored primarily to cater for the needs of the military and civil servants from colonial countries. In

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some countries hospitals were established for various communities, including French and Italian, and for indigenous Muslims, with varying standards in biomedical equipment and personnel. In some countries insurance systems were copied from those of the colonial rulers, in social and private health insurance.

On the eve of independence, the situation in most countries of the Asia and Africa was marked by poor health indicators and by an acute scarcity of human resources for health that was worsened by the departure of qualified foreign professionals, leading to a high level of dependency of national health systems on the former colonial powers in the field of health personnel education and human resource development. The lack of human resources for health was and remains aggravated by imbalances in skill mixes, by inequitable distribution inside the countries, and by internal as well as external migration of professionals.

Real health system development in the Region started in the late 1950s and 1960s under the leadership of national governments. This development was made possible through the implementation of the national social and economic development agendas, where health was among the main priorities. In many constitutions health care and education were referred to as human rights and governments were entrusted to ensure their free provision. Most countries adopted a tax-based health system where most of the funding was from the government budget and health services were free at the point of use. Such a situation contributed to increasing coverage by health care, leading to improved health outcomes as reflected in increased life expectancy and overall reduction of morbidity and mortality. Governments contributed to the development of social protection for various categories of workers, building on existing employer-based insurance schemes and expanding their coverage gradually.

The national commitment is also reflected in educational policies aimed at securing self-sufficiency in human resources development. Important investments were made to develop medical schools, schools of pharmacy, and schools of nursing and allied personnel throughout the Region. Needless to say, analysis of time series data has shown a positive correlation between the increase in human resources for health and the improvement of health outcomes. Training institutions were also used to support research activities in the various fields of health, to raise public health standards and to control endemic diseases which were prevalent in most countries of the Region.

Governments, utilizing public resources, continue to make most of the investments in health system infrastructure including health personnel and physical facilities. The growth of the private sector in service delivery and in health personnel education was made possible through the direct and indirect involvement of governments. Incentives were given to private investors by governments in several countries in the form of tax credits and other facilities.

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Legislative support, norms and standards were developed by ministries of health and higher education with a view to improved regulation of the development of the private sector.

Domains of Government Role in Health Development

Ministries of health are responsible for leading health development through the implementation and improvement of main health system functions, including leadership and governance, health care financing, provision of health services, and generation of inputs for health development, including human resources for health and biomedical technology. Efforts are coordinated with other related ministries and departments.

Leadership and Governance

Governments are the guardians of social commitments and values such as solidarity, social justice and equity, which are stated in their constitutions, signed treaties and conventions. In many constitutions worldwide, and in the Eastern Mediterranean Region, the rights to health care and education are clearly indicated and governments are responsible for providing access to these services without financial barriers and for ensuring that the value of health as a basic human right of all is protected.

Ministries of health oversee the overall development of health systems using their governance function, which includes policy analysis and formulation, regulating service delivery between partners, developing norms and standards for quality assurance and ensuring the implementation of agreed upon policies and strategies. The governance function is supported by a routine information system, supplemented by population-based surveys and by health legislation in line with national ethical values. The governance role is becoming of paramount importance in view of the increasing complexity of health systems and changing epidemiological and demographic scenarios. Ministries of health are mandated to assess the performance of health systems in terms of equity, quality improvement, and efficiency and population satisfaction with health services. Several analytical tools have been developed by WHO to help ministries of health in carrying out periodic performance assessment exercises and to develop their strategies based on evidence.

The need for government intervention in health care is explained by the peculiarity of health services which cannot be left to market forces only for generation and distribution. Evidence shows that market forces have failed to work in the health sector for several reasons including *inter alia* the asymmetry of information between patients and health care providers, the existence of public goods with positive externalities, adverse selection and moral hazard. Patients, who are not knowledgeable about their health problems, rely on health care

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professionals to make health and medical decisions on their behalf. Patients are ill-equipped to assess the adequacy of physicians' decisions and actions and focus on the environmental and interpersonal aspects of clinical services, the elements that they are best able to evaluate. Some important health services, called public goods, such as mass immunization, environmental health activities, health education and promotion, surveillance, control for communicable diseases at borders, etc., are not profitable for private providers and are mainly provided by governments.

Over-consumption of health services or "moral hazard", occurs when these services are free at the point of use and is also caused by over-production of services by providers when no costs are incurred to patients, particularly those who are insured. Such behaviour escalates the cost of health care and calls for cost-containment strategies and programmes which are usually initiated by governments.

Adverse selection is practised by private insurers not willing to enrol the old, the chronically ill and some vulnerable groups who are in greater need of social protection. Governments usually intervene to compensate for the market's reluctance to ensure inclusion of the most vulnerable groups. Also, in view of the unpredictable nature of diseases and risk of impoverishment during sickness, governments are major players in developing pre-payment and insurance schemes, whether social, private or a mix of both.

Health Service Delivery

In most OECD countries, while health care financing is socialized, delivery of health care services is secured by both public and private providers and nongovernmental organizations. The role of government is often to steer the overall health development by designing health policies and programmes, securing essential public health functions and regulating the delivery of health services. In most OECD countries, governments provide health care services, including public goods such as promotive and preventive services and hospital care. While the role of private hospitals in service delivery is growing in these countries, public hospitals remain the reference for quality standards, prices of services, training of quality health professionals and health and medical research in various aspects.

Ministries of health are responsible for health protection and undertake that responsibility by implementing the essential public health functions, including surveillance systems and provision of public goods such as programmes for mass immunization, environmental protection, food fortification, food safety, etc. The delivery of essential public health functions is becoming complicated in view of increased globalization and its impact on changing lifestyles, including eating habits and the rapid increases in international travel and communication technology.

In order to fulfil its public health functions and to protect national health security, governments, through ministries of health, are responsible for the provision of necessary medicines and vaccines and supporting laboratory networks. Access to quality and affordable vaccines used in national immunization programmes faces several challenges, including limited financial resources, inappropriate supply systems and lack of effective national regulatory authorities to implement quality and safety standards. Strategic decisions have to be made by governments in terms of national investment in developing self-reliance and self-sufficiency in medical technology, including medicines and vaccines.

Governments are also involved in the provision of clinical services at primary, secondary and tertiary levels of health systems. These services are provided in communities, work settings and public institutions including health centres, investigation networks and hospitals. In most countries health services are provided to the military, security forces and to their dependents in special settings.

The role of government in service delivery contributes to increasing equity in access to health care, particularly in rural and remote areas where qualified private providers, concerned about their income, are in limited supply. The direct provision of health services by governments contributes to market regulation for both pricing and quantity of services.

Government-owned health and hospital facilities are the reference places for training of human resources and are often the most appropriate sites for research activities in the field of health, public health and medicine. The development of bio-medical and health research is totally indebted to the support of government institutions in design, funding, protection of ethical values and in monitoring the impact of research activities on health outcomes.

Governments are becoming increasingly concerned about managing the public–private mix in health service delivery, the result of the many active privatization policies initiated in welfare-oriented health systems and aimed at increasing the supply of private services. The last two decades of the 20th century witnessed waves of health policy and sector reforms aimed at improving the efficiency of health systems and increasing equity in relation to access to health care. For example, reforms have been designed to introduce private practice in publicly owned hospitals in the United Kingdom, Australia and some developing countries as part of public-private partnership. Business-oriented rules for management have been introduced in publicly dominated service delivery systems in OECD countries and elsewhere. The main stakeholders, which include professional associations and unions, have different attitudes towards these reforms, ranging from active support to total disapproval. Governments and researchers are equally interested to assess the impact of privatization policies in the financing and health delivery systems.

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In USA, when for-profit hospitals were compared with not-for-profit hospitals, the performance was found to be similar. Extensive study of immunization programmes in Canada has shown that public institutions offer advantages over private institutions with respect to accountability, standardization of procedures, vaccine handling practices, human resource use, records management, cost, etc.. In California, seven local county governments turned their public hospitals over to private management in the late 1970s in the hope of achieving greater efficiency. After several years of trial, five of the seven "private management contracts" were terminated as no evidence of reduced unit operating costs or improved efficiency could be found.

In Cuba, after the revolution of 1959, the abrupt transformation of the health system from being dominated by the private sector to one of almost wholly public character, and its association with a vast increase in service delivery, and spectacular improvement in Cubans' health status and a number of social determinants including literacy, is well documented. In Chile, the military dictatorship of the 1970s reduced government involvement in service delivery and encouraged privatization of health care with negative impact on access for the poor segments of the population although life expectancy for the population as a whole did not decrease as a consequence.

In 1989, a general review of health service privatization throughout the world was published which concluded that while the main objective of privatization was to widen individual choice, "the luxury of truly having free choice in the health care field remained confined to a small group of privileged consumers in industrialized societies". It predicted that the pendulum will gradually shift to more state control, as the conceptual and methodological lessons of health services privatization are learned, but that the timing of such a shift will depend on larger political forces in a turbulent world.

Health Care Financing

Governments play a major role in health care financing by mobilizing the necessary resources through public budgets and other contributive mechanisms, pooling resources allocated to health development, guiding the process of resource allocation and purchasing health services from various providers. Ministries of health are entrusted to protect equity in access by improving financial risk protection, by reducing financial barriers to access particularly to the poor and to vulnerable populations, and by ensuring that health care financing by all income groups is fair. Health care financing is becoming an important function in health systems as inequities inside and between countries with respect to access increase because of financial barriers and lack of appropriate social protection.

Human Resource Development

As human resources constitute the main inputs and assets in health systems, governments are responsible for designing appropriate policies for human resource development aimed at meeting the real needs of populations, securing appropriate skills mix, improving equity in distribution of human resources, managing them properly, and monitoring and evaluation of the national health workforce. Governments set national standards for health personnel education and develop systems for accreditation of training institutions.

Appropriate policies and strategies for human resources development depend on the degree of intersectoral collaboration between ministries of health and ministries of education and other related departments. Often the lack of coordination among various stakeholders leads to duplication and inefficient production of the health workforce.

Promotion of the Centrality of Health in Socioeconomic Development

Governments play a crucial advocacy role in promoting the central role of health in overall social and economic development. Several studies, including the report of the Commission on Macroeconomics and Health, have shown the interplay between health and economic development and have concluded that intersectoral collaboration should be developed in order to harness the important synergies between health and development.

The focus on the social determinants of health gained momentum following the Declaration of Alma-Ata, which targeted the achievement of health for all through primary health care, and this focus was further affirmed in the UN strategies for comprehensive socioeconomic development following the World Summits for Social Development in 1995 and 2000. Several initiatives were taken by ministries of health and other related ministries of the Region to improve health outcomes through promoting the social and economic determinants of health, such as a sustainable environment, literacy, female education and empowerment, and poverty reduction.

Key Challenges Facing Governments in Health Development

The changes and challenges which evolved globally, regionally and nationally during the last half of the 20th century have had significant impact on health systems, on the pace of their development and on health outcomes. In the political field, democratization with more participation of civil society in governance and focus on local and decentralized government has affected the configuration of health systems worldwide and in the Region. Policy development is becoming more participatory, and organization and management of health services delivery is being further decentralized to provinces and even to communities. This trend was strengthened following the Alma-Ata Declaration.

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The main challenge since the early 1980s is represented by the move towards market economies and the reduction in interest in central planning in social and economic development. In many developing economies, macroeconomic reforms including structural adjustment and stabilization programmes, were implemented under pressure from the International Monetary Fund and the World Bank and were often accompanied by cuts in public spending on social sectors including health and education. Costsharing policies were implemented in order to compensate for diminishing government budgets allocated to health. Macroeconomic reforms led to restrictions in recruitment of new health professionals and replacement of retirees as part of public sector downsizing policies and programmes. The reduction in government health spending contributed to passive privatization, as public institutions increasingly lacked the necessary medicines and motivated human resources, encouraging those users of the public sector who could afford it to shift to private providers.

Active privatization policies were also adopted in most health systems through incentives provided to private investors in the form of subsidized loans and tax credits, particularly in poor and deprived regions. Incentives were also developed in many health systems of the Region allowing government health workers to practise privately inside and outside the public facilities.

In the social field, the main challenges are represented by growing poverty, widening disparities within and between countries and increasing social exclusion. Almost 3 billion people are living on less than US$ 2 per day, despite rising per capita income in many developing countries. The average income ratio at global level of the richest 20% of the population to the poorest 20% is 82 to 1, compared to 30 to 1 in 1960. The increase in social, economic and environmental vulnerability is associated with a deterioration of health status among deprived communities and calls for a more proactive role from governments.

Globalization has also had an impact on health systems, and particularly on access to health care. The conflict over acquisition of affordable antiretroviral treatment for poor AIDS patients in South Africa and other developing countries illustrates some of the threats posed by the implementation of TRIPS agreements. The migration of scarce human resources from countries of the South will further weaken health systems as a result of GATS (General Agreement on Trade in Services), as is being witnessed in some regions including Africa.

3.4 MARKET AND HEALTHCARE

Students might find it strange to hear that marketing plays an important and pervasive role in the health care marketplace. They are probably aware of the marketing efforts of pharmaceutical and medical device companies to sell their branded products and services. But what about hospitals, nursing homes,

hospices, physician practices, managed care organizations, rehabilitation centers, and other health care organizations?

These organizations, for the most part, didn't think about marketing until the early 1970s. But today we see a great deal of marketing taking place in health care organizations. Consider the following facts :

- Virtually every hospital places ads in newspapers and magazines to tout its facilities and services. Some hospitals run community health programmes. Some hospital CEOs appear on talk shows. All of these efforts go toward building their brand.
- Managed care organizations (MCOs) develop health insurance products and use marketing tools to vie with other companies in promoting themselves to employers and their employees.
- New physicians seeking to open their own practices use marketing to help determine good locations, attractive office designs, and practice styles that will attract and retain new patients.
- The Indian Cancer Society, Indian Heart Association, and other associations turn to social marketing to encourage more people to adopt healthier life styles, like quitting smoking, cutting down on saturated fats in their diet, and increasing exercise.

These illustrations demonstrate one side of marketing, namely the use of influential advertising and selling to attract and retain customers. But marketing tasks and tools go beyond developing a stream of persuasive messages.

We recognize that many health sector participants are trying to solve their problems by relying on marketing tools and concepts. People who already work in the health care field may recognize some of these tasks as the realm of epidemiology; however, the discipline of marketing is much broader. The American Marketing Association offers the following definition: *Marketing is an organizational function and a set of processes for creating, communicating, and delivering value to customers and for managing customer relationships in ways that benefit the organization and its stakeholders.*

Marketing takes place when at least one party to a potential transaction thinks about the means of achieving desired responses from other parties. Thus marketing takes place when —

- A physician puts out an advertisement describing his practice in the hope of attracting new patients.
- A hospital builds a state-of-the-art cancer center to attract more patients with this affliction.
- A health maintenance organization (HMO) improves the benefits of its health plan to attract more patients.

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- A pharmaceutical firm hires more salespeople to gain physician acceptance and preference for a new drug.
- The American Medical Association lobbies Congress to gain support for a new bill.
- The Centers for Disease Control and Prevention (CDC) runs a campaign to get more people to get an annual flu shot.
- Health Canada develops a campaign to motivate more Canadians to exercise more and eat healthy foods.

Thus a marketer may aim to secure various responses : a purchase of a product or service; an increased awareness, interest, or preference toward an offering or supplier; a change in behaviour; or a vote or expression of preference of some kind.

THE ELEMENTS OF MARKETING THOUGHT

In this section, we introduce the purpose of marketing, some important marketing concepts and skills, and how marketing is organized in health care organizations.

The Purpose of Marketing

There are two quite different opinions about marketing's purpose. One might be called the *transaction view*, which says that its aim is to get an order or make a sale. Marketing's role is, therefore, to use salesmanship and advertising to sell more "stuff." The focus is on doing everything possible to stimulate a transaction.

The other opinion about marketing can be called the *customer relationship - building and satisfaction view*. Here the focus is more on the customer and less on the particular product or service. The marketer aims to serve the customer in such a way that he or she will be satisfied and come back for more services or products. In fact, the marketer hopes that the satisfaction will be sufficiently high that the customer will recommend the seller to others. For example, we know that a physician who develops an excellent service reputation will attract many new patients as a result of word-of-mouth recommendations. Also, as patients experience new medical needs and problems, they will return to the same physician for treatment and advice.

Some marketers question the use of terms such as *consumer* and *patient*. The traditional view of a consumer or patient is that of someone who is passively consuming something, but today's consumers are also producers. With respect to health care products and services, they are actively sending messages about their experiences, creating new uses, providing new findings from the Internet and other resources to their physicians, and lobbying for more and better benefits.

Predicting this current environment, Peter Drucker viewed marketing as playing the role of serving as the customer's agent or representative.

In fact, more organizations are moving from the transaction view to the relationship view of marketing, in a shift from Old Marketing to New Marketing. In this environment, the New Marketer's job is to create a long-term, trusted, and valued relationship with customers, which means getting the whole organization to think about and serve customers and their interests. For instance, hospitals that have built a pervasive marketing culture will usually outperform those that see themselves simply as selling visits, tests, and services, one at a time.

Marketing Uses a Set of Concepts

The first question a health care organization must ask is, "Who is potentially interested in the kind of products or services that we offer or plan to offer?" Examples include young women and obstetric services, older adults and bypass surgery services, and diabetics and portable blood sugar testing devices. Very few organizations try to serve the entire market, preferring, instead, to distinguish different groups (segments) that make up a market. This distinguishing process is called *market segmentation*.

The organization will then consider which market segments it can serve best in light of the segments' needs and the organization's capabilities. We call the chosen segment the *target market*. Building on this concept of a target market, we can summarize the customer-focused marketing philosophy with the acronym CCDV; the aim of marketing is to *create, communicate, and deliver value*. Value is the fundamental concept underlying modern marketing. It is not value just because the supplier believes he or she is giving value; it must be perceived by the customer. One job of the marketer is to turn invisible value into perceived value. We can extend CCDV into CCDVT, with the T standing for a *target market*. Instead of an organization generating general value, it aims to generate specific value for a well-defined target market. If a nursing home decides to serve a high-income market, it must create, communicate, and deliver the value expected by high-income families, with the price set high enough to cover the extra costs of better facilities and services.

We need to extend the expression further to CCDVTP, with the P standing for *profitably*. The marketing aim is to *create, communicate, and deliver value to a target market profitably*. Even a nonprofit organization must earn revenues in excess of expenses in order to continue its charitable mission.

To help their firms prepare a valued offering, marketers have long used a tools framework known as the 4Ps *marketing mix : product, price, place,* and *promotion*. The organization decides on a product (its features, benefits, styling, packaging), its price (including list price as well as rebate and discount

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its place (namely, where it is available and its distribution strategies), and the promotion mix (such as advertising, personal selling, and direct marketing). It turns out that the 4Ps are already present in the CCDVT formulation. Creating value is very much about developing an excellent *product* and appropriate *price*. Communicating value involves *promotion*. Delivering value requires an understanding about *place*. Thus CCDV is a more active way to state the 4Ps. Some critics have also proposed adding more Ps (*people, passion, process*, and so on).

Marketers recognize that the 4Ps represent the set of the seller's decisions, not the buyer's decisions. Part of the transition from the Old Marketing to the New Marketing, mentioned previously, involves marketers looking at everything from the buyer's or consumer's point of view. For a consumer to be interested in an offering, the consumer must have *awareness* of the offering and find it *acceptable, available* at the right time and place, and *affordable*. Professor Jagdish Sheth calls these attributes the "4As of marketing."

We introduce one final concept—positioning. An organization or company positions itself to be the place of choice for its target market. Thus a hospital might position itself as having the most advanced medicine or the best patient service, or being the most efficient hospital. Good positioning requires looking at how to best implement the 4As of that target market. We refer to these steps of *segmentation, targeting*, and *positioning* by the acronym STP.

Combining this concept with those just described, we now have a more robust model of marketing strategy: first segment, next target position, then determine the 4As, and finally set the appropriate 4Ps.

When we say that marketing's purpose is to create value for the customer and profits (or surpluses) for the organization and its stakeholders, we don't mean that the organization should give customers everything that they want. Customer desires and needs must correspond with the mission or purpose of the organization.

For example, a rehabilitation hospital does not need to open a cardiac bypass program just because some of its patients have heart disease. A further problem arises when the customer wants something that is not in his or her best interest. For example, a patient may request an antibiotic to treat a cold or ask for a narcotic for nonmedical reasons.

The Main Skills of Marketing

Marketers rely on seven traditional skills: marketing research, product design, distribution, pricing, advertising, sales promotion, and sales management. Effective marketing must start with marketing research, which in turn consists

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of other skills. Suppose a hospital is planning to build a second facility in one of several neighboring communities. It clearly needs to conduct systematic marketing research to find which site is the most promising.

The marketing research will use both secondary and primary data. Secondary data comes from existing sources and yields information about such factors as the population's size, age, income, and education distribution as well as land costs and transportation resources. Primary data comes from making firsthand observations in each community by hosting focus groups to gather consumer reactions to different proposals, conducting in-depth interviews with specific community members, undertaking surveys to get a more accurate picture of customer attitudes and needs, and, finally, applying statistical techniques to draw insights from the data. By combining primary and secondary data, the hospital hopes that some neighboring community will emerge as the best target market to be served by a second facility.

Product design is the second marketing skill. Suppose a manufacturer of hospital beds wants to design a product that patients can more easily adjust on their own. It will assign a product team to design the new bed, consisting of an engineer, a designer, and a marketer. The marketer will supply some preliminary data about how patients feel about different features of a hospital bed, including functions, colours, and general design appearance. After the design is developed, the marketer might test it with a number of patients.

Although we are talking about designing a physical product, the same principles apply to a service. Many people complain about their experience in emergency rooms (ERs), including long waiting times, crowded facilities, and perfunctory service. Marketers are increasingly studying how to improve the ER experience, because hospital administrators realize that it is the place in which patients often experience their first encounter with the institution and that influences their probability of choosing it for future care.

The third traditional skill of marketers is distribution. Marketers have to choose places in which their products and services will be readily accessible and available to the customers. Marketers have learned to work with different types of wholesalers, jobbers, brokers, retailers, and transportation companies. This knowledge is very useful in activities ranging from pharmaceutical channel distribution to setting up a regional or national chain of in-store medical clinics.

Pricing is the fourth traditional skill of marketers. Marketers have gained much of their experience through setting prices and adjusting them for different markets and in different circumstances. They are guided by both internal constraints (such as their companies' production cost structure) as well as the realities of the marketplace (such as price elasticity of demand). In the realm of health insurance, the marketplace also demands flexibility to customize the

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product, with an attendant set of fixed and optional services and their varied prices.

The fifth traditional skill of marketers is the use of advertising. Marketers have extensive experience in working with ad agencies in designing messages, choosing media, setting budgets, and evaluating outcomes of advertising campaigns. The marketer must advise the organization about the best media mix to use, choosing among newspapers, magazines, radio, television, and billboards. Within each medium, the marketer must also make such decisions as whether to employ full-page or part-page ads, thirty-second TV spots or infomercials, and which radio stations will best reach target customers at certain times of the day.

The sixth traditional marketing skill is sales promotion: the use of incentives to stimulate trial or purchase of a product or service. Sales promotions include a wide variety of incentives. For example, community leaders might want 100 percent of citizens to get a flu vaccination; to achieve a big turnout, they may offer a discount for family members, a free booklet on staying fit, or a free coupon for a blood test.

The seventh traditional skill of marketers is management of a sales force. For example, the General Electric (GE) Medical Products division uses a well-trained sales force to sell sophisticated diagnostic imaging equipment to hospitals. This equipment is expensive, so hospitals must be convinced not only that they need this technology, but also that they should prefer to purchase it from GE. GE's professional sales force will explain the benefits of buying this equipment as justifying its high cost. Thus GE needs to hire, train, compensate, motivate, and evaluate hundreds of skilled professional salespeople.

Many suggest that, in addition to these seven skills, organizations need some newer marketing know-how, including :

- Direct marketing (mail and e-mail)
- Telemarketing
- Public relations
- Product placement
- Sponsorship
- Event management
- Internet marketing
- Blogs and podcasts

How Marketing Is Organized in Health Care

Formal marketing positions (such as marketing researchers, sales managers, and advertising managers) have existed in pharmaceutical firms, medical device firms, and medical supply firms for many years. As more hospitals began to

appoint a marketing head, two variations emerged : director of marketing and vice president of marketing. The director of marketing provides and orchestrates marketing-related activities and resources. The vice president of marketing performs these activities and also sits with the other hospital officers in developing policies and strategies. The VP of marketing also brings the voice of the customer (VOC) into management and board meetings.

When hospitals first started appointing marketing heads, the public relations (PR) person on the staff often objected on the grounds that he or she was doing the marketing. The PR person's job was to generate good news about the hospital and defend it against bad news. Hospital CEOs soon realized, however, that PR and marketing have quite different roles and skills, although there is some overlap.

Public relations persons are trained in communication skills and work closely with media (editors, journalists) and occasionally with government officials, although the latter contacts are often handled by public affairs officers. Marketing people, on the other hand, are trained in economic analysis and the social sciences to understand and analyze markets and customer choice behaviour. Marketers use the tools detailed earlier to provide estimates of a defined market's size and its needs, preferences, perceptions, and readiness to respond to alternative offers. Marketers develop a strategy and tactics for serving the target market in a way that will meet the organization's mission.

Today the marketing department in a large hospital may be staffed with a marketing researcher or analyst, an advertising and sales promotion manager, a sales force director, and in some cases product managers and market segment managers. Even when there are no specific positions dedicated to the functions of product development, pricing, communication, and distribution, these will be carried out by various people in the organization.

3.5 PRIMARY HEALTHCARE

The primary responsibility for the care of a large displaced population falls on the government authorities in the host country where a displaced population has "settled." If the host country is unable to meet the health needs of the affected people, the host government authorities should invite humanitarian organisations to strengthen the local emergency response. The health needs of large displaced populations are not any different from the everyday health needs of many urban or rural communities in developing countries. Once the crisis is over, the displaced population is likely to return to an environment with limited resources for health care. It would be inappropriate to get them used to a standard of health care that cannot be achieved with their local resources. Therefore, humanitarian assistance should be delivered within the Primary Health Care (PHC) framework so that whatever skills the displaced population gains through community participation,

health education, nutrition, and preventive health measures, can enable them to take responsibility for their health and rebuild their future.

Primary Health Care (PHC) is defined as:

> *Essential health care based on practical, scientifically sound, and socially acceptable methods and technology made 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 in the spirit of self-reliance and self-determination.* (Health for All by the Year 2000, WHO 1978, Alma Ata)

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Table 1: Terms and Definitions

Basic Health Facility — The first level of health care in the health system. Offers mainly ambulatory care, outreach and referral services. It is usually staffed by medical assistants, nurses, and auxiliary staff.
Community Participation — Involving families and communities who, rather than being mere beneficiaries of health care, share the responsibility of caring for their health. This promotes individual involvement and self-reliance.
Decentralisation — Transferring authority or responsibility in planning, managing resources and/or decision-making from the central level of government to the district and local levels.
District — The smallest, well-defined, administrative and operational unit of a central government. Represents the level where qualified personnel from different sectors can work directly with the community and other agencies.
District Health System (DHS) — A health care system set up for delivering primary health care to a population within a well-defined geographical area. It includes all concerned health care agencies, which are organised and co-ordinated by district health authorities. Managing a DHS requires involvement of multiple sectors as well as the community.
Equity — Providing equal health care to all groups of people according to their needs. Concerned with ethical aspects of service being delivered: giving highest priority to those with greatest health needs.
Health Workers — Physicians, medical assistants, nurses, auxiliaries, community health workers (CHWs) and traditional healers functioning within the health care system.

PRINCIPLES OF PRIMARY HEALTH CARE

Primary health care is based on five main principles :

1. **Equity** — Services should be physically, socially, and financially accessible to everyone. People with similar needs should have equal access to similar health

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services. To ensure equal access, the distribution of resources and coverage of primary health care services should be greatest in those areas with the greatest need.

2. **Community Participation** — In addition to the health sector, families and communities need to get actively involved in taking care of their own health. Communities should participate in the following :

- creating and preserving a healthy environment,
- maintaining preventive and promotive health activities,
- sharing information about their needs and wants with higher authorities,
- implementing health care priorities and managing clinics and hospitals.

3. **Inter-Sectoral Approach** — PHC requires a co-ordinated effort with other *health-related sectors* whose activities impact on health *e.g.*, agriculture, water and sanitation, transportation, education, etc. This is necessary to achieve social and economic development of a population. The health sector should lead this effort. The commitment of all sectors may increase if the purpose for joint action and the role of each sector is made clear to all concerned.

4. **Appropriate Methods**— An increasing complexity in health care methods should be observed upward in the PHC pyramid, (see Figure 1 below). Care-givers should be trained to deliver services using the most appropriate and cost-effective methods and equipment for their level of care.

Note: *Appropriate technology does not necessarily mean low technology.*

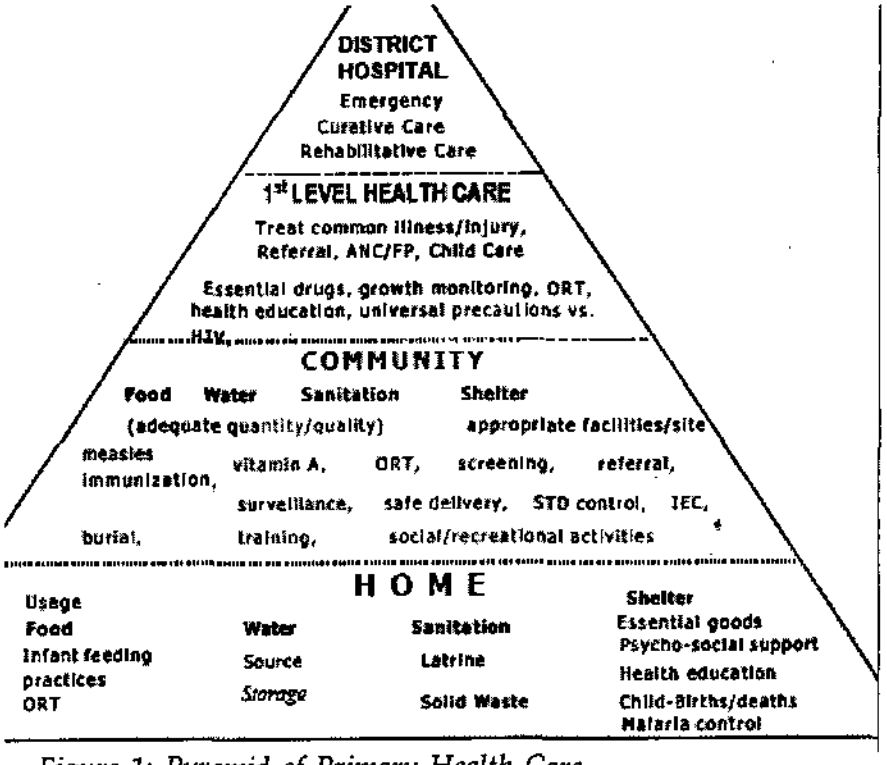

Figure 1: Pyramid of Primary Health Care

5. **Health Promotion and Prevention** — PHC requires a comprehensive approach that is based on the following interventions :

- **Promotive** — *addresses basic causes of ill-health at the level of society.*
- **Preventive** — reduces the *incidence* of disease by addressing the immediate and underlying causes at the individual level.
- **Curative** — reduces the *prevalence* of disease by stopping the progression of disease among the sick.
- **Rehabilitative** — reduces the long-term *effects* or complications of a health problem.

Comprehensive PHC combines facility-based health services (curative and rehabilitative) with multisectoral public health interventions (promotive and preventive). Because this approach is more effective in sustaining the overall well-being of a population, it should be supported by the community. The following table shows how the comprehensive framework of PHC services can be used to address common health problems.

Comprehensive PHC requires health workers to identify solutions that involve the community, as follows :

1. It is not enough to provide oral rehydration solution and medical treatment to a sick child with diarrhoea. Maintaining the health of the child also requires providing family education on child care and environmental hygiene, as well as improving access to food.
2. In addition to counselling on breast-feeding, growth monitoring, nutrition rehabilitation, and child care, a nutrition programme should promote weaning foods that are available locally.
3. PHC services for healthy people (*e.g.*, pre-natal care, immunisation, health education) should be established as soon as possible through community-based health interventions.

Challenges to Primary Health Care

Large gaps may be observed when planning and implementing comprehensive Primary Health Care (PHC). Some of the current challenges to PHC include the following :

- Improper translation of PHC as *primary level of care* (first level health care in the pyramid), which ignores the overall integrated nature of PHC.
- The community may not be willing to take responsibility for the health care system.
- Drugs may not be available at lower levels of the PHC system. Therefore, patients will go directly to hospitals.
- Prolonged delays in health worker salaries may result in hostile attitudes towards patients.

- Referral system may not be functioning well.
- Lack of supervision and training may result in poor quality of services.
- Different sectors may not be used to working together.

Translating Primary Health Care

PHC is based on the fact that most health problems can easily be handled outside the hospitals. Therefore, to provide the best possible care for the greatest number of people, certain health care functions should be transferred to lower levels in the PHC pyramid as illustrated in Figure 2 below :

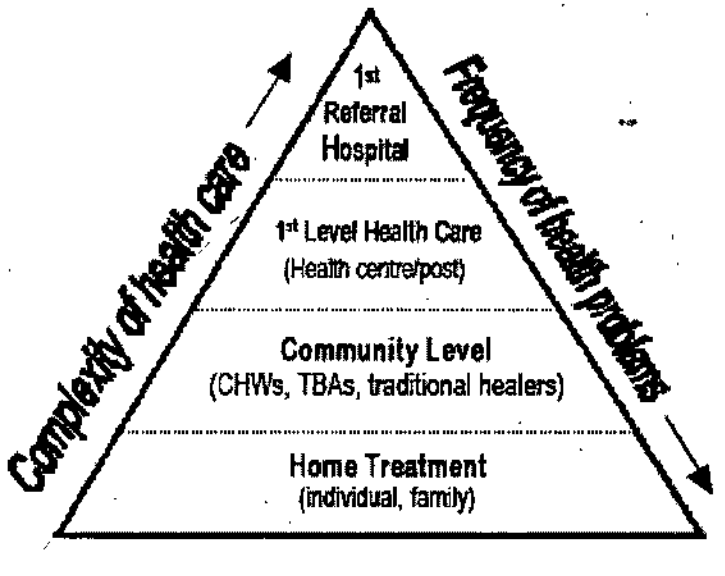

Figure 2: Functional Levels of Primary Health Care

Note: *The second referral (provincial or regional hospital) and third referral levels (national hospital) do not fall under PHC.*

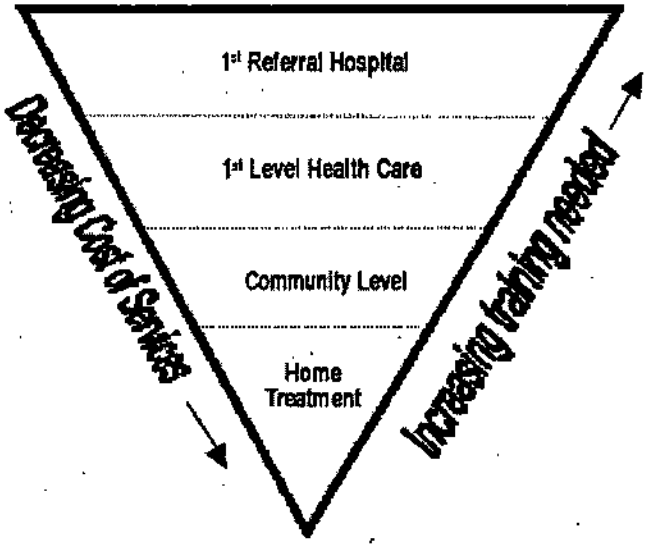

Figure 3: Resource Needs for Different Levels of Health Care

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Because resources for health care are always limited, health planners should first focus on strengthening health centres and medical posts rather than referral hospitals. Providing basic level health care at health centres and health posts or dispensaries is more cost-effective, whereas services at referral hospitals are more costly since they are delivered by personnel with more advanced training (refer to the inverted pyramid in Figure 3).

Even though first referral hospitals are expensive to run, they should be supported within the PHC framework because they provide care for serious medical conditions and injuries that cannot be adequately treated at the lower levels of the PHC system.

The District-Level Health System

A health system where the central authorities within the Ministry of Health (MOH) are responsible for running the health services for the entire nation is known as a *centralised health system*. Primary health care is best implemented in a *decentralised* system, which transfers the authority and responsibility for planning, managing resources and/or decision-making from the central MOH to the district and local levels. Transferring management functions closer to the local health authorities gives the local communities a louder voice in determining how clinics and hospitals can improve the quality of health care being provided.

Defining the District-Level Health System

The following table defines the characteristics of a well-functioning district health system :

Table 3: Characteristics of a Well-Functioning District Health System

A district health system is based on primary health care. It serves a well-defined population living within a clearly delineated administrative and geographical area. It includes all relevant health care agencies in an area (government, private, professional or traditional) which co-operate to create a district system and work together within it.
The district health system contains a variety of inter-related elements that contribute to health in homes, schools, work and communities, and is multi-sectoral in orientation. It includes self-care and care provided through health care workers and facilities, including the hospital, with supportive services (laboratory, logistical, etc.)
It needs to be managed by an individual with public health and curative responsibilities in order to combine the elements and institutions into providing a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities, and to monitor progress.

Expected benefits of a well-functioning district health system include :

- a rational and unified health system that meets the basic health needs,
- flexible management of health services, with minimum logistical and administrative delays,
- more equitable health services to the entire population,
- improved management of resources,
- co-ordination and integration of health care with activities of other sectors,
- a means for facilitating community participation and accountability to the community,
- better performance through an efficient and motivated workforce.

Because **health centres** are often the first contact the community has with the formal health system and most of the district level health workers are based there, health centres should be equipped to function as the focal point for comprehensive PHC. Resources should be readily available at this level to maintain adequate and stable levels of staffing and supplies.

Health centres should function in the following ways to reflect their important role :

- the centre for community participation,
- the base for preparing community health programmes (*e.g.*, health education, immunisations, sanitation),
- the focal point of inter-sectoral teamwork within the district-level health system.

The figure below illustrates the central role of health centres :

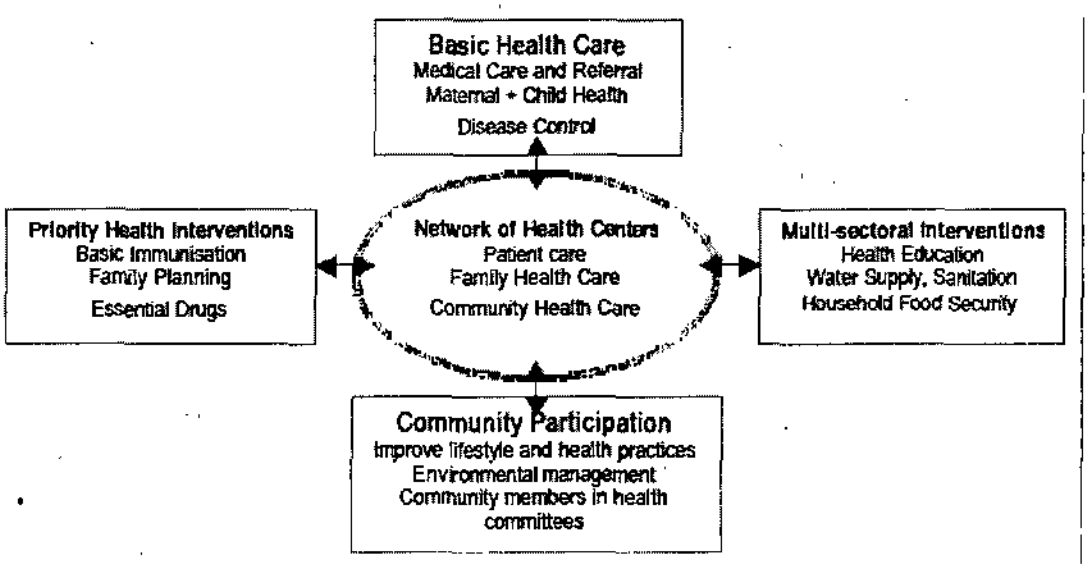

Figure 4: The District-Level Health System

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Key Issues of a District-Level Health System

The following key issues should be addressed to ensure a well-functioning district health system :

1. Co-ordination — The highest authority in the district-level health system should be made responsible for organising and coordinating comprehensive PHC services for the entire population. However, coordination depends on adequate logistical financial support and training from the central authorities.

2. Health Management Teams — In a district-level health system, decision-making is shared among the central MOH, the district health offices, the health facilities, and the community. This can only be achieved through formation of health management teams at every level of health care, for example :

- District health management teams should include the medical superintendent, the senior nursing officer (matron), the hospital secretary, and elected community leaders.
- At the health centre level, the management team may include the clinical officer or the nurse in charge, other staff, and members of the community.
- At the community level, a health committee may include the health auxiliary, the community health worker, and the village elders.

Local authorities from other health-related sectors, representatives from NGOs and other interested groups may be included in these health management teams. Each team should be given advisory roles and regulatory powers for managing the PHC services (immunisation, maternal health/pre-natal care, water and sanitation, treatment of tuberculosis/leprosy, clinical services).

3. Community Participation — Community participation may be interpreted in various ways. It may range from district authorities informing community leaders about what the health sector has planned to community leaders being actively involved in making decisions (*e.g.*, determining health priorities or strategies). The level of participation may greatly depend on the community leaders in local health committees: how they were selected, their capacity to mobilise community action and to demand accountability, and the amount of social and political support they can rally. The community should be encouraged to join forces with other sectors, organisations and groups when planning comprehensive PHC programmes.

4. Resources for PHC — Implementing PHC requires resources to be readily available, particularly at the health centre level. Adequate and stable levels of staffing and essential supplies need to be maintained. In addition, district health authorities should encourage all levels to make maximum use of resources available locally. Sometimes these resources are not available because of logistical, financial, or managerial problems. In such situations, appeals for funding may

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be sent to donors that are interested in strengthening the district health system infrastructure. Otherwise, local NGOs and existing community groups may be supported to extend services to outlying areas.

5. Health Information — Indicators for monitoring the PHC programme should be defined for all essential PHC services. Information from monitoring these indicators can be used for making decisions and setting policy. The following table gives examples of PHC indicators :

Table 4: PHC Indicators, Target Group, and Optimal Coverage

PHC SERVICES INDICATOR	TARGET GROUP	OPTIMAL COVERAGE
No. of under-five children weighed per month	All children aged 0-59 months	100% of under-5/month
No. of women provided ante-natal care per month	All pregnant women	50% of pregnant women/month
Number of assisted deliveries per month	All deliveries	1/12 of total group/month
No. of children immunised against measles per month	All children aged 9-12 months	1/12 of total group/month
No. of OPD consultations per month	4 per person/year	0.33 per person/month

Primary Healthcare Relief Programmes

Goal of PHC in Emergencies

Primary health care in emergency relief programmes aims to do the following:

- Reduce morbidity and mortality rates of the displaced population to regional norms.
- Build on existing knowledge and skills of the displaced community to improve overall health.
- Link emergency relief to rehabilitation, reconstruction, and development by building the capacity of the affected population. This will make it possible to sustain resources.

Lessons in PHC Planning

Planning and implementing PHC into reality in relief programmes can be a slow and challenging process. Reasons for this include centralised decision-making, administrative delays, lack of supervision, and insecure professional health workers. The following lessons have been learned over the years about how a PHC programme should be planned :

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A unified approach for making referrals to other sectors or levels within the PHC system can be developed in the following way :

- all field workers understand the PHC system: their responsibilities, functions of neighbouring levels, and the procedures for co-operation.
- each sector sets its own targets for services in terms of quality and coverage to make the system more effective.
- collaboration within the referral system is promoted to maximise the use of resources and labour, and to provide the appropriate level of care.

Specific responsibilities that may be defined for each of the following are described below :

- *Central level*
- *District level*
- *Relief programme level*
- *Relief worker level*
- *Community level*

Central Level

For PHC to be effective, the central Ministry of Health must be committed to its role of coordinating the emergency health system, mobilising resources and encouraging district-level decision-making. The main functions at this level should include the following :

- Making policies on emergency PHC operations and drawing formal agreements or memoranda with relief organisations and other providers.
- Regulatory authority for monitoring the level and quality of emergency PHC services and supplies.
- Promote inter-sectoral co-operation and inter-agency collaboration within the defined geographical area.
- Restrict relief organisations from setting up emergency PHC programmes without considering the overall health needs of the affected community, in order to avoid duplication of services.
- Give formal support in the training of emergency PHC service providers.

District Level

The function of the district level should include :

- Co-ordinating health services in all PHC facilities in the district (including the referral hospital), based on the local budget and available resources.
- Encouraging all sectors to work well together.
- Initiating dialogue in the community and promoting active community participation in planning the district-level health system.

- Ensuring that community health workers have enough support and supervision.
- Collecting, compiling, and regularly forwarding health information to the central government.

If the administrative capacity of the district level health authorities is weak, relief organisations may strengthen it by providing on-the-job training in PHC principles, district-level management, information systems, supervision, and health-related support. Training should target all senior managers from the district health office, the implementing agency and other health-related sectors who need to broaden their skills.

Relief Programme Level

Every relief sector (*e.g.*, food and nutrition, water and sanitation, basic health care, etc.) should organise on the-job training for its staff in the following :

- Comprehensive PHC using problem-solving techniques that emphasise integrating preventive and promotive health interventions with the hospital-based curative and rehabilitative care.
- Developing and reinforcing standard ways of delivering services in order to improve the quality of the service. Standard methods should be adapted to the local situation and regularly reviewed.
- The planning process so all staff members will understand the programme goals and objectives, their roles and duties, and the available resources.

Relief Worker Level

In any emergency operation, field workers are recruited in order to implement the PHC program. However, they must change from being the major "providers" of PHC services to becoming "enablers." Many field workers may be unwilling to take over new responsibilities since they, like many health workers, are only trained to *deliver* services to the beneficiaries rather than to make decisions about the programme. Therefore, field workers need training in the following :

- How to increase the community's awareness of the association between poor health and poor living conditions or unhealthy behaviour. This will help strengthen active community support for multisectoral actions.
- How to meet regularly with the community to build support for the PHC programme and to strengthen community participation.
- How to involve community representatives in determining priorities and in planning, implementing, and monitoring relief programmes.

Note: *It is very important to recruit staff from among the displaced community. Recruiting an adequate number of female CHWs will increase access to individuals and households with the greatest need.*

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Community Level

A partnership should be forged involving everyone who can improve the well-being of the community. This includes social groups, community groups, and traditional practitioners.

Getting communities to actively participate in decision-making on the emergency PHC programme takes time and effort. They need to learn how to identify health priorities and the importance of co-operating and participating in PHC activities to improve their overall health. The most important role of the community is to give regular feedback to the relief agency about the delivery of PHC services in terms of the following :

- equity in how services are provided,
- access to care,
- relevance between the services offered and the needs of the affected population.

In some situations, the local power structure may have to be readjusted to ensure satisfactory community participation. This can be achieved by including members from different social groups, such as women, youth, traditional healers, and school teachers in the health committees. This will ensure that the interests of the displaced population will be represented.

3.6 PHILOSOPHY OF HEALTHCARE

The ***philosophy of healthcare*** is the study of the ethics, processes, and people which constitute the maintenance of health for human beings. For the most part, however, the philosophy of healthcare is best approached as an indelible component of human social structures. That is, the societal institution of healthcare can be seen as a necessary phenomenon of human civilization whereby an individual continually seeks to improve, mend, and alter the overall nature and quality of his or her life.

The philosophy of healthcare is primarily concerned with the following elemental questions :

- Who requires and/or deserves healthcare? Is healthcare a fundamental right of all people?
- What should be the basis for calculating the cost of treatments, hospital stays, drugs, etc.?
- How can healthcare best be administered to the greatest number of people?
- What are the necessary parameters for clinical trials and quality assurance?
- Who, if anybody, can decide when a patient is in need of "comfort measures" (euthanasia)?

However, the most important question of all is 'what is health?'. Unless this question is addressed any debate about healthcare will be vague and unbounded. For example, what exactly is a health care intervention? What differentiates healthcare from engineering or teaching, for example? Is health care about 'creating autonomy' or acting in people's best interests? Or is it always both? A 'philosophy' of anything requires baseline philosophical questions, as asked, for example, by the philosopher Professor David Seedhouse.

Ultimately, the purpose, objective, and meaning of healthcare philosophy is to consolidate the abundance of information regarding the ever-changing fields of biotechnology, medicine, and nursing. And seeing that healthcare typically ranks as one of the largest spending areas of governmental budgets, it becomes important to gain a greater understanding of healthcare as not only a social institution, but also as a political one. In addition, healthcare philosophy attempts to highlight the primary movers of healthcare systems; be it nurses, doctors, allied health professionals, hospital administrators, health insurance companies (HMOs and PPOs), the government (Medicare and Medicaid), and lastly, the patients themselves.

Ethics in Healthcare

The ethical and moral premises of healthcare are convoluted and numerous. In order to consolidate such an enormous field of ethical thought, it becomes necessary to focus on what makes healthcare ethics truly different from other forms of morality. And on the whole, it can be said that healthcare itself is a "special" institution within society. With that said, healthcare ought to "be treated differently from other social goods" in a society. It is an institution of which we are all a part whether we like it or not. At some point in every person's life, a decision has to be made regarding one's healthcare. Can he/she afford it? Does he/she deserve it? Does he/she need it? Where should he/she go to get it? Does he/she even want it? And it is this last question which poses the biggest dilemma facing a person. After weighing all of the costs and benefits of her healthcare situation, the person has to decide if the costs of healthcare outweigh the benefits. More than basic economic issues are at stake in this conundrum. In fact, a person must decide whether or not his/her life is ending or if it is worth salvaging. Of course, in instances where the patient is unable to decide due to medical complications, like a coma, then the decision must come from elsewhere. And defining that "elsewhere" has proven to be a very difficult endeavour in healthcare philosophy.

Medical Ethics

Whereas bioethics tends to deal with more broadly-based issues like the consecrated nature of the human body and the roles of science and technology in

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healthcare, medical ethics is specifically focused on applying ethical principals to the field of medicine. It is a large and relatively new area of study in ethics. And one of the major premises of medical ethics surrounds "the development of valuational measures of outcomes of health care treatments and programmes; these outcome measures are designed to guide health policy and so must be able to be applied to substantial numbers of people, including across or even between whole societies." Terms like beneficence and non-maleficence are vital to the overall understanding of medical ethics. Therefore, it becomes important to acquire a basic grasp of the varying dynamics that go into a doctor-patient relationship.

Nursing Ethics

Like medical ethics, nursing ethics is very narrow in its focus, especially when compared to the expansive field of bioethics. For the most part, "nursing ethics can be defined as having a two-pronged meaning," whereby it is "the examination of all kinds of ethical and bioethical issues from the perspective of nursing theory and practice." This definition, although quite vague, centers on the practical and theoretical approaches to nursing. The American Nurses Association (ANA) endorses an ethical code that emphasizes "values" and "evaluative judgments" in all areas of the nursing profession. And since moral issues are extremely prevalent throughout nursing, it is important to be able to recognize and critically respond to situations that warrant and/or necessitate an ethical decision.

Business Ethics

Balancing the cost of care with the quality of care is a major issue in healthcare philosophy. In Canada and some parts of Europe, democratic governments play a major role in determining how much public money from taxation should be directed towards the healthcare process. In the United States and other parts of Europe, private health insurance corporations as well as government agencies are the agents in this precarious life-and-death balancing act. According to medical ethicist Leonard J. Weber, "Good-quality healthcare means cost-effective healthcare," but "more expensive healthcare does not mean higher-quality healthcare" and "certain minimum standards of quality must be met for all patients" regardless of health insurance status. This statement undoubtedly reflects the varying thought processes going into the bigger picture of a healthcare cost-benefit analysis. In order to streamline this tedious process, health maintenance organizations (HMOs) like BlueCross BlueShield employ large numbers of actuaries (colloquially known as "insurance adjusters") to ascertain the appropriate balance between cost, quality, and necessity in a patient's healthcare plan. A general rule in the health insurance industry is as follows:

The least costly treatment should be provided unless there is substantial evidence that a more costly intervention is likely to yield a superior outcome.

This generalized rule for healthcare institutions "is perhaps one of the best expressions of the practical meaning of stewardship of resources," especially since "the burden of proof is on justifying the more expensive intervention, not the less expensive one, when different acceptable treatment options exist."

3.7 HEALTHCARE CHALLENGES

Health provision varies around the world. Almost all wealthy nations provide universal health care (the US is an exception). Health provision is challenging due to the costs required as well as various social, cultural, political and economic conditions.

The World Health Organization (WHO) is the premier organization looking at health issues around the world. When looking at the pattern of health care around the world, the WHO found some common contradictions.

Inverse Care

People with the most means – whose needs for health care are often less – consume the most care, whereas those with the least means and greatest health problems consume the least. Public spending on health services most often benefits the rich more than the poor in high- and low-income countries alike.

Impoverishing Care

Wherever people lack social protection and payment for care is largely out-of-pocket at the point of service, they can be confronted with catastrophic expenses. Over 100 million people annually fall into poverty because they have to pay for health care.

Fragmented and Fragmenting Care

The excessive specialization of health-care providers and the narrow focus of many disease control programmes discourage a holistic approach to the individuals and the families they deal with and do not appreciate the need for continuity in care. Health services for poor and marginalized groups are often highly fragmented and severely under-resourced, while development aid often adds to the fragmentation.

Unsafe Care

Poor system design that is unable to ensure safety and hygiene standards leads to high rates of hospital-acquired infections, along with medication errors and other avoidable adverse effects that are an underestimated cause of death and ill-health.

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1. PHC can be adapted to all types of situations, including complex emergencies, provided the long-term goals are clear.
2. Factors that may influence planning PHC in emergencies include the political support of the host country, the historical experience of the health care system, the capability of the affected community, and the presence of NGOs and donors.
3. Decentralised planning helps to make relief programmes more relevant to the needs of the displaced population rather than responding to the wants of the leadership.
4. When setting priorities, encourage active support and communication with the displaced community. This will lead to a consensus. The methods used will depend on the existing political structure.

Establishing an Emergency PHC Programme

The type of emergency health services set up depends on several factors, including :

- the health system of the host country,
- the available resources,
- the context of the disaster,
- the health needs of the affected population.

Providing hospital-based care alone is appropriate only where a displaced population is concentrated within a limited space and the facility is accessible to all (located near a road or at the centre of the camp). Setting up a field hospital is only justified when access to a referral hospital for surgical and obstetric emergencies is difficult or delayed.

To ensure a more cost-effective and sustainable programme, relief agencies should establish an emergency PHC programme within the framework of a district-level health system. This programme should be :

- Based on the policies, standards and treatment protocols of the host country and integrated within the national health system.
- Functioning in a decentralised manner that reflects the community's identified health needs and priorities.
- Comprehensive; involving all components of the health and other health-related sectors).
- Having clearly defined decision-making authority and responsibility for each level.
- Balanced in terms of the distribution of resources between curative, preventive, and promotive health programmes.
- Sharing health information and promoting co-operation between all levels of the health system, and with other sectors and the community.

Relief agencies should aim at strengthening the existing public health infrastructure (basic health facilities, community health network, the local referral system and water supply, disease control, etc.) and at limiting dependence on external resources.

To establish emergency PHC services, first set up the health centre to function as the focal point for all PHC services in the area and establish a network of CHWs to extend services into the community. Community participation and inter-sectoral teamwork should be promoted from the beginning. Peripheral health units or dispensaries may be set up later, if necessary. All levels of the PHC system, from the home and community level to the district hospital, should be provided with essential resources (for example, staff, equipment, drugs) and logistical support. This will ensure PHC services are equitable and increase access to care.

Emergency PHC services should be co-ordinated within a functioning referral system so that the lowest skilled workers with minimum training provide the appropriate care at lower levels of the PHC system. At the same time, these workers must screen for conditions that require referral to higher levels of the system for care by more skilled PHC workers. Supervision should be arranged for all levels, carried by supervisors from the next higher level of the health system. For example :

- One auxiliary nurse-midwife based at a peripheral maternity unit may supervise ten traditional birth attendants within the community.
- A nurse-midwife at the health centre can supervise the auxiliaries at peripheral health units.
- Senior health workers based at the first referral hospital may supervise health centre staff.

This approach to supervision will ensure that a larger number of people receive quality health care more efficiently than when all patients are required to see only the most highly trained health workers.

Each level of health care should also form a health committee in order to be accountable to the communities they serve. In addition, training community health worker teams to report their findings to different levels of referral system can greatly promote the effectiveness of PHC services at the peripheral health units.

Division of Responsibilities

Implementing PHC for emergency situations requires the community and other sectors to be involved in decision-making, and on-the-job training and supportive supervision to be organised for all levels of the emergency PHC system.

Misdirected Care

Resource allocation clusters around curative services at great cost, neglecting the potential of primary prevention and health promotion to prevent up to 70% of the disease burden. At the same time, the health sector lacks the expertise to mitigate the adverse effects on health from other sectors and make the most of what these other sectors can contribute to health.

Health care provision is incredibly complex and many nations around the world spend considerable resources trying to provide it. Many other rights and issues are related to health, inequality being an important one, for example. Education, gender equality and various other issues are also closely related. Viewed from the spectrum of basic rights, the right to health seems core.

3.8 HEALTH AS A HUMAN RIGHT

As noted by the Office of the United Nations High Commissioner for Human Rights (OHCHR) and the WHO,

> "The right to health is relevant to all States: every State has ratified at least one international human rights treaty recognizing the right to health. Moreover, States have committed themselves to protecting this right through international declarations, domestic legislation and policies, and at international conferences."

The above fact-sheet also provides a useful breakdown of different aspects of rights to health, describing the relationship between health and —

- Inclusive rights,
- Freedoms (from non-consensual medical treatment, from torture and other cruel or degrading treatments or punishments),
- Entitlements (to prevention, treatment and control of diseases; access to essential medicines; maternal, child and reproductive health; health-related education; participation; timely services),
- Non-discrimination,
- Accessibility, acceptability and quality of services.

A wide range of factors, or "determinants of health" allow us to lead a healthy life, including —

- Safe drinking water and adequate sanitation,
- Safe food,
- Adequate nutrition and housing,
- Healthy working and environmental conditions,
- Health-related education and information,
- Gender equality.

UNIVERSAL HEALTHCARE

Universal health care is health coverage for all citizens of a nation.

Does provision of *universal* health infringe on *individual* human rights? Some argue that a universal system requires some level of transfer of wealth from those who have to support those who have not. Any such transfer infringes on the freedom of the individual being taxed.

Others argue that providing access to health *enables* one to enjoy freedom, and as a society it is a shared responsibility (much like sharing the burden of funding a military or providing education for all). As such, social equity and individual freedom do not necessarily have to conflict.

At some point the debate becomes ideological rather than practical, and most nations that attempt universal health care, while often supporting individual freedoms see value in a society generally being healthy.

There are numerous ways such a system is provided, for example :

- Government funded (tax paid) national systems,
- Government funded but user fees to top up (often at point of use),
- Health insurance systems (funded by governments, citizens, or some mixture),
- Decentralized, private systems run for profit or not for profit.

Different parts of the world have used different means for health care and generally, poorer nations have struggled to provide adequate health care.

3.9 SUMMARY

- Health care systems are designed to meet the health care needs of target populations. There are a wide variety of health care systems around the world. In some countries, health care system planning is distributed among market participants, whereas in others planning is made more centrally among governments, trade unions, charities, religious, or other co-ordinated bodies to deliver planned health care services targeted to the populations they serve.
- Governments, through ministries of health and other related ministries and agencies, play an important role in health development, through strengthening health systems and generation of human, financial and other resources.
- Formal marketing positions (such as marketing researchers, sales managers, and advertising managers) have existed in pharmaceutical firms, medical device firms, and medical supply firms for many years. As more

hospitals began to appoint a marketing head, two variations emerged : director of marketing and vice president of marketing.

- The ***philosophy of healthcare*** is the study of the ethics, processes, and people which constitute the maintenance of health for human beings. For the most part, however, the philosophy of healthcare is best approached as an indelible component of human social structures. That is, the societal institution of healthcare can be seen as a necessary phenomenon of human civilization whereby an individual continually seeks to improve, mend, and alter the overall nature and quality of his or her life.

3.10 REVIEW QUESTIONS

1. Discuss the evolution of the role of government in healthcare development.
2. What are the main challenges before the governments in healthcare development?
3. How is marketing organised for healthcare? Discuss.
4. Expalin the division of responsibilities for primary healthcare.
5. What are the current challenges in the healthcare sector?

3.11 FURTHER READINGS

- Collins, Charles. ***Management and Organisation of Developing Health Systems***. Oxford University Press, 1994.
- Mills, A et al. ***Health System Decentralisation: Concepts, Issues and Country Experience***. Geneva, World Health Organisation, 1990.
- Hannah Bradby, ***Medical Sociology : An Introduction***, Sage Publications.
- Dr. Kavin White, ***An Introduction to Sociology of Health and Illness***, Sage Publications, 2nd edition, 2009.
- Rose Weitz, ***The Sociology of Health, Illness and Health Care : A Critical Approach***, Wardsworth Publising, 5th edition, 2009.

UNIT – IV

SOCIOLOGY, HEALTH AND HEALTH INSTITUTIONS

STRUCTURE

4.1 LEARNING OBJECTIVES

After studying the chapter, students will be able to :

- State the role of behaviour science in health and illness;
- Explain the social determinants of health and healthcare;
- Discuss various important aspects of hospital sociology;
- Describe the relationship of culture and healthcare;
- Understand the concept of etiology;
- Focus on the important aspects of environmental sanitation;
- Explain the need of hygiene for healthy society.

4.2 INTRODUCTION

Sociological approaches to health and health care have a long history. Many of the current preoccupations within the field of study of what for many years has been known as 'medical sociology', but now which has increasingly been redesignated as 'the sociology of health and illness', can be traced back to the founding figures of the discipline of sociology in the 19th Century. These concerns

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relate on the one hand to the extent to which social and economic structures determine people's life chances and possibilities, including their possibilities of health. On the other hand they relate to the extent to which people through individual or collective actions may have some control over their lives, including in relation to their health. There continues to be a debate within medical sociology about the extent to which structures determine health, compared to the degree to which people have the capacity to control (to use their agency over) their health.

Currently there is considerable research in medical sociology on the precise effects of a range of inequalities - economic, class, gender, age and ethnicity for example - on specific patterns of illhealth and disease. Further there is complementary research on the degree to which the remedy to the differential distribution of health and illness should be addressed mainly at a structural level (particularly by lessening economic inequalities in populations), or at an individual level - through an individual's own lifestyle decisions and actions. However the basic thrust of recent sociological findings is that whilst lifestyle changes can be made at an individual level, they generally have a far smaller effect on the health status of populations compared to more structural changes.

4.3 BEHAVIOUR SCIENCE AND HEALTH

A number of psychosocial theories has been developed to predict, explain, and change health behaviours. These theories can be divided into two main groups which are commonly referred to as social cognition models and stage models, respectively.

The term 'social cognition models' refers to a group of similar theories each of which specifies a small number of cognitive and affective factors ('beliefs and attitudes') as the proximal determinants of behaviour. The five models that have been used most widely by health behaviour researchers in recent years are: the health belief model, protection motivation theory, self-efficacy theory, the theory of reasoned action, and the theory of planned behaviour. These models are outlined in turn, their similarities and differences are noted, and common criticisms are discussed.

Stage models use similar concepts but organize them in a different way. According to this approach, behaviour change involves movement through a sequence of discrete, qualitatively distinct, stages. The dominant stage model of health behaviour, the transtheoretical model, is described, and some problems with the model and the research based on it are mentioned.

How does behaviour change occur? This question probably has as many answers as there are diverse populations and cultures. Every HIV prevention programme, however, is based on those answers — theories about why people change their behaviours. These underlying principles may not be formally

recognized as theories, but they focus HIV prevention efforts on the elements believed to be essential for individuals to enact and sustain behaviour change.

Social Cognition Models

The term 'social cognition models' is used to refer to a group of similar theories, each of which specifies a small number of cognitive and affective factors ('beliefs and attitudes') as the proximal determinants of behaviour. These models do not deny that behaviour is influenced by many other factors (*e.g.*, social structural, cultural, and personality factors), but they assume that the effects of such distal factors are largely or completely mediated by the proximal factors specified by the model. Unlike the distal factors, the proximal factors are assumed to be amenable to change, for example by provision of relevant information. Thus social cognition models can be used as the basis for health behaviour interventions.

The Health Belief Model

The health belief model (HBM; Becker 1974) was developed in the 1950s by a group of social psychologists working in the field of public health who were seeking to explain why some people do not use health services such as immunization and screening. The model is still in common use. There are four core constructs: the first two refer to a particular disease whereas the second two refer to a possible course of action that may reduce the risk or severity of that disease. Perceived susceptibility (or perceived vulnerability) is the individual's perceived risk of contracting the disease if he or she were to continue with the current course of action. Perceived severity refers to the seriousness of the disease and its consequences as perceived by the individual. Perceived benefits refer to the perceived advantages of the alternative course of action including the extent to which it reduces the risk of the disease or the severity of its consequences. Perceived barriers (or perceived costs) refers to the perceived disadvantages of adopting the recommended action as well as perceived obstacles that may prevent or hinder its successful performance. These factors are commonly assumed to combine additively to influence the likelihood of performing the behaviour. Thus, high susceptibility, high severity, high benefits and low barriers are assumed to lead to a high probability of adopting the recommended action. Another factor that is frequently mentioned in connection with the HBM is cues to action (events that trigger behaviour), but little empirical work has been conducted on this construct.

There have been two meta-analyses (quantitative reviews) of research using the HBM. Janz and Becker (1984) calculated significance ratios showing how often each HBM construct was statistically significant in the predicted direction across 46 studies. These ratios were 81 percent for susceptibility, 65 percent for

severity, 78 percent for benefits, and 89 percent for barriers; the pattern of findings was similar when only the prospective studies were examined.

Thus, barriers is the most consistent predictor of behaviour and severity is the least consistent. Harrison et al. (1992) used extremely strict inclusion criteria; they included only 16 of the 234 studies they originally identified. Across these 16 studies, the mean correlations between HBM components and behaviour were 0.15, 0.08, 0.13, and -0.21 for susceptibility, severity, benefits, and barriers, respectively. While statistically significant, these correlations are small in substantive terms. Harrison et al. found that benefits and barriers had significantly larger effect sizes in prospective compared with retrospective studies, whereas severity had a significantly larger effect size in retrospective studies.

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Protection Motivation Theory

Protection motivation theory (PMT; Rogers 1983) was originally developed to explain how people respond to fear-arousing health threat communications or 'fear appeals.' It can be regarded as an adaptation of the HBM. Protection motivation refers to the motivation to protect oneself against a health threat; it is usually defined operationally as the intention to adopt the recommended action. Of the determinants of intention specified by the model, the four that have received the most empirical attention are vulnerability and severity (equivalent to perceived susceptibility and severity in the HBM), response efficacy (the belief that the recommended action is effective in reducing the threat), and perceived self-efficacy (the belief that one can successfully perform the recommended action; Bandura 1997). Thus, a person will be more motivated to protect himself or herself (i.e., have a stronger intention to adopt the recommended action) to the extent that he or she believes that the threat is likely if the current course of action is continued, that the consequences will be serious if the threat occurs, that the recommended action is effective in reducing the likelihood or the severity of the threat, and that he or she is able to carry out the recommended action.

In many studies using this model (*e.g.*, Wurtele and Maddux 1987), specific PMT variables are experimentally manipulated in a factorial design and their effects on intention (and sometimes behaviour) are measured. In fact, PMT is unique among social cognition models with respect to the relatively large number of experimental tests that have been conducted. To date, two meta-analyses of PMT studies have been conducted (Floyd et al. 2000, Milne et al. 2000). The analyses used different study inclusion criteria and different effect size measures. Floyd et al. analyzed 65 studies with about 30,000 research participants whereas Milne and colleagues included 27 studies with about 8,000 participants. There were only 12 studies in common. Both analyses found support for each of the mainPMT variables as predictors of intentions and/or behaviour. Self-efficacy had the strongest, most consistent, and most robust effect.

Self-efficacy Theory

Self-efficacy theory (SET) is a subset of Bandura's (1986) social cognitive theory. According to this approach, the two key determinants of behaviour are perceived self-efficacy and outcome expectancies. The latter construct refers to the perceived positive and negative consequences of performing the behaviour. See Schwarzer and Fuchs (1996) for a version of this model that incorporates risk perceptions and behavioral intention, as well as components of the action phase of behavior change. No meta-analysis of SET has been published, though there is substantial evidence for the predictive validity of self-efficacy (Schwarzer and Fuchs 1996).

The Theory of Reasoned Action and the Theory of Planned Behaviour

The theory of reasoned action (TRA; Ajzen and Fishbein 1980) developed out of social–psychological research on attitudes and the attitude–behaviour relationship. The model assumes that most behaviours of social relevance (including health behaviours) are under volitional control, and that a person's intention to perform a behaviour is both the immediate determinant and the single best predictor of that behaviour. Intention in turn is held to be a function of two basic determinants : attitude towards the behaviour (the person's overall evaluation of performing the behaviour) and subjective norm (the perceived expectations of important others with regard to the individual performing the behaviour in question). Generally speaking, people will have strong intentions to perform a given action if they evaluate it positively and if they believe that important others think they should perform it. The relative importance of the two factors may vary across behaviours and populations.

The TRA also specifies the determinants of attitude and subjective norm. Attitude is held to reflect the person's salient behavioral beliefs concerning the possible personal consequences of the action. For example, a person who believes that performing a given behaviour will lead to mostly positive personal consequences will hold a favourable attitude towards the behaviour. Specifically, attitude is held to be a function of the sum of the person's salient behavioral beliefs concerning the outcome of the action each weighted by their evaluation of that outcome. An indirect, belief-based, measure of attitude can be created by multiplying each behavioral belief by its corresponding outcome evaluation and then summing over outcomes. In a similar way, subjective norm is a function of the person's beliefs that specific individuals or groups think he or she should, or should not, perform the behaviour. A person who believes that most significant referents think he or she should perform the behaviour will perceive social pressure to do so. Specifically, subjective norm is held to be a function of the person's salient normative beliefs with respect to each referent, each weighted by their motivation to comply with that referent. An indirect measure of subjective norm

can be created by multiplying each normative belief by its corresponding motivation to comply and then summing over referents.

Many behaviours cannot simply be performed at will; they require skills, opportunities, resources, or cooperation for their successful execution. The theory of planned behaviour (TPB; Ajzen 1991) was an attempt to extend the TRA to include behaviours that are not entirely under volitional control, for example giving up smoking or using a condom. To accommodate such behaviours, Ajzen added a variable called perceived behavioral control to the TRA. This refers to the perceived ease or difficulty of performing the behaviour, and is assumed to reflect past experience as well as anticipated obstacles. According to Ajzen, perceived behavioral control is a function of control beliefs in just the same way as subjective norm is a function of normative beliefs. It is assumed to have a direct influence on intention.

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For desirable behaviours, greater perceived behavioral control should lead to stronger intentions. Perceived behavioral control may also have a direct predictive effect on behaviour, through two different mechanisms. First, holding intention constant, an individual with higher perceived behavioral control is likely to try harder and to persevere for longer than an individual who has lower perceived control. Second, people may have accurate perceptions of the amount of actual control they have over the behaviour.

A number of meta-analyses of the TRA/TPB have been conducted. The findings show that when intention is predicted from attitude and subjective norm, or from attitude, subjective norm and perceived behavioral control, between 40 and 50 percent of the variance is explained, on average. When behaviour is predicted from intention alone or from intention and perceived behavioral control, between 19 and 38 percent of the variance is explained (Sutton 1998).

Comparison of Social Cognition Models

The five social cognition models outlined above show a number of important similarities and differences. Some constructs are common to more than one model. For example, perceived susceptibility or perceived vulnerability occurs in both the HBM and PMT. Other constructs appear to be very similar, for example, perceived behavioral control and self- efficacy.

Resolution of current controversies concerning the extent of overlap between such constructs requires the development of clear definitions, so that similar constructs can be distinguished on conceptual grounds, and more frequent tests of discriminant validity to investigate whether sets of apparently similar measures are tapping the same or different constructs.

All the models assume that individuals are future oriented and that they weigh up the costs and benefits of possible future courses of action. They all

incorporate to a greater or lesser extent the expectancy–value principle which derives from the classical expected utility model, a normative model of decision making. In its weak form, this principle states that expectancies (subjective probabilities) and values are important determinants of behaviour. In its strong form, the principle states that expectancies and values are combined multiplicatively, or at least that people behave as if they combine their cognitions in this way. Both the TRA and the TPB employ the strong form of the expectancy–value principle. The most systematic application of the principle is found in the subjective expected utility model (SEUM; Edwards 1954) which is based directly on expected utility theory. Versions of the SEUM have been applied to a number of health behaviors (*e.g.*, Sutton et al. 1987). Researchers who use models such as the TPB and the SEUM need to be aware of the problems that arise from the use of multiplicative composites (Evans 1991).

This raises the thorny issue of rationality. Social cognition models are often criticized for offering an unrealistically rational account of how people form intentions and make decisions. However, the models do not imply that individuals always deliberate carefully and always make optimal decisions. People may not be aware of all the options available to them and of all the consequences that may follow from their actions. They may hold incorrect beliefs about the outcomes. They may make rapid decisions based on a few salient considerations.

Having made a considered decision (*e.g.*, to go jogging every Sunday morning), they do not necessarily have to weigh up the pros and cons again unless circumstances change; they may simply retrieve their previously formed intention from long-term memory and act on it. Thus, social cognition models imply a more limited rationality than is sometimes suggested by their critics.

Social cognition models are also sometimes criticized for being static. This criticism is unfounded: social cognition models summarize dynamic causal processes. In the TRA, for example, changes in behavioral beliefs and/or outcome evaluations are assumed to produce changes in attitude which in turn lead to changes in intention which ultimately produce changes in behaviour. Models of health behaviour should specify the time lags involved in these causal processes but most of them do not. However, it is often assumed implicitly that effects on intention are almost instantaneous whereas effects on behaviour may be delayed.

Social cognition models differ in the degree to which they specify the content of the cognitions they identify. With the TRA, for example, once the behaviour of interest has been defined, it is possible to generate questionnaire items for intention and for the direct measures of attitude and subjective norm. However, in order to generate items for behavioral beliefs, outcome evaluations, normative beliefs and motivations to comply, it is recommended that researchers gather information on salient beliefs from members of the target population.

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These constructs remain 'content-free' until such information is obtained. Compared with the other models, research on the TRA and the TPB shows a relatively high degree of standardization of measures based on published recommendations (Ajzen and Fishbein 1980). In addition, these authors emphasize the principle of correspondence (or compatibility) which, put simply, states that for maximum prediction the measures of all the constructs in the model should use similar wording. This principle is not widely applied in research using the other social cognition models.

The models also differ with regard to their scope of application. Key constructs in the HBM and PMT include perceived susceptibility and perceived severity with respect to a given health threat. Although these components can be extended to nonhealth-related events, for example the risk of financial loss, the scope of both models is necessarily limited by the nature of these two constructs. By contrast, the other three models are general theories that can be applied to any domain or behaviour, for example voting, career, and purchasing decisions. Stated differently, SET, and the TRA and the TPB, regard health behaviours as having the same proximal determinants as other kinds of behaviour. Thus, they offer the potential benefit of parsimony.

Stage Models

Stage models use similar concepts to social cognition models but organize them in a different way. They are fundamentally different in structure from social cognition models (Weinstein et al. 1998). According to this approach, behaviour change involves movement through a sequence of discrete, qualitatively distinct, stages. Different factors are assumed to be important at different stages. Hence, people in different stages are assumed to require different interventions to encourage or help them to move to the next stage in the sequence.

Current models of health behaviour that incorporate stage assumptions include: the transtheoretical model (TTM; Prochaska et al. 1992) and variants of it (*e.g.*, De Vries and Mudde 1998), the precaution adoption process model (Weinstein and Sandman 1992), the health action process approach (Schwarzer and Fuchs 1996), and the health behaviour goal model (Gebhardt 1997). This section focuses on the TTM because it is the dominant model in the field.

The TTM developed from studies of the processes of change in psychotherapy and smoking cessation. Smoking still accounts for the majority of applications of the model but it has been applied to a wide range of other health behaviours, including condom use, exercise, sunscreen use, and healthy eating (Prochaska and Velicer 1997). Although it is often referred to simply as the stages of change model, the TTM includes 15 different theoretical constructs drawn from different theories of behaviour change. These include the stages of change

(which provide the basic organizing principle), the 10 processes of change, the perceived pros and cons of changing, and self-efficacy and temptation. The TTM was an attempt to integrate these different constructs in a single comprehensive framework—hence the name transtheoretical.

The version of the TTM used most widely in recent years specifies five stages : precontemplation, contemplation, preparation, action, and maintenance (DiClemente et al. 1991). Table 1 gives the operational definitions of the stages as applied to smoking cessation. Using a 'staging algorithm,' participants are classified into stages on the basis of their responses to a small number of questionnaire items. The first three categories contain the current smokers, the remaining two the ex-smokers; people who have never smoked are not represented in this scheme. Precontemplation, contemplation, and preparation are defined in terms of current intentions and past behaviour (whether or not the person has made a 24h quit attempt in the past year), whereas action and maintenance are defined purely in terms of behaviour; ex-smokers' intentions are not taken into account.

Table 1. Stage definitions (from DiClemente et al. 1991)

Precontemplation — Currently smoking and 'not seriously considering quitting within the next 6 months'.

Contemplation — Currently smoking and 'seriously considering quitting within the next 6 months'; 'were not considering quitting within the next 30 days, had not made a quit attempt of 24h in the past year, or both'.

Preparation — Currently smoking, 'were seriously considering quitting in the next 6 months and were planning to quit within the next 30 days,' and 'had made a 24h quit attempt in the past year'.

Action — Currently not smoking; quit in last 6 months.

Maintenance — Currently not smoking; quit >6 months ago.

Prochaska et al. (1992) represented the stages of change as a spiral. People start at the bottom in precontemplation. They then move through the stages in order (contemplation, preparation, action, maintenance) but may relapse to an earlier stage. They may cycle and recycle through the stages several times before achieving successful long-term behaviour change.

Of the other constructs in the TTM, the 10 processes of change refer to the things that people think and do to help them move through the stages, the pros and cons are the perceived advantages and disadvantages of changing, self-efficacy is borrowed from Bandura's social cognitive theory, and temptation is a related concept that refers to the degree to which a person expects to feel tempted to lapse in different situations.

The TTM is popular among clinicians and practitioners and there is a large body of evidence which is interpreted by its proponents as supporting the model. However, a closer examination of this literature reveals a number of serious problems with the TTM itself and with much of the research based on it (Sutton 2000). These problems include : lack of standardization of measures, particularly of the central construct of stages of change; logical flaws in current staging algorithms; inadequate specification of the causal relationships among the different constructs; misinterpretation of cross-sectional data on stages of change; and confusion concerning the nature of stage models and how they should be tested.

It is unfortunate that the model that has dominated the field to date is surrounded by a 'thicket of problems,' to use Bandura's (1997) phrase. The notion that behavior change involves movement through a sequence of qualitative stages is an important idea that deserves further consideration. Health behaviour researchers should turn their attention to the other stage models that have been proposed.

4.4 SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.

Responding to increasing concern about these persisting and widening inequities, WHO established the Commission on Social Determinants of Health (CSDH) in 2005 to provide advice on how to reduce them. The Commission's final report was launched in August 2008, and contained three overarching recommendations :

1. Improve daily living conditions,
2. Tackle the inequitable distribution of power, money, and resources,
3. Measure and understand the problem and assess the impact of action.

Improve Daily Living Conditions

Equity from the Start

At least 200 million children globally are not achieving their full potential. This has huge implications for their health and for society at large. Investment in early years provides one of the greatest potentials to reduce health inequities. The Commission calls for :

- an interagency mechanism to be set up to ensure policy coherence for early child development;

- a comprehensive package of quality programmes for all children, mothers and caregivers; and
- the provision of quality compulsory primary and secondary education for all children.

Healthy Places, Healthy People

Where we live affects our health and chances of living flourishing lives. Last year saw, for the first time, the majority of human beings living in urban settings. Almost 1 billion live in slums. The daily conditions in which people live have a strong influence on health equity. Access to quality housing and clean water and sanitation are human rights. The Commission calls for :

- greater availability of affordable housing by investing in urban slum upgrading including, as a priority, provision of water, sanitation and electricity;
- healthy and safe behaviours to be promoted equitably, including promotion of physical activity, encouraging healthy eating and reducing violence and crime through good environmental design and regulatory controls, including control of alcohol outlets;
- sustained investment in rural development; and
- economic and social policy responses to climate change and other environmental degradation that take into account health equity.

Fair Employment and Decent Work

Employment and working conditions have powerful effects on health equity. When these are good, they can provide financial security, social status, personal development, social relations and self-esteem, and protection from physical and psychosocial illness. The Commission calls for :

- full and fair employment and decent work, to be a central goal of national and international social and economic policy-making;
- economic and social policies that ensure secure work for men and women with a living wage that takes into account the real and current cost of healthy living;
- all workers to be protected through international core labour standards and policies; and
- improved working conditions for all workers.

Social Protection Throughout Life

Everyone needs social protection throughout their lives, as young children, in working life, and in old age. People also need protection in case of specific shocks, such as illness, disability, and loss of income or work. Four out of five people worldwide lack the back-up of basic social security coverage. Extending

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social protection to all people, within countries and globally, will be a major step towards achieving health equity within a generation. The Commission calls for :

- establishing and strengthening universal comprehensive social protection policies;
- ensuring social protection systems include those who are in precarious work, including informal work and household or care work.

Universal Health Care

Access to and utilization of health care is vital to good and equitable health. Without healthcare, many of the opportunities for fundamental health improvement are lost. Upwards of 100 million people are pushed into poverty each year through catastrophic household health costs. The Commission calls for:

- healthcare systems to be based on principles of equity, disease prevention, and health promotion with universal coverage, focusing on primary health care, regardless of ability to pay.

Tackle the Inequitable Distribution of Power, Money, and Resources

Inequity in the conditions of daily living is shaped by deeper social structures and processes. The inequity is systematic, produced by social norms, policies and practices, and practices that tolerate or actually promote unfair distribution of and access to power, wealth and other necessary social resources. The Commission calls for :

- health equity to become a marker of government performance;
- national capacity for progressive taxation to be built;
- existing commitments to be honoured by increasing global aid to 0.7% of GDP;
- health equity impact assessments of major global, regional and bilateral economic agreements;
- strengthening of public sector leadership in the provision of essential health-related goods/services and control of health damaging commodities;
- gender equity to be promoted through enforced legislation;
- a gender equity unit to be created and financed;
- the economic contribution of housework, care work, and voluntary work to be included in national accounts;
- all groups in society to be empowered through fair representation in decision-making;
- civil society to be enabled to organize and act in a manner that promotes and realizes the political and social rights affecting health equity;

- the UN to adopt health equity as a core global development goal and use a social determinants of health framework to monitor progress.

Measure and Understand the Problem and Assess the Impact of Action

Action on the social determinants of health will be more effective if basic data systems, including vital registration and routine monitoring of health inequity and the social determinants of health, are put in place so that more effective policies, systems and programmes can be developed. Education and training for relevant professionals is vital.

Who should be doing what?

While the Commission advocates strongly the central role of government and the public sector in taking action, it also recognises the need for support and action across the field – global institutions and agencies, governments themselves (national and local), civil society, research and academic communities, and the private sector.

Multilateral Agencies

The Commission calls for coherence between sectors in policy-making and action to achieve improvements in health equity. The Commission calls on multilateral specialist and financing agencies to :

- adopt health equity as a fundamental shared goal, and use a common global framework of indicators to monitor development progress;
- ensure that increases in aid and debt relief support coherent social determinants of health policy-making and action among recipient governments;
- support equitable participation of Member States and other stakeholders in global policy-making. adopt health equity as a fundamental shared goal, and use a common global framework of indicators to monitor development progress;
- ensure that increases in aid and debt relief support coherent social determinants of health policy-making and action among recipient governments;
- support equitable participation of Member States and other stakeholders in global policy-making.

WHO

WHO is the mandated leader in global health. It is time that WHO's leadership role is enhanced through the agenda for action on the social determinants of health and global health equity. The Commission calls on WHO to :

- adopt a stewardship role supporting social determinants of health capacity-building and policy coherence across partner agencies in the multilateral system;
- support goal setting on health equity and monitor progress on health equity between and within countries as a core developmental objective through a global health equity surveillance system;
- build internal social determinants of health capacity across WHO.

National and Local Government

Underpinning action on the social determinants of health and health equity is an empowered public sector, based on principles of justice, participation, and collaboration. Actions include: policy coherence across government; strengthening action for equity and finance; and measurement, evaluation, and training

Civil Society

Civil society can play an important role in action on the social determinants of health. Actions include: participation in policy, planning and programmes; and evaluation and monitoring of performance.

Private Sector

The private sector has a profound impact on health and well-being. Actions include: strengthening accountability; and investing in research

Research Institutions

Knowledge – of what the health situation is; of what can be done about it; and of what works effectively to alter health inequity – is at the heart of the Commission. Actions include: generating and disseminating evidence on the social determinants of health.

4.5 HOSPITAL SOCIOLOGY — HEALTH INSTITUTIONS AND HEALTHCARE

Health institutions are healthcare organizations that have set goals. Healthcare institutions vary to one or other degree both in structure and functions across cultures; they include organizations like the hospitals, basic health centres, maternity centres, pharmacies etc. These vary in scope, size and function. The levels of healthcare institutions are not the same but each of them to one degree or the other provides some form of care to the patients.

Definitions of Health Institutions

Health institutions can be defined as healthcare organizations. Health institutions can be classified into two – the public and the private. In Nigeria, the two operate as parallel organization, each having its own proprietors. The public-

oriented health institutions are organized under the auspices of the federal and state ministries of health as well as the local government authorities.

Development and Functions of the Hospital

The hospital developed in response to the needs, values, attitudes and aspirations of the societies they serve. Historically, hospitals have passed through four distinct phases or stages of development. Cockerham (1982) has highlighted these stages as :

i. centres of religious practice,

ii. poor house,

iii. death houses, and

iv. centers of medical technology.

The origin of the hospital as a healthcare organization is usually associated with the rise of Christianity. It was part of Christian theology that spiritual salvation could be obtained by providers of care to the sick and needy. When religious institutions were relieved of their control of hospital in Europe, the hospitals were left 'loose' under many separate administrations. This led to gross abuse, lowering of standard and misappropriation of funds. The poor became major victims.

After the Renaissance and the Reformations, there was still much to be desired in public hospitals with respect to their potentials to provide welfare services for the poor. Towards the 14th Century however in Europe, physicians started to associate themselves with hospitals as they now saw themselves as major stakeholders in the administration of healthcare services. Even up to the 18th Century, hospitals were regarded as death houses because typically, hospitals were dirty, poorly ventilated and congested.

Hospitals as centers of medical technology became a new phenomenon since the end of the 19th Century. This new image of hospitals has been attributed to the improvement in the quality of medical care:

One major factor for this change was the fact that medicine had become a science in terms of employing the scientific method for the acquisition of accurate medical knowledge. Also, the discovery and use of antiseptic measures in the hospitals to help curtail infection has been a good development. There has also been a significant development in the quality of hospitals personnel in modern times, not only in Euro-American societies, but also in many developing economies of the world.

Types of Hospital

Hospitals can be categorized into the tertiary, secondary, primary and comprehensive. A tertiary healthcare institution, among others performs functions

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that include research and teaching. The secondary is next and is superior in hierarchy to a Primary Healthcare (PHC) scheme. Comprehensive health institutions are mainly for ambulatory care. They are cottage, or district health centres.

Functions of the Hospital

Hospitals perform the functions of :

i. Providing service (care) for the sick;

ii. Teaching and research;

iii. Support for the health system;

iv. Performing societal duties which may be related to state legitimacy or political authority;

v. Serving as the base for medical power; and

vi. Providing employment opportunities.

Hospitals-Patient Role

The occupational growth in the hospitals setting and those who perform most healthcare tasks in the hospital wards are the nurses and auxiliary nursing worker. Nurses are responsible to the physicians for carrying out the physicians' orders. Nurses however, are also responsible to the nursing supervisors and other superiors in hospital administration.

It is common place to note that hospital services are mainly oriented towards supporting patient welfare. It is known also that hospital rules and regulations are generally designed for the benefit of hospital personnel in order that patients can be more efficiently taken care of. Usually, the sick and the injured are categorized into various classes such as obstetrics, neurology, orthopaedics, urology, paediatrics, psychiatric, etc. It has been observed an improved patient care can result in increased organizational efficiency and that this ultimately serves the interest of the patient.

The Concept of the Sick Role

The concept of the sick role represents the most consistent approach to explaining the behavioural pattern of sick people. According to Talcott Parsons (1951), being sick is not a deliberate choice of the sick person even though illness may occur due to exposure to infection or injury. The sick person usually is unable to take care of himself, and this is why it is necessary for him to seek medical advice and cooperate with medical experts.

THE SPECIFIC ASPECTS OR ATTRIBUTES OF THE SICK ROLE

The specific aspects of the sick role include the following :

i. The sick person is exempt from "normal" social roles. The sick has an exemption from normal role performance and social responsibilities because of the state of his health. Usually, in many societies the more severe the illness, the greater the exemption.

ii. The sick person is not responsible for his or her condition. A sick person's illness is assumed to be beyond his or her own control.

iii. The sick person should try to get well. Since being sick is an undesirable condition, the sick individual must have the desire to regain normal health.

iv. The sick person should seek medical advice and cooperate with medical experts. The desire to get well by the sick person must inevitably lead to his being desirous to cooperate with the physician and other health workers.

THE PATIENT-PHYSICIAN ROLE RELATIONSHIP

The Patient-Physician role involves mutual relations between two parties. The patient is on one side of the party and the physician on the other. Each participant in the social situation is expected to be familiar with his expectation as well as the expectation of the others in the same social situation. The patient usually has a conception of what a physician is in terms of the social role. Also the patient is expected to recognize the fact that being sick is undesirable and that he has an obligation to get well by seeking the physician's help. The physician in turn has an obligation to return the sick person to his/her normal state of functioning. In a nutshell, the patient-physician relationship involves mutuality as a kind of behavioural expectation. The patient-physician relationship is intended to serve some therapeutic functions in most societies and promote some significant change in the health of the patient.

THE PROCESS AND THE NEED FOR THE SICK TO SEEK MEDICAL CARE

In the previous section we saw the need for the patient to seek medical care. Reasons for seeking medical help and advice by the sick include that :

i. illness is an undesirable state;

ii. illness and disease obstruct normal social functioning;

iii. illness is a kind of grievance;

iv. illness reduces human potentials, and capabilities; and

v. in most societies, illness brings stigmatization on its victims.

It is not yet fully known the exact processes involved in making decision to obtain medical care, however, research findings have revealed some social factors

which tend to encourage or discourage a person from seeking medical care. These factors include socio-demographic variables including age and sex, ethnicity, economic status and education.

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Age and Sex

Findings from epidemiological studies have shown that in many societies, the use of health service is greater for female than male and is greatest for the elderly.

Ethnicity

Several studies in medical sociology have tried to relate a person's utilization of healthcare services to his/her cultural background. Some studies in the Western World have revealed the interplay of group relationship with an individual personal orientation toward medicine and their health-seeking behaviour.

Economic Status

Some cross-structural studies in medical sociology have also established a correlation between help-seeking behaviour and socio economic status. There is an assumption that lower class person tend to underutilize health service because of financial cost and/or a sub culture of poverty.

Education

There are studies that have confirmed the positive correlation between education and healthcare services utilization. In most developing countries; many people through ignorance and low level of awareness tend to underutilize health services even when they can afford the cost.

The Development of Nursing as an Occupation

In some advanced societies like the United States, the licensed registered nurse rank second in status only to the physician as a health provider. Males have been known historically to perform nursing tasks but the social role of the nurse has been profoundly affected by its identification with traditionally feminine functions (Davis 1966, Strauss 1966). As a result of the rise of Christianity in the Western world, the practice of nursing as a formal occupation was significantly influenced by the presence of large numbers of nuns who performed nursing services under the auspices of the Roman Catholic Church (Cockerharm, 1982). Before the 19th Century, hospitals were mostly regarded as places for the poor and lower social classes. Patients who could afford it were usually cared for at home. Nursing activities therefore, were viewed as acts of charity since they were usually done under difficult and unpleasant situations. Nursing as at this time was regarded by the church as a means by which those persons providing the services could obtain salvation as they were regarded as people helping the less fortunate.

The original concept of nursing therefore was not as a formal occupation, with its own body of knowledge and specialized training procedure. Even then in the 19th Century in many nations, nursing could be described as an activity for women who lack specialized training in medical care. Besides, nursing was not an occupation held in high esteem by the general public. However, the role of nursing in Western society began to change in the middle of the 19th Century through the effort of Florence Nightingale. She was an English Protestant from a respectable middle class family who established a hospital in England in 1853 for "Sick Gentlewomen in "Distress Circumstances." Nightingale staffed the hospital with trained nurses. Till date, this lady's role has continued to influence the traditional social roles of the nurse as a female supervised and controlled by a male physician.

Nursing Education

The first accredited nursing schools in the United States were established on the bases of Florence Nightingale's ideas. It should be noted that many of the students in the early nursing schools did not receive the training which Nightingale had required. Nursing students were merely used as exploitable sources of hospital labour up to the first decades of the 20th Century.

Unlike medical schools, which follow a prescribed and generally similar programme for education, nursing was exposed to a curious assortment of different types of educational experiences. In Nigeria, nursing education has greatly improved in the past two decades especially for the priority being given to Primary Healthcare (PHC). Nurses now undergo specialist training in surgery, psychiatry, community health, etc. The advent of many teaching and specialist Hospitals, to which many of these nursing schools are affiliated makes nursing to be relatively more esteemed than it used to be among the paramedical occupations.

The Doctor-Nurse Relationship

Nursing like the other paramedical professions occupies a subordinate position in the hospital. And the technical knowledge employed by the nurses tends to be developed and approved by the physicians. This background explains in part why nurses appear powerless and dependent practitioners. It is believed by some scholars that nurses see themselves as victims in most power struggles with the medical structure. There is also a kind of inferiority complex on the part of most nurses. Obedience to the physician is an emphasized slogan in nursing tradition. Nurses often feel cheated and marginalized by the doctor. There is today a trend of "suspicion" between the two players in the health industry even though the central rule of the game is to avoid open confrontation. The doctor-nurse game has both pleasant and unpleasant consequences for healthcare delivery in

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any society. When nurses play the game well, they put up some pretence, giving total allegiance, albeit superficial, to the doctors. Otherwise they are relegated to the background in the social life of the hospital.

Other Health Practitioners

Other health practitioners apart from the physicians are nurses, pharmacists, laboratory technicians, physical therapists, health technologists, social workers, etc. These are known as paramedical occupations. It has been pointed out in some studies that the physician is like an autocrat and this is why he does not enjoy a good reputation with his co-workers. Whereas, health matters can only be tackled through a collaborative approach by all the health workers, it is argued that the doctor tends to regard other health personnel as working for him rather than working for the patient. He also regards others health officers as non-professionals and servants rather than as associates or colleagues (McGraw, 1966). In traditional Africa, the physician is facing a stiff competition by traditional health practitioners who tend to enjoy a relatively higher level of confidence of patients than their orthodox counterparts.

4.6 CHANNELS OF HEALTHCARE

There is usually a hierarchy in pathways to healthcare in every society. Illness is acted upon when it becomes a discomfort to the individual. The channels for receiving healthcare tend to vary from one society to another. There are specific healthcare organizations in all known human societies that are charged with the responsibility of providing healthcare for the citizenry.

Healthcare Organizations

Healthcare Organizations, weather in advanced or developing nations can be classified into two : the public and private. In advanced economies where there is an elaborate national health system, the two are inter-twined or interrelated in their operation or functions and not as parallel system.

The Need for Seeking Medical Care

To the extent that illness and disease are health burdens while treating the normal functioning of the body system, it becomes crucial therefore, for the sick individuals to seek medical care and in good time. Illness militates against the performance of one social role and disability and discomfort and therefore, can become worrisome. Although, factors such as cost of medical bills, proximity to health facilities, and accessibility to health facilities and personnel can create major obstacles for patient's seeking medical care, effort should be intensified to overcome these challenges because "health is wealth."

Levels of Healthcare

There are three main levels of healthcare, namely the tertiary, secondary and comprehensive (primary). A tertiary healthcare institution performs several functions which include research and teaching e.g., teaching and specialist hospitals.

The secondary is next and it performs services that are next to those being performed by the tertiary ones. These institutions provide medical, surgical or the psychiatric care for the sick (Erinosho, 2005). The comprehensive or primary healthcare institution is of a lower order. These institutions are mainly for ambulatory care. They are sometimes described as comprehensive, cottage or community health institutions. Patients, through a well defined referral network can have access to health facilities and services at any of the healthcare levels.

Channels for Receiving Healthcare Services

There is a hierarchy in the pathway to healthcare in any society. In western societies, the practice of obtaining health services oscillates between the private and the public health system. The two are off-shoots of orthodox medicine. In Africa south of the Sahara, this is a bit different. A good number of patients tend to utilise the services of traditional healers before seeking help from western-style health workers and facilities. Next to this is, the services of western-style care agents such as specialist practitioners, patent medicine sellers and pharmacists. Quite often, there is a simultaneous use of both modern and traditional medicine by patients among indigenous Indians.

4.7 CULTURAL FACTORS IN HEALTH AND DISEASES

Culture plays a very important role in health and illness. It can be argued that the health status of a society is a function of the norms and values of that society. Culture and health cannot be separated because each represents, to some extent, different aspects of the same coin.

The Concept of Culture

Culture can be defined as a system of norms, values and customs which is socially learned by members of a group and is transmitted from generation to generation. Culture is the total way of life of a people.

The Relevance of Culture to Health

Culture is relevant to health in many ways. These include :

i. Culture derives from societal practice, norms, and values, health habits inclusive.

ii. Cultural practice can enhance or worsen the health status of a people.

iii. The definition of health and illness of a people can only be understood within their cultural context.

Some Aspects of Indian Culture that are Beneficial to Health

i. Prolonged breast-feeding of babies promotes healthy growth among babies.

ii. Child spacing is a kind of natural family planning.

iii. Prolonged cooking of food prevents food contamination and destroys deadly bacterial.

Some Aspects of Indian Culture that are not Beneficial to Health

i. the practice of female genital mutilation;

ii. the practice of widowhood rites;

iii. food taboos (*e.g.*, eating of nutritious items like egg and protein)

iv. child marriage;

v. child labour and child abuse; and

vi. Cross-coursing marriage among some ethnic groups, a kind of in-breeding which contributes to congenital malformations.

4.8 POLITICS AND HEALTHCARE

Sometimes we decry the interference of politics in health matters. The assumption is that only scientific and humane considerations should determine health policy. However, in reality, there is the pre-eminence of politics in policy formulation, in general, and in healthcare system, in particular. In health planning, the influence of politics in health is well recognized as it leads to a better understanding of the healthcare problems. The World Health Organization (WHO), through its declaration on Primary healthcare (PHC) had insisted that there is need for strong political will and support at national and community levels so as to enhance healthcare planning and management (WHO/UNICEF, 1978).

Definitions of Health and Politics

'Health, according to the World Health Organization (WHO), is a state of "complete physical, mental and social well-being and not merely the absence of disease or infirmity". With this definition we know that there is a close relationship between women activities and the level of health and there is an interdependence of physical and social factors.

Politics has been defined as the "authoritative allocation of values through the use of legitimate power, authority and rules (Easton, 1965, Dahl, 1970). Politics, according to Lasswell (1958) relates to the question of who gets what, when and how.

Policy however, means "the projected programme of goal, values and practices" (Lasswell and Kaplan, 1950).

Relationship between Politics and Healthcare Delivery

The relationship between politics and healthcare delivery includes the fact that :

i. there is a heavy political influence in community mobilization and involvement in healthcare;

ii. politics is sometimes involved in the location of health facilities;

iii. political forces do affect the health programming and planning;and

iv. the conception and definition of health is usually moulded by the existing political culture.

4.9 ETIOLOGY

Etiology is the study of causes. A number of disciplines utilize etiology, ranging from anthropology to physics, but it is most commonly associated with the medical world. In medical research, understanding the origins and causes of medical conditions is extremely important, because etiology can be used to provide clues into methods of treatment which might be effective.

This word comes from the Greek aitia, which means "cause." Outside of the United States, it is usually spelled as "aetiology," rather than "etiology," and sometimes as "aitiology." These alternate spellings are primarily a matter of personal preference; people who are familiar with one spelling can easily understand an alternate spelling, especially in context. This word has been used in English since 1555, borrowed from the Greek.

In the case of an individual patient, understanding etiology can be extremely important, as it may provide a vital piece of the puzzle when it comes to treating a condition. When a cause cannot be determined, the disease is said to be "idiopathic," meaning that it has no known etiology. Idiopathic conditions can be very frustrating for physicians and patients alike, as the lack of an etiology can make it difficult to pin down the precise nature of a disease

Medical researchers, especially those who respond to epidemics, also rely heavily on etiology. When a disease outbreak occurs, the more quickly the etiology can be determined, the more quickly it can be brought under control, because the factor which creates the disease can be eliminated, controlled, or avoided. For instance, when a large bunch of cases of food borne illness are reported, a database is constructed to compare the patients, looking for the common denominator so that a batch of tainted food can be recalled and destroyed.

The study of etiology is quite ancient. Ancient China, Greece, and Rome all had individuals who examined the nature of disease, although many of them

drew erroneous conclusions. Many people date the serious study of etiology to the Muslim world, where physicians first started to draw conclusions about the spread of epidemics, and the need for controlled clean conditions in outbreaks to prevent the spread of disease.

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Medicine

In medicine, the term "etiology" refers to the causes of diseases or pathologies. The medical study of etiology in medicine dates back to Muslim physicians in the medieval Islamic world, who discovered the contagious nature of infectious diseases such as scabies, tuberculosis and sexually transmitted disease. In Ibn Sena's (Avicenna) text, The Canon of Medicine, he discovered that many infectious diseases are caused by contagion that can spread through bodily contact or through water and soil. He also stated that bodily secretion is contaminated by foul foreign earthly bodies before being infected.

Ibn Zuhr (Avenzoar) was the first Muslim physician to provide a scientific etiology for the inflammatory diseases of the ear, and the first to clearly discuss the causes of stridor. Through his dissections, he proved that the skin disease scabies was caused by a parasite, a discovery which upset the Galenic theory of humorism, and he was able to successfully remove the parasite from a patient's body without any purging or bleeding.

When the Black Death (bubonic plague) reached al-Andalus (Spain) in the fourteenth century, Ibn Khatima posited that infectious diseases are caused by microorganisms which enter the human body. Another Andalusian physician, Ibn al-Khatib (1313-1374), wrote a treatise called On the Plague, stating that contagion can spread through garments, vessels and earrings.

Etiological discovery in medicine has a history in Robert Koch's demonstration that the tubercle bacillus (Mycobacterium tuberculosis complex) causes the disease tuberculosis, Bacillus anthracis causes anthrax, and Vibrio cholerae causes cholera. This line of thinking and evidence is summarized in Koch's postulates. However, proof of causation in infectious diseases is limited to individual cases that provide experimental evidence of etiology.

In epidemiology, several lines of evidence together are required to infer causation. Sir Austin Bradford-Hill demonstrated a causal relationship between smoking and lung cancer, and summarized the line of reasoning in the epidemiological criteria for causation. Dr. Al Evans, a US epidemiologist, synthesized his predecessors' ideas in proposing the Unified Concept of Causation.

Further thinking in epidemiology was required to distinguish causation from association or statistical correlation. Events may occur together simply due to chance, bias or confounding, instead of one event being caused by the other. It is also important to know which event is the cause. Experimental evidence,

involving interventions (providing or removing the supposed cause), gives the most compelling evidence of etiology.

Etiology is sometimes a part of a chain of causation. An etiological agent of disease may require an independent co-factor, and be subject to a promoter (increases expression) to cause disease. An example of the above, which was recognized late, is that peptic ulcer disease may be induced by stress, requires the presence of acid secretion in the stomach, and has primary etiology in Helicobacter pylori infection. Many chronic diseases of unknown cause may be studied in this framework to explain multiple epidemiological associations or risk factors which may or may not be causally related, and to seek the actual etiology.

4.10 ENVIRONMENTAL SANITATION AND HEALTH

Environmental sanitation involves controlling the aspects of waste management that may lead to the transmission of disease. Included in the term waste management are water, solid waste, and industrial waste. Environmental sanitation also covers the topic of pollution.

The environmental conditions in a given area may be affected by waste disposal. Methods of waste disposal often vary based on living conditions and the accepted standard of living in a geographical area. While some countries provide wastewater treatment and trash collection, other countries may not have these systems in place to control environmental hygiene. When waste is not removed and treated properly, pollution may lead to the spread of disease.

According to the World Health Organization (WHO), there are three areas that must be reviewed in order for environmental sanitation to be effective. These are water supply, sanitation, and hygiene education. The WHO currently offers guidelines on implementing environmental hygiene programmes to improve overall health.

The water supply can play a huge part in pollution and the spread of disease. The most common sources of water include rainwater, surface water, and groundwater. Groundwater can be the least threatening of all potable water. The sources of groundwater, usually wells and springs, are often untainted by waste disposal. Rainwater and surface water, on the other hand, are often considered the least potable, and in need of water treatment before human consumption.

The most threatening source of water is often surface water. If waste is not disposed of properly, it can mix with water on the ground that may be collected for drinking and cooking. Contamination can be caused by household trash and human waste. The consumption of tainted water can lead to new disease outbreaks and the spread of current outbreaks.

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Environmental sanitation is not limited to the pollution of water and improper disposal of waste. When factories or businesses dispose of chemical and physical waste in ways that directly affect the water supply, it is often referred to as industrial pollution. While the actual dumping site may occur several miles away from the main source of water, drainage and rainfall can cause the chemicals and physical waste to mix with the water supply. Water treatment plants may not be able to remove certain chemicals and waste products from water, which can lead to the spread of diseases. Many waste disposal and water treatment plants are established to address and insure environmental sanitation. When proper disposal and treatment methods are followed, disease and pollution can be reduced.

4.11 HEALTH, HYGIENE AND DISEASES

You must have heard the saying 'health is wealth'. Most of you must be in good health. If you keep good health your parents may not have to worry about your health. Health is of prime concern for individuals as well as for the community at large. Good health requires certain efforts and cannot be purchased. In this section we will discuss the characteristics of good health and the various factors that help to maintain it. Cleanliness inside and outside the house, along with proper sanitation helps in keeping the environment disease free. Knowledge of first aid can be of great help in saving a victim's life in case of an emergency.

Health and Hygiene

What is good health? Different people may consider good health differently. But to define it formally, **health is a state of complete physical, mental and social well-being.** We take health as being free from diseases but it is much more than just the absence of a disease. Good health may enable us to do well at work and in life. Good health involves proper functioning of all body organs. It also involves feeling well both in body and in mind. People enjoying good health are cheerful, free from stress, and enjoy life to the fullest. Only if you are in good health you can be of help to others and the community.

Do you consider yourself to be in good health by the above-mentioned definition? To keep ourselves free from diseases and to have good health, we should be careful about hygiene. **The various practices that help in maintaining good health are called hygiene.** The word hygiene comes from a Greek word *hygiea* that means *'Goddess for health'* and deals with personal and community health. **Thus, health and hygiene go hand in hand or they are interrelated.**

Proper nutrition, physical exercise, rest and sleep, cleanliness, and medical care are essential parts of maintaining good health. Health includes both **personal and community health.**

PERSONAL HEALTH

Taking care of oneself to remain healthy and free from diseases is personal health. Some important aspects of good personal health are as follows :

1. Balanced diet: Obtaining a balanced diet depends on one's choice and what one can usually afford. It also includes the correct proportion of carbohydrates, proteins, vitamins, minerals and roughage in your diet.

2. Personal hygiene: There are some activities you perform everyday in order to keep yourself clean. Can you list them out? These activities are :

- **Regular toilet habits:** Regular bowel movements keep us free of body wastes generated inside the body.
- **Washing hands before eating:** Having food with dirty hands may make us sick because the dirt in our hand might carry certain diseasecausing germs. We should wash our hands after going to the toilet. Washing hands with soap makes them germ free.
- **Bathing regularly and wearing clean clothes:** Dirt is a place for germs to grow. Bathing regularly keeps your body free of dirt, body lice and germs.
- **Cleaning the teeth:** After eating food, some food particles may remain sticking to your teeth. These food particles form a medium for the germs to grow, harm your gums and teeth, and cause bad breath. Brushing of teeth every day do not let the germs grow. Brushing of teeth before going to bed is a very good habit.
- **Washing hair, cleaning eyes, ears and nails:** Regular washing and combing of hair helps in preventing dirt accumulation to keep the germs away. Nails should be clipped regularly; nail biting is unhygienic and must be avoided.

3. Domestic hygiene

- House should be kept clean and free from dirt, flies and germs.
- Cooking utensils, plates, cups and other utensils should be kept clean.

4. Clean food and water

- Fruits and vegetables should be washed in clean water to make them free from germs and pesticides (chemicals sprayed on plants to keep them insect free) before consumption and cooking.
- Water used for drinking, cooking, bathing and washing utensils should be from a clean source.

5. Cooking with care: Food should be prepared in a clean kitchen and in a clean manner.

- While cooking food, it is important to heat it to high temperature to kill any germs present in it.
- Cooked food should be eaten fresh or stored in cool, fly-proof place.
- Milk stored in the refrigerator or outside should be boiled again to make it germ free.

6. Abstaining from habit-forming substances: To keep healthy, one should avoid smoking, chewing of betel nut; gutka and tobacco, and drinking alcohol. Intake of such habit-forming substances may lead to health problems such as liver damage, kidney failure and heart failure.

7. **Exercise:** Regular walking and physical exercises have a good effect on health. Outdoor games and sport maintain the heart and circulatory system in good condition. Walking keeps the joints of bones healthy.

8. **Regular sleep and relaxation:** These also play an important part in maintaining sound mental health. They also help in the repair of body tissues.

Community Health

> Activities, undertaken at the Government or local organisation level to maintain health of the people (for controlling diseases) are known as community health.

We often read in the newspaper or see on television about the fast spread of certain diseases in a particular area. Many people seem to get affected. This may not be an individual problem, but the problem of community and requires immediate attention. Local or government organisations may take steps to control spreading of a disease, by creating awareness and ensuring adequate supplies of medicines. You must have seen notices and banners put up by the government agencies stating the date and time of immunization programmes and the precautions to be taken against different diseases. Such awareness is regularly created through nationwide campaigns against the spread of diseases such as malaria, dengue, AIDS, polio, leprosy, and Hepatitis B.

There are several organisations working towards good community health. Some of these are listed below.

1. Government hospitals, and dispensaries
2. The National Malaria Eradication (removal) Programme
3. The Tuberculosis (T. B.) Eradication Programme
4. National Immunization Programme
5. National Pulse Polio Programme

Some of the important tasks, which the community health centres undertake are :

- To maintain proper cleanliness by ***disposing off the sewage*** *from colonies.*
- To provide safe and **germ free drinking water.**
- To run various **immunization** (vaccination against various diseases) programmes and other health awareness programmes wherever there is danger of spreading of a disease.
- To provide **health education.**
- To spray insecticides to kill harmful insects.
- To maintain food standards, regular inspection at food stores, meat and milk outlets.
- To prevent mosquito breeding, cover open drains and pour kerosene oil on the surface of stagnant water.

Environmental Hygiene

You can keep your body clean but what will happen if you live in dirty surroundings? If so, you are sure to fall sick. Thus, to have a healthy living one must live in clean surroundings. Unclean surroundings may become breeding ground for flies and germs, thus, leading to spread of diseases.

> Environmental hygiene includes environmental sanitation or keeping the surroundings clean.

To keep the environment healthy, we should be careful about the disposal of the garbage. Some of the practices for disposing the garbage are :

- **Keeping the house clean:** The house must be cleaned every day. We must sweep and mop the house to remove dirt from every nook and corner of the house. The furniture must also be wiped clean. The cobwebs from the walls and roof should be cleared at least once a week.
- **Throwing garbage in dustbins:** Do not throw your household garbage on the roadside. This makes street dirty and allows flies, mosquitoes and other animals to breed. This garbage not only gives a dirty look but also produces foul smell. Garbage should be thrown inside the dustbins. The bins should also be cleaned after emptying the garbage.
- **Keeping dustbins covered:** To prevent entry of insects and other animals inside the house dustbins should be kept covered.

Disease

> A disease is defined as any deviation from health or any state when body is not at ease.

Disease may be the sickness of the body or the mind. A disease can be as mild as a sore throat, common cold, and stomach upset or as serious as cancer. Disease can strike almost any part of the body and anybody at some stage or the

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other. They can also affect a person's mental and emotional health. In this section we will mainly discuss diseases of the body.

You may have heard of some common diseases or may be you have seen people suffering from some diseases, such as typhoid, malaria, rickets, jaundice, scurvy, common cold, etc. Can these diseases be categorised on some basis? One of the bases could be the cause of the disease. **Diseases that are transmitted through air, water and physical contact or spread through vectors like flies and mosquitoes are termed communicable diseases.**

Diseases

Communicable	*Non-communicable*
• Diseases that spread from infected person to another	• Do not spread from an infected person to another
• Caused by pathogens, such as viruses, bacteria, fungi, protozoa and worms	• Pathogens are not involved
• Some examples are malaria, typhoid, common cold, measles and tuberculosis	• These diseases may be caused due to dietary deficiency (rickets, scurvy, kwashiorkor), genetic defects, hormonal imbalances

Epidemics

Sometimes you would have seen or heard about a disease affecting a large number of people in a small period. **A disease that affects a large population in a particular area is considered to be an epidemic.** Sometimes, cholera takes an epidemic form in our country. Cholera is a bacterial disease and marked by uncontrolled vomiting and diarrhoea. It may affect large number of people, leading to dehydration and death.

What is a communicable disease?

Diseases that spread from one person to another by the entry of athogens are called infectious or transmissible or communicable diseases.

How do communicable diseases spread?

We all know that there are a lot of germs or pathogens (disease causing organisms) in the environment we live in. To carry on their life cycle, the pathogens try to come out of the body of an infected person and reach out to more hosts for their survival. They produce toxins in the host's body which leads to symptoms, such as fever and eruption of rashes, etc. These pathogens may be transferred from one person to another by the following methods.

- Direct method
- Indirect method

Direct method: by contact with the infected person.

Indirect method may include the following :

- **Touching and sharing items used by the infected person:** Using the same towel or sharing a handkerchief or same bed with the patient may also spread diseases.
- **Contaminated food and drink:** Food and drinks may get infected by flies and insects carrying germs.
- **Carriers:** These organisms carry germs from one place to another, for example housefly, cockroach, etc.
- **Vectors:** These are agents that harbour germs but they themselves remain unaffected. For example, animals such as dogs and monkeys, or mosquitoes.
- **Air:** Through droplet method, i.e. coughing and sneezing by the infected person.
- **During blood transfusion** or other equipment such as infected needles.

4.12 SUMMARY

- The term 'social cognition models' is used to refer to a group of similar theories, each of which specifies a small number of cognitive and affective factors ('beliefs and attitudes') as the proximal determinants of behaviour. These models do not deny that behaviour is influenced by many other factors (*e.g.*, social structural, cultural, and personality factors), but they assume that the effects of such distal factors are largely or completely mediated by the proximal factors specified by the model.
- The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.
- Health institutions can be defined as healthcare organizations. Health institutions can be classified into two – the public and the private. The public- oriented health institutions are organized under the auspices of the federal and state ministries of health as well as the local government authorities.
- Etiology is the study of causes. A number of disciplines utilize etiology, ranging from anthropology to physics, but it is most commonly associated

with the medical world. In medical research, understanding the origins and causes of medical conditions is extremely important, because etiology can be used to provide clues into methods of treatment which might be effective.

4.13 REVIEW QUESTIONS

1. Discuss the protection motivation theory of health.
2. What is stage model of health and healthcare?
3. What are the important functions of hospital?
4. Explain the essential aspects of culture-health relationship.
5. What is the need of environmental sanitation?

4.14 FURTHER READINGS

- Abraham, C and Johnston, M (eds.), (1998). Special issue on self-regulation and health. *Psychology and Health*, **13**, pp. 565–766.
- Ajzen, I, (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, **50**, pp. 179–211.
- G Stanley, Jaya Kumar and P Siva Kumar, ***Medical Sociology : Grooming Social Scientists in Medical Field***, Sonali Publications, 2007.
- Dr. Kavin White, ***An Introduction to Sociology of Health and Illness***, Sage Publications, 2nd edition, 2009.
- Erinosho, A.O. (1998). ***Health Sociology***, Ibadan: Bookman Educational and Communication Services.

UNIT – V

SOCIOLOGY OF HEALTH IN INDIA

STRUCTURE

5.1 LEARNING OBJECTIVES

After studying the chapter, students will be able to :

- State the sociological perspective of the development of traditional health system in India and world;
- Explain historical background and development of healthcare system in India;
- Discuss the various trends of development of India's health system;
- Describe the current status and challenges of health sector in India.

5.2 INTRODUCTION

Human life is inherently frâil - from the inevitability of decay and death to that of disease and sickness. Whether following the Parsonian logic or Goffman's model it is called, "assuming a sick role", alleviation of disease and preservation of health, both conditioned by culture, have been a human pursuit since antiquity. Using drugs and diet as remedies for the disruptive episodes in the life process, is

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not something new. It is as old as human existence. The prehistoric humans derived the therapeutic agents from nature, without maligning the environment. The plant kingdom, since the very beginning of human civilization, served as the reservoir of medicine therapeutic agents to restore health. Over time, the need to cover a wider variety of disease patterns and to augment the therapeutic potential of these agents, mineral and animal constituents began to be incorporated into this plant-based medicines. Needless to say, this use of natural resources as therapeutic agents was predicted on a unique belief system encompassing the concepts of health, physical or mental illness, diagnosis, treatment and of prevention. The accumulated knowledge of such health practices and products is a rich cultural heritage common to all human societies, sometimes ignored or unrecognized in a format or institutional sense.

What separates this body of knowledge referred to as "traditional medicine" (TM) for lack of a better term from "modern medicine" is the fact that the latter is anchored in "science", while the former in practical experience. As long as science continued to be narrowly defined, traditional medicine remained largely unnoticed. It took sort of a scientific revolution, a paradigm shift, to draw renewed interest in traditional medicine. Increasingiy, the very validity of this "traditional-modern" dichotomy is being questioned. Traditional medicine differs from the "modern" or "western" medicine not in terms of goals or effects, but in terms of their underlying cultures and historical contexts. Viewed from this perspective, the World Health Organization (1977) noted, "ail medicine is modern in so far as it is satisfactorily directed towards the common goal of providing health care, despite the setting in time, place and culture". This "traditional-modern" dichotomy is also a cultural construct that relates to certain socio-political dynamics. So, a sociological approach is needed to analyze and fully comprehend these socio-political factors.

The present chapter taps on this renewed interest and attempts to explore the nature of traditional medicine in different countries and India in particular, analyzes their differential development and examines some of the policy alternatives in bringing about a harmony between the traditional and the modern systems of medicine.

5.3 TRADITIONAL HEALTH SYSTEMS (INDIA AND WORLD) : A SOCIOLOGICAL PERSPECTIVE

Traditional medicine, its nature, axioms and practices, varies from one country to another, or more precisely, from one culture to another. Even its nature, and that of its practices and products, vary from one place to another depending on the socio-cultural heritage, religious and political identity. From China, India, Indonesia to the African states and the indigenous people throughout the

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Americas, there are a variety of systems that may be termed "Traditional Medicine" - the Ayurvedic, Unani, herbal medicine, etc. Although, as noted earlier, for lack of a better term, these diverse systems are lumped together under the rubric "traditional medicine", the term does not really reflect the fundamental nature of these systems. The term "medicine", for example, tend to emphasize the treatment or curative aspect of these systems, ignoring their preventive aspects. Moreover, the term "medicine" neglects diverse practices that encompass any system of TM. In Pakistan, India or Bangladesh, there is the Unani and Ayurvedic systems of medicine. Chiefly based on remedial agents from plants, the Unani system derived its knowledge from Greece - Unan in Persian. It proudly proclaims Aristotle as its founder, being responsible for registering the therapeutic value of thousands of plants. It has its own theories and principles. Long before the WHO, declaration, the Unani system considered health, not merely in terms of absence of disease, but as a relative "physical, mental, spiritual and social well-being". This system adopts a holistic approach and considers humans to be an integral part of the totality of the environment. Health implies a state of equilibrium among all the constituent elements of the environment. In such an approach, the individual's social, cultural and physical environment, temperaments, constitution, predispositions, as well as diet regimen, food, compatibilities, living habits and mental composure or spiritual beliefs are considered significant in causation and cure of ill health. Such a holistic perspective on human health is perhaps a common link between all traditional medicines prevalent in diverse settings - from the herbalists and shamans in rain forest areas of South America through to the spiritual healers among the Natives in Canada, Australia, the United States and the Latin American countries.

Philosophy, religion and spirit are central to TM found among the indigenous peoples of the Americas. Traditional medicine, in this case, is intricately tied to the belief system. According to a recent study, their belief system "is built upon the concept of a balanced universe made up of energy fields. The world, the environment, the community, the family, and the self are interwoven and move in harmony to each other. The medicine wheel reflects this philosophy. It depicts the circularity of life, of energy never being lost, and of continuous learning and quest for knowledge. It encompasses the teachings, the values, the beliefs, and the social mores of traditional Aboriginal American Indian culture" (Aboriginal Nurses Association of Canada Report, 1993).

Aboriginal Indian culture believes in four components of the self: body (one's physical self), mind (cognitive abilities), emotion (the psychological self), and spirit (spiritual/religious beliefs). These components are intertwined, and for one to be healthy, all these components of the self must be in a state of equilibrium. Good health is God's precious gift; by maintaining good health we are showing

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our appreciation to the creator. And to maintain good health, one must establish a balance between these four elements of the self. If one element is neglected, an imbalance pervades all other elements and, ultimately, affects the self (Malloch, 1989). For good health, one must establish a balanced relationship with oneself, with family, community, the land and the world. In other words, sickness is being perceived as an imbalance which may begin in the physical or the mental realm; or in the emotional or the spiritual realm.

It is important to note that in the indigenous culture, the term medicine is also defined in a much broader sense than in the western tradition. "Medicines include all things that heal. These can be internal to oneself such as laughter, tears, communication; or it can be external such as, words that one hears, behaves or actions or medical remedies and tonics. Placed within this perspective, TM includes what western scientific medicine calls health practices and behaviours, as well as, medical treatments and remedies. Medicines are believed to be gift from the Creator (ANAC Report, 1993).

The Chinese or Vietnamese TM practitioners may differ in vocabulary and formulary from their Pakistani, Bangladeshi or Aboriginal Indian counterparts. However, they all share a remarkably similar philosophy of human health, illness and nature. Yet, it is the underlying culture that makes them different and distinct. It is misleading to say that "some 80% of the people in the developing countries have no health care system at all", as quite a few reports by respected international agencies tend to conclude. "These people depend on their traditional and indigenous health care systems and their healer, practitioners of TM and traditional birth attendants or so-called native midwives are indeed their primary health care workers" (Bannerman, 1981).

This discussion may lead to two conclusions : (1) "traditional medicines are found in all societies throughout all periods of history and predate the rise of modern scientific medicine or allopathy at the beginning of the nineteenth century", and (2) "any culture's TM includes perceptions of health and definitions of illness, beliefs about etiology and appropriate preventive and curative practices, as well as roles for indigenous practitioners who not only treat illness but also act to restore health of individuals and a sense of well-being to the community as a whole. Traditional beliefs and practices do not develop in isolation but are part of an integrated set of social institutions within a cultural system. Consequently, they serve many functions for adherents and are often highly resistant to change even when the cultural tradition itself is no longer viable" (Mathews, 1992).

Differential Evolution: Legacy of Colonialism?

The TM of different countries and cultures vary from one another in respect of level of formal recognition. While in China or in the Indian sub-continent or in

other parts of Asia, TM is fully recognized formally, in most African or South American countries such recognition is largely missing. In the Americas, particularly involving health practices and products of indigenous people, there is little acceptance of even their very existence. Consequently, indigenous knowledge in health is in danger of being lost, unless rigorous efforts are made to preserve them for future generations.

This differential evolution of TM can be traced back to the differential nature of colonialism that countries around the world had to endure. Apart from brutal incursions from imperial Japan, the Chinese belt of Asia remained largely unscat-hed by colonialism. India, Pakistan, Bangladesh, on the other hand, endured almost 200 years of British Raj. Before the British, the Moghuls from Central Asia came to conquer India and settled in and ruled it as rather benevolent rulers. The Moghuls not only brought a rich cultural heritage of their own, but also contributed immensely in further cultural, social and economic development of India. Under the Moghul rule, the Indian traditional medicine (Kabiraji, Ayurvedic, Siddha, etc.) received royal encouragement to flourish. The Unani system came through the Muslims who settled in India during the Moghul rule. Surprisingly, these traditional medicinal systems acquired and retained to this day, a religions orientation - unani by Muslims, while Kabiraji/Ayurvedi by Hindus. In Pakistan or Bangladesh, there is no Hakim (Unani practitioners) who is a Hindu; similarly, there are hardly any Ayurved or Kabiraj who is a Muslim. By the time the British came, these systems were quite developed, with their own schools and formularies. The religio-ethnic groups identified so strongly with one or other of those systems that the British found it difficult to ignore them, even when they were looked upon with disdain. Between 1757 and 1835, the new colonial power largely tolerated the indigenous medical systems, while laying the foundation for the Western medical system. Since 1835, officially at least, the British Raj adopted a policy of regarding Western medicine "as the hallmark of a higher civilization, as a sign of the moral purpose and legitimacy of colonial rule in India, just as indigenous medical ideas and practices could be casually equated with ignorance and barbarism" (Arnold, 1993:57).

Nevertheless, the social, political and geographical reality of India made the British adopt an attitude of benign neglect towards the indigenous medical systems. Quite often, in the interest of political expediency and in following the policy of divide-and rule, the British Raj was almost forced to patronize one or the other TM system from time to time. Consequently, these systems continued to develop along with the newly introduced "western" system of medicine.

Encouragement and support given by post-colonial or, in case of China, post-revolutionary governments also contributed to the continued development of these traditional medical systems in the Indian sub-continent and China. As

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early as in 1955, a few years after the revolution, the Chinese government emphasized the need to promote traditional medicine. Driven by pragmatic reasons, the Chinese government concluded: "We must also fully realize that our ancient cultural heritage is the fruit of the genius and creative labour of the Chinese people, and that many of our contributions to culture are worth preserving and developing... If only we could enlarge the scope of our studies in Chinese medicine, rediscover the hidden treasures in pur ancient science and art of healing, and make them available to the people, great achievements could result" (Chinese Medical Journal, 1955).

In India, Pakistan and Bangladesh, traditional health systems received recognition and state support only after independence. It was in 1962 that Pakistan first enacted the Unani and Ayurvedic Medical Practitioners Act to recognize and regulate these traditional health systems. In India, the Ayurvedic system gained recognition during the 1950s and gradually became a "separate profession". In the Indian subcontinent and China, traditional medical services are available as a routine part of national health services. Practitioners are trained in four or five year degree programmes in separate institutions recognized and regulated by the government. Often TM associations oversee the licensing process and establish and monitor professional standards. In most part of Asia, traditional medical practitioners provide most to the health care services in rural areas, where the overwhelming majority of its population live.

The African countries went through a different kind of colonialism. Labelled as the "Dark continent", it suffered the indignity of slavery, apartheid, most extreme form of repression and oppression. When slaves were not treated as humans, there was no question of providing any respect for their culture. Thus there was least or no respect for their health practices and products. On the contrary, they were repressed, often brutally. In Africa, "colonial governments and early Christian missionaries despised and therefore attempted for many year to discourage the use of traditional medicine", remarked one of the foremost authorities on African traditional health systems, Professor G.L. Chavunduka (1986). "They attempted to suppress the traditional medical system for a number of reasons", wrote Professor Chavunduka. The colonizers "did not know that traditional medicines are effective in curing many illnesses. They believed that the traditional healer was just a rogue and a deceiver who prevented many patients, who would otherwise be treated effectively with modern drugs and surgery, from reaching government and mission hospitals." Their belief that traditional healers encourage witchcraft "which was regarded as one of the greatest hindrances and stumbling blocks in the way of Christian missionary work", also played a role in this policy of suppression. According to Professor Chavunduka there was a powerful economic reason too. "It was the desire on the part of colonial

administrators to force Africans everywhere to depend entirely on medicines produced in western countries. Complete dependence on Western medicine would, of course, benefit Western countries and their pharmaceutical companies. Attempts are still being made to discredit traditional healers for this reason" (Chavunduka, 1986:30).

Unlike their Asian counterparts, the African traditional medicine, therefore, did not enjoy a natural process of evolution and development. It remained undeveloped, neglected and unrecognized. Consequently, African TM stagnated, and often, further degenerated during the long period of colonial rule.

A different type of colonialism prevailed-in the Americas, Australia and New Zealand. In those places, colonialism was physical and permanent. The Aborigines were physically uprooted and annihilated. A new society was created on the ashes of the old. "When the first European arrived in the fifteenth century, Native Americans had already inhabited the continent for some thirty thousand years and numbered several million" (Dobyns, 1966). The European settlement and parallel policy of "replacement of the Natives" were so efficient that "by the early 1800's few Native Americans remained east of the Mississippi river" and "by the beginning of this century, the vanishing Americans numbered only about 250,000 in the United States" (Tyler, 1973). The indigenous population of Mexico, decreased from 2.3 million in 1650 to about one million in 1890's.

Little can be expected of such colonialism. Quite obviously, this brand of colonialism had scant respect for the culture of the vanquished. Health practices and products of the indigenous peoples of the Americas, therefore, remained unrecognized and unexplored. It not only suffered from lack of a natural growth, but also faced the spectre of total extinction along with the annihilation of its adherents. Unlike the African or the Asians, the Natives did not regain independence, but struggled with continued discrimination, segregation and socio-political isolation. Not surprisingly, Native traditional medicine is perhaps one of the most endangered cultural heritage of modern times. Some of the indigenous knowledge is fast disappearing, and is likely to extinct, if not preserved immediately. Preserving and further developing indigenous health practices and products must be regarded as great challenges of our time.

Resurgence of Interest

In the past decade there has been a resurgence of interest and activities in TM both in developing and developed countries. A number of factors contributed to this resurgence of interest. Perhaps, the most important factor is the nationalist spirit that engulfed the developing countries on their independence from the colonial rule. With political independence during 1950s and 1960s, most of these countries experienced a sense of cultural revival. Reviving one's own culture and

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taking pride in it, became a nationalist goal. Nationalist political leaders of this postcolonial era, like India's Nehru, Ghana's Nkrumah, Algeria's Ben Bella, Indonesia's Sukarno, Tanzania's Nyrere, Egypt's Nasser and Zambia's Kaunda, championed such cultural revival. Traditional medicine, along wrth other cultural heritage, undoubtedly benefitted from this nationalist revivalism. For the Indigenous people of the Americas, the growing demand for self-determination, land rights and self-government have produced a similar result. This cultural revival renewed the interest in traditional health practices and products among the Indigenous people. At a recent PAHO conference on indigenous people and health, many country representatives from South America and Canadian and American Indian bands, stressed the need to "rediscover and restore" the traditional healing systems practised by indigenous people of these centuries. Latin American representatives reported on the growth of activity and interest in TM in their countries. Several countries established a separate department or division of traditional medicine within their health ministry. Fifty-two different associations representing traditional health systems were represented at a recent meeting on TM in Mexico City.

More recently, hard economic realities also contributed to this renewed interest in TM. For many developing countries, the Western health care system became economically too burdensome. This system, in most cases, is based on institutions (hospitals) with a curative focus. In many developing countries, hospitals are primarily located in large urban centres while the bulk of the population lives in rural villages. These hospitals, with all their modern technology, often consume more than 90 % of the health budget, leaving little resources for other essential activities. In some countries, one single urban-based large hospital often accounts for more than 50% of the total health budget. Drugs, produced by multinationals, and often imported from outside, are also a cost burden that few developing countries can afford. Faced with such economic pressures, many developing country governments have recently increased their support for the long-standing traditional medical practices.

In part this resurgence is also simply an acceptance of reality. In many developing countries, more than 80% of the population, mostly living in rural areas, depend almost exclusively on traditional medical practitioners for their primary health care needs. Governments could hardly continue to ignore this reality. On the other hand, the priority for these governments was to create a legal framework for standardizing and regulating diverse traditional medical practices within their borders.

International concern and pressure to conserve bio-diversity is the latest source of influence on the promotion of TM. Two other interrelated factors must also be noted: clinical tests on the efficacy of some traditional medical practices

(with positive outcome) and, consequently, a rush by some multinationals to patent and market those products. These latest developments brought forth a plethora of problems and issues, but at the same time, ushered in a new era for traditional medicine.

Search for Substance

The use of natural products for medicinal purposes, according to proponents of traditional medicine, '-has many benefits. For example, a crude herb contains numerous chemical elements along with the "active ingredient". Since the herb is used as a whole, often in combination with a number of others, a natural mechanism is there, according to this argument, to protect the user of the drug from its potential side effects. This argument underscores two fundamental principles: that the synergistic effects of all the chemical constituents present in a particular herbal drug make traditional medicine less susceptible to side-effects and, inter alia, that in so far as traditional medicine is concerned, it is counter productive to look for the "active ingredient". The very desirability and practicality of applying Western scientific approach is thus questioned.. Needless to say, such a line of reasoning is anathema to the Western medical tradition.

Not surprisingly, such conclusions about the efficacy of traditional health products are often questioned. Sceptics are willing to accept them only after careful scientific research. The identification and separation of the active ingredient and its clinical trial are two fundamental elements of such scientific investigation. In these days of scientific development and rigorous experimental methodology, concern for consumer safety and security, and, not least of all, fear of litigation, such insistence on scientific validity is neither unexpected nor unjustified. It is argued that traditional medical practices and products, to be considered safe and effective, must have the saure scientific basis like western medicine. In some cases, multidisciplinary studies on pharmacologically active chemicals isolated from medicinal plants have clearly validated their traditional claims. Studies and tests are being carried out around the world - from China, Vietnam and India to Mexico, Nicaragua and Peru. A recent study on Neem (funded by IDRC) has validated numerous pharmacological qualities of this tree leaf used in different Asian and African countries for a variety of ailments. A recent article in the Times of India notes : "the government too is pouring money into research on herbal and minerai medicines. The ICICI is funding testing of the first Ayurvedic formulation for Parkinson's disease. Ayurvedic treatments for AIDS are being tested in the JJ Hospital in Bombay and the Madras General hospital. The ICMR plans to spend over Rs. 8.5 crore on a systematic search for drugs and techniques in indigenous systems. It has identified 20 diseases not amenable to satisfactory treatment by allopathy, and chosen to evaluate Ayurvedic treatments for six of

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them - anal fistula, bronchial asthma, viral hepatitis, urolithiasis, diabetes mellitus and filariasis - with the help of experts from both traditional and allopathic medicine, pharmacologists and biostatisticians" *(Srinivasan, 1994)* . Such studies and, often, resultant scientific validations, have generated an intense interest on traditional medicinal plants among pharmaceutical multinationals in particular, and the Western medical practitioners and researchers in general.

In most developing countries, the use of TM has considerably increased in recent years. In spite of phenomenal progress in the area of synthetic drugs, traditional medicine is the only form of medical care available to the mass population in those countries. It is relatively cheap, and its practitioners are usually more accessible, both geographically and culturally. Most of them are ordinary folks, coming from similar socio-economic background as their clients. Referring to traditional medical practitioners in Thailand, for example, one researcher points out, "indeed, traditional health services tended to be generally less expensive and more easily accessible...; more importantly, however, they were tied in with religion and the occult. In other words, traditional healers and therapies were, and are, quite integrated with the indigenous culture and ways of life. Even today, the social roles of traditional healers are well accepted and relatively close to those of the ordinary people. For instance, the role of the traditional midwife is similar to that of a grandmother in a village and the names of traditional healers are associated with the status of a an uncle, aunt, or a grandfather. The relationships between traditional health practitioners and patients are therefore two-way interactions, that is, reciprocal relationships.... In consultations with traditional healers, patients feel free to ask questions on the ways to solve a problem or how to obtain more herbs or more remedies. Traditional healers are respected and held in high esteem in their village. Most healers are old, and they are respected for the experience that comes with age. Also, their is fees low and the therapy they prescribe is associated with ritual and religion. The popularity of traditional health care in Thailand then is due to the way that specific concepts, techniques, and medicines of traditional healers merge with the familiar and reassuring lay knowledge and beliefs. The system of explaining illness is familiar and comprehensible" (Sermsri, 1989). In short, there is an affinity or social bond between the TM practitioners and their clients. The ultimate benefits of TM may, at least partly, be attributed to this cultural/social congruity between its practitioners and consumers.

At the same time, there is a persistent belief, yet to be fully explained, that TM has effective cure for certain complex diseases such as cancer, arthritis, asthma, diabetes, severe dermatological disorders, sexual malfunction etc. In making treatment. decision people tend to be guided by some perceived relative efficacy of the modern and traditional health systems (Cavunduka, 1986). Some recent studies, conducted in China, India, Bangladesh and elsewhere, tend to support

this view. For example, in treating eczema and certain chronic skin conditions, Chinese traditional herbal therapy has produced quite encouraging results. In India and Bangladesh, Ayurveds and Hakims often claim specific advantage in treating such chronic diseases as asthma, liver cirrhosis, atopic dermatitis, etc.

The fact that traditional medicine does not include such "invasive" practices as blood transfusion, surgery, injections, etc. may have also contributed to their appeal. On the one hand, this reduces the risk of infections (such as AIDS through contaminated blood transfusion or from one partner to the other, *i.e.*, from the doctor to the patient or vice-versa) ; and on the other, dependence on technology, and hence, the cost. The cost factor alone, in the context of ever-increasing cost of the everchanging technology based western medical system, must be regarded as an important incentive for developing countries to opt for traditional medicine. It should be pointed out that, these characteristics of the traditional health system (avoidance of "invasive" practices and nonuse of "modern" technology), may also explain, at least partially, its historical lack of appeal to the Western educated, primarily urban-based, population in developing countries. Vaccines, surgery, x-rays, ultrasound, etc. have their own aura of scientific authenticity which traditional medicine clearly lacks.

It would be misleading to say that the appeal or prospect of traditional medicine is limited to developing countries. Obviously, China, India, Pakistan, Bangladesh, Sri Lanka, Vietnam, Indonesia, Malaysia, Sudan, Egypt, Ghana, Nigeria, the Philippines, Mexico and other countries have made great advances in traditional medicine. In China traditional medicine is fully integrated with the modern medical system. In India, as Srinivasan (1994) points out, there are "more than 100 Ayurvedic colleges, 26 Unani colleges and two Siddha colleges", and they "turn out nearly 9,000 graduates every year pretty close to the 10,000 churned out by the allopathic mill". In Bangladesh, there are 10 Unani Diploma colleges and 5 Ayurvedic Diploma colleges. There is also a graduate Unani college in the capital of Bangladesh that has a five-year study curriculum and is accredited by the University of Dhaka.

It is interesting to note that herbalism has slowly emerged as an alternative form of medicine in much of the developed world too. A recent article published in the United States, claimed that "alternative medical treatment is finally coming out of the medical closet and into the mainstream. The recent opening of an Office of Alternative Medicine within the National Institutes of Health has added to the interest in alternative healing sparked by the Bill Moyers PBS series Healing and Mind" (Ullman, 1993). The article also quotes a recent survey, published in the New England Journal of Medicine (January 28, 1993), that 34% of Americans used some type of alternative therapy in 1990, with an estimated cost of $13.7

billion, 75% of which was paid by the users themselves. The establishment of the Traditional Medicine Programme at the World Health Organization in 1978 should be regarded as an important milestone in this resurgence of interest in traditional medicine. And in 1992 the National Institutes of Health, the pioneer health research facility in the United States, established an office of Alternative Medicine'. Needless to say, the term "Traditional or "Alternative" medicine is not a foreign term any more with. international agencies like the World Health Organization or the World Bank or with multinational drug companies.

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Challenges and Prospects

Despite ail these renewed interest and real progress, TM is yet to be accorded its, proper role with the overall health care system in developing countries. The case of Bangladesh may be used as an example in this respect. It is one of the poorest countries of the world, with a per capita GDP of only US$ 210. With a population of 113.7 million crammed in a meagre 56,000 sq. miles of land mass, it has one of the highest population density (789 per sq km). Poverty, illiteracy, malnutrition and ill health have created a vicious cycle in Bangladesh. According to some estimates, the life expectancy at birth is only 52.5 years, infant mortality rate is 108 per 1000, maternai mortality is as high as 113. Only about 35% of the population has access to modern health care resources (primarily consisting of hospitals and public physicians). The government of Bangladesh spends, or able to spend, only about Tk 20 (US 50 cents) per capita for health. There are one hospital bed for every 3,300 people, and the physician-population ratio is 1:5,338.

More than 80% of the population in Bangladesh uses traditional medicine. Traditional practitioners are readily available in most villages and towns. It is obvious that Bangladesh cannot achieve the lofty goal of "Health for All by the Year 2000", without vigorous participation of traditional medical practitioners in the health care system. Some steps were taken to promote greater cooperation between these two systems and to give its proper role to TM. The Unani and Ayurvedic Board was created in the 1960s to bring the Hakims and Kaviraj within the fold of the "formal" health care system. Nevertheless, the gap persists. In the national health care plans, TM receives little recognition. Effective collaboration of the "modern" and the "traditional" still seems to be an elusive goal. Other countries, particularly those in Africa (Last and Chavunduka, 1986), and the indigenous people of Americas (Young, ed., 1988), face similar challenges.

Policy Options and Issues

Although médical pluralism is a fact in almost every society, the relationship between the traditional and modern systems of health may take one of the following four forms :

(a) *Intolerant Medical Orthodoxy:* The western system has a monopoly on health care, and traditional healing systems are either made explicitly illegal or institutionally repressed. Kenya and Ivory Coast are the countries in Anglophone and Francophone Africa that made traditional healing systems illegal. Aboriginal healing systems, on the other hand, are suppressed and ignored.

(b) *Tolerant Medical Orthodoxy:* TM is informally recognized and tolerated. This policy option applies "the liberal principle of 'laissez-faire' in the domain of health. In practice, this means that the State is officially concerned only with the-modern medical sector, leaving the other to develop on its own without state control. However,a modern system cannot permit itseif to ignore an activity which is so basic to the life of its citizens...Dealing with this medicine in the negative, the state cannot include it in the planning of health services, and thus deprives the state of an important resources which could help it to meet the health needs of the population" (Kikhela, et al., 1979). In this model, alternative therapies or techniques are.often used by the orthodox medical practitioners with a view to become more culturally relevant to the client population. The multicultural health care movement in Canada is also a manifestation of such a tolerant approach.

(c) *Parallel Development of Multiple health Systems:* The alternative healing practices are not only recognized legally, but also regulated by the state. There is increased professionalization of these multiple systems resulting in their co-existence. However, parallel development may not translate into active collaboration between the custodians of the traditional systems and the western medical orthodoxy. Countries in the Indian subcontinent and South East Asia may be the best examples of such parallel development.

(d) *The policy of Integration:* This policy aims at combining the theory and practice of different health systems and creating a new, better, and comprehensive one. China is perhaps the best example of this policy. However, since philosophical underpinnings of the traditional and western medical systems are quite different and often contradictory, real integration is extremely difficult, if not impossible. At the same time, a policy to combine two or more systems in which there is power disequilibrium among the partners can not lead to integration in the true sense of the term. In such a scenario, one may end up dominating the other. In such cases, perhaps establishing equity is more important than integration.

(e) *Active Collaboration between Fully Recognized Health Systems:* It presupposes equity, mutual respect and understanding among the

partners. "This option envisages the establishment of structures permitting the integration of the two systems through experiments in cooperation; at the same time, such an option follows from more basic studies on the characteristics and originality of the medicine of the healers. This encounter of two medicines aims first of all at the basic establishment of a health structure which takes of each of them into account; it tends also more basically, to gradually move the centré of gravity of the entire medical systems" (Kikhela, et al., 1979)). It is an emerging trend that needs to be promoted and enhanced. Once fully developed, this will establish medical pluralism-in the real sense of term.

In fact, there are 'structural, social, and political barriers in achieving true medical pluralism. Current renewed interest in traditional medicine provides an opportunity to further explore these problems and promote pluralism. This contemporary focus on TM has also brought forward other related issues. Unfortunately, national and international policy has not kept abreast of these changes by developing appropriate strategies for addressing many issues involved in the support for and provision of traditional health services. These issues may be grouped under four broad categories :

(1) preserving and promoting indigenous knowledge, practices and products,

(2) collaboration/cooperation of traditional and modern systems of health care,

(3) production/research and development of TM with full attention to all the complex issues of intellectual property rights, patent rights, the role of multinationals, etc.; and

(4) national and international policies regarding traditional medicine and bio-diversity, and environmentally and culturally sustainable and equitable development.

These issues are complex and critical. Most of them transcend national boundaries and cannot be resolved without international efforts and agreements. It is time that we embark on a serious dialogue, both within and among nations, to address these fundamental issues for human health in all its dimensions. Social scientists in general and, sociologists in particular, must play a central role in this dialogue and in the quest for better understanding and more meaningful collaboration between the traditional and modern health systems.

5.4 HISTORICAL BACKGROUND AND DEVELOPMENT OF HEALTHCARE SYSTEM IN INDIA

The WHO Constitution defines health as a state of complete physical, mental and social wellbeing and not merely the absence or infirmity".

"Life is not mere living but living in health" with this words, the Honorable Mrs. Indira Gandhi the Prime Minister of India, opened her address on 6th May

1981 to the Thirty-fourth World Health Assembly, meeting in Geneva. She further stated that "the health of the individual, as of nations, is of primary concern to us all. Health is not the absence of illness but a glowing vitality, a feeling of wholeness with a capacity for continuous intellectual and spiritual growth". Life means Living in Health:

The evolution of Healthcare Management System in India was a mixed one. Medicine and Medical records go parallel to each other, hence to know more about the medicine, one has to witness the progress with medical records. The India has glorious period wherein the history of medical record parallels the history of medicine. Primitive medical records carved in wood and chipped in stone date back to the approximately 25000 B.C. Throughout the millennia, medical records have evolved in conjunction with the advances in the art and science of medicine. The 20th century brought India a mixed experience; such as struggle for independence coupled with First and Second World War that was a dark era for India. However, later half of the century, gave India the freedom that allowed moving forward. During the last decade, India has accomplished tremendous progress in integrating healthcare system supported by ICT and Electronic Health Records.

Historical Background of Healthcare Management

The history of medical record parallels the history of medicine. Primitive medical records carved in wood and chipped in stone date back to approximately 25000 B.C. In subsequent centuries, hieroglyphics found on parchments recorded scientific progress. These chronicles preserve medical achievement of those eras for later generations.

Flourishing of Medical Practice in India

Ample evidence exists to substantiate the flourishing of medical practice in India many centuries before the birth of Christ. Art forms such as the icons, friezes, and frescoes in the caves and temples of Ajanta and Ellore and on the Buddhist Stupas of Amaravathi and Nagarjuna Konda portray medical concepts. There are innumerable references to the science of medicine and surgery in Indian epics like Mahabharata and Ramayana. The earliest documentation of medical practice in India is found in Athervaveda. The first Indian textbook of medicine Atreya Samhita was written by the sage Atreya during the Sutra period following the Vedic ages; this book united previously scattered medical care details into a comprehensive compendium. Agnivesa Samhita also documents the art of healing in a textbook containing about twelve thousand verses.

First Indian Textbook of Surgery

Charka Samhita represents the view of points of numerous scholars through many centuries, beginning with practices during the period of Agnivesa and

ending with those propounded by Dridhabala fifteen centuries later. This Samhita excellently records a glorious period of creative Indian medicine. Susruta Samhita became the first Indian textbook of surgery, describing twenty sharp and one-hundred-and-one blunt surgical instruments, methods of preparation for major surgery, and native methods for anesthesia administration. Ashtanga Hridaya by Vegabhatta described surgical procedures and discussed innovative drugs for medical care. The translation of this work from Sanskrit to Persian by Ali Mohammed Ben Ali Ismail Asavali Asseli as Tibb Shifa Mohammed Sahi is considered an outstanding masterpiece.

Unani Tibba System of Medicine

Unani Tibba System of Medicine with origins tracing to ancient Greek medicine, was introduced into India by Muslim rulers by the Thirteenth Century A.D., this system of medicine was firmly entrenched in places like Delhi, Aligarh, Lucknow and Hyderabad. The Hakims who practiced this system quite willingly also utilized the effective drugs of the Ayurveda system and included them in their Pharmacopoeia.

Decline in the Indigenous System of Medicine

The successive invasions of India and eventual British Colonial Rule of India evoked a decline in the indigenous system of medicine. Allopathic medical missionaries arrived form other countries to establish hospitals and dispensaries.

Modern medicine was introduced into India by the Portuguese in the Sixteenth Century. In 1510, Albuquerque founded the first Indian hospital, the Royal Hospital in Goa. This hospital highly touted as one of the finest worldwide, was transferred to Jesuit control in 1591. Rudimentary medical teaching began there in 1703 and by 1842 a complete school of medicine and surgery was extant. The Ecole de Pondicherry was a school of medicine established in India by the French government in 1823.

The Medical Department of the East India Company was created in 1740. This unit was comprised of British military surgeons and their local assistants. A committee appointed by Lord William Bentnick drafted the principles of a medical curriculum in 1833. This effort culminated with the establishment of Madras Military Medical School in 1835. A medical college was opened in Calcutta in January 1836, and the Grant Medical College in Bombay was opened in November 1845 under the auspices of Sir Robert Grant, the then Governor of Bombay.

Homeopathy, which Samuel Heinemann (1755-1843) of Germany propounded, gained a foothold in India between 1819 and 1839. This system of pharmacodynamics is based on natural laws of cure. Homeopathy is practised in

numerous countries worldwide, but India claims to have the largest number of practitioners of this system.

Prior to Independence

The struggle for independence went on for decades coupled with the First and Second World War, there was a great vacuum in the development of medical and medical record system; although it is well-known, medicine and medical records go together, due to unknown reasons the status of medical records in India prior to fifties was deplorable. There was only a vague concept of the value of medical records among the professional staff. Establishing or ensuring the proper functioning of the medical records departments in hospitals and health institutions was absent. Many hospitals had no medical record departments; records were bundled and kept inwards, store rooms only for a short duration. The basic forms required for a complete record and vital laboratory, x-ray and other tests necessary for establishing a correct diagnosis, were absent. The International Classification of Diseases was not known to many medical people. As for statistics, there was no insight as to what type of statistics were important and why, and need for standardized procedures on collecting, compiling and reporting was also absent.

Primary Health Care Center

Earlier during the sixties and seventies the medical record system in PHCs was very poor, majority of the health centers *i.e.,* 90 to 95% of them depended much upon the registers maintained for administrative and other purposes and patient information was disintegrated. Very few teaching hospitals especially mission hospitals had special record forms. Majority of the population in India sought healthcare mainly through primary healthcare centers or sub-centers specially people living in rural areas.

Outpatient Record System

The people in urban and cities used primarily, the outpatient services and the medical record systems utilized in these outpatient services can be broadly classified into two categories namely the :

(i) Outpatient slip/chit system

(ii) Departmental record system

(i) ***Outpatient Slip/Chit System:*** More than 90 -95% both large and small hospitals in India employed Outpatient slip/chit system. Although a simple, economical, and time saving procedure, the slip/chit system is inadequate from the stand point of comprehensive patient care. Clinicians, administrators, and even patients were convinced of the deficiencies of this method. The outpatient chit supplies the patient with an identity card

and also served as a treatment chart. Frequently, patients lose or misplace the outpatient slip and then register as a new case on subsequent episode of care.

(ii) ***Departmental Record System:*** Although superior to the outpatient slip system, this departmental record system used in outpatient of hospitals also lacked effectiveness. The system consists of departmental outpatient cards designed to meet the needs of each clinical specialty (cardiology, neurology, obstetrics, psychiatry and so forth...) The unit record is not achieved with this system because each specialty department registered patients directly and maintained its own record system. Patients do not have custody of their records. If a patient visits four separate clinical departments for treatment, that patient will have four separate health records. Records from a particular department are generally not available to other clinical departments; as a result, a composite health history of an individual patient is not readily available.

Inpatient Record System

The inpatient record system was greatly organized and records were of book type with sheets measuring thirteen inches by eight inches. With each facility standard forms are utilized for the history and physical examination report, the report of diagnostic investigations, operative report, treatment and progress notes, intake and output record, authorization for release and records of linen, room rent collection, messages to police, and so on...

The majority of hospitals in India had an admission office for admitting patients. The inpatient chart originates with the admission office and is sent to the ward along with the patient. The ward nurse was responsible for this record until the patient was discharged from the hospital. Certain hospitals returned discharged patients charts to the admission office on a weekly basis where the admission clerk enters statistical data into admission/accession register.

Post Independence

India attained independence in the year 1947 and became Sovereign Republic in the year 1950, since then the Government of India has been making all efforts to develop simultaneously many national programmes such as agriculture, industry, communication and healthcare service for its large population.

Establishment of Central Bureau of Health Intelligence (CBHI)

On the recommendation of Douglas Burdick of Health Division of Planning Commission, the Government of India (GOI) established the Central Bureau of Health Intelligence (CBHI) in the year 1961 to function as the National Nodal

Institute of the Director General of Health Services (Dte. GHS), Ministry of Health and Family Welfare (MOHFW), GOI. Its objectives include providing ready information on National Health Profile of India envisaging demography, healthcare, morbidity and mortality indicators, as well as medical/paramedical education and infrastructure in the country.

Appointment of A. L. Mudaliar's Committee

The Government appointed "A. L. Mudaliar's Committee" in the year 1964, which recommended "Provision made in the 4th 5 year plan to establish MRDs in Teaching Hospitals". In accordance with the committee's proposal, the Central Council of Health in its Srinagar Session in October 1964 passed the following resolutions :

> "The Central Council of Health Recognizing the important role played by Medical Records in efficient hospital care and Teaching and Research recommend that the available training facilities in medical records may be fully utilized and adequate provision made in the 4th Five year plan for proper medical records department (MRD) in all teaching and major hospitals in the country".

Establishing of MRD to improve healthcare in all the Teaching and Major Hospitals

The Government of India as a follow up action sanctioned 50% of grants for those who establish the medical record department (MRD) in their hospitals. This facility was availed by many and many teaching and major hospitals have established MRDs. The Christian Medical College Hospital (CMCH) and Jawaharlal Postgraduate Medical Education and Research hospitals (JIPMER) were the only two institutes which had comprehensive medical records system at par with international standards that were able to meet excellent patient care, medical education and research programmes.

Hospital Information Systems as an International Perspective

Hospital Information System

Since the early beginning in the 1960s, hospital information system (HISs) has been developed to cover both administrative and medical functions. However, it must be recognized that the first systems often focused on the billing and reimbursement aspects of hospital activities. These systems were designed to provide a money-oriented return on investment and streamline patient admissions.

The system included managed appointments and provided (stand-alone) ancillary services for hospital laboratories, the pharmacy and radiology departments to support existing manual procedures without adding value, and

they functioned as a bonding element among the many disparate systems inside and outside the hospital.

The 1980s saw the implementation of two nearly worldwide changes with a significant impact on the way computer applications were used in hospitals. On one hand, reimbursement systems gradually evolved from a free-for-service basis to a fixed budget system where figures on resource consumption played a central role. On the other hand, medical systems initially developed to simply automate existing processes became systems supporting physicians, nurses, and other healthcare providers in their daily patient care activities. The aim was to attempt to guarantee standards of care and lead to improved levels of decision making.

Health care data are the source of healthcare information, so it stands to reason that a health care organization cannot have high quality healthcare information without first establishing that it has high-quality healthcare data. Data quality must be established at the most granular level. Much healthcare information is gathered through patient care documentation by clinical providers and administrative staff.

In the new millennium, information technology will catalyze dramatic change in many aspects of medicine, including patient records. Good medical care requires accurate records of greater detail than in the past. Malpractice protection mandates more organized and complete records. Third party payers are requiring more justification for the expenses generated by physicians' actions. Today's economics require more efficient and cost-effective methods of keeping the patient's clinical records.

Telemedicine

Telemedicine is distance consultation among health professionals or between health professionals and patients by use of telecommunications technology such as real-time audio or visual systems, most notably video conferencing. The potential advantages are obvious in dispersed communities (rural areas) where expertise is thinly spread, and when traveling is difficult or inconvenient for doctor or patient. Uses are wide and varied and include direct interview and history taking, observation of physical signs, and distance reporting of imaging procedures. The location of consultation varies from hospital inpatient and outpatient settings, to broader residential and home settings, and even outer space.

Internet and Web-based Medical Communication

The Internet is a means to improve health and health care delivery, its full utilization is not clear. Nevertheless, an increasing proportion of the public is using the Internet for health information. The advantages of the Internet as a source of health information include convenient access to a massive volume of

information, ease of updating information, and the potential for interactive formats that promote understanding and retention of information. Health information on the Internet may make patients better informed, leading to better health outcomes, more appropriate use of health service resources, and a stronger physician-patient relationship.

5.5 TRENDS IN POLICY DEVELOPMENT

India is currently in the process of developing a new national health policy (NHP- 2001). The existing national health policy (NHP) was adopted in 1983. Its main focus was the formulation of an integrated and comprehensive approach towards future development of health services, appropriately supported by medical education and research, with special emphasis on PHC and related support services. During the 7th five-year plan (FYP), there was considerable achievement in terms of establishment of a health infrastructure, especially in rural areas. The 8th FYP (1992-97) identified "human development" as its main focus, with health and population control listed as two of six priority objectives. It was emphasized that health facilities must reach the entire population by the end of the 8th plan. The plan also identified peoples' initiative and participation as a key element. With the enactment of the 73rd Constitutional Amendment Act (1992), Panchayati Raj Institutions (PRIs) were revitalized and a process of democratic decentralization ushered in, with similar provisions made for urban local bodies, municipalities and nargapalikas.

Recognizing the importance of sustainable development, a national conservation strategy and a policy statement on environment and development were formulated in 1992 to bring environmental considerations into the developmental process. Linkages were drawn between poverty, population growth and the environment. The NHP identified nutrition as a problem needing urgent attention and in 1993 a national nutrition policy was formulated with long and short-term strategies.

The vertically structured family welfare programme needed to be replaced by a more democratic, decentralized alternative. In 1994 a draft national population policy was submitted to parliament as well as a revised report in 1996. It advocated a holistic, multisectoral approach towards population stabilization, with no targets for specific contraceptive methods except for achieving a national average total fertility rate (TFR) of 2.1 by the year 2010. This has resulted in a radical shift in implementation from centrally fixed targets to a target-free dispensation through a decentralized, participatory approach. A Population and Social Development Commission was also established in support of the population policy.

India has accepted the recommendations of the ICPD (1994) and has also ratified various international conventions for securing equal rights for women.

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Following the World Summit on Survival, Protection and Development of Children in 1990, India formulated a Plan of Action for Children in 1992 with actions that directly and indirectly affect child health.

Despite the commitment to HFA, enormous health problems still need to be addressed. While overall mortality has declined considerably, living standards are still among the poorest in the world. The major constraints facing the health sector are lack of resources, lack of an integrated multisectoral approach, insufficient IEC support, poor involvement of NGOs, inadequate laboratory services, a manually operated health management information system (HMIS), poor disease surveillance and response systems, and the heavy investments needed in dealing with noncommunicable diseases. The problems of gender disparity still manifest themselves in various forms, as evidenced by the declining female to male population ratio, social stereotyping, violence at the domestic and social level, and continuing open discrimination against the girl child, adolescent girls and women.

Thus the period after the last National Health Plan was announced in 1983 has seen major developments in India. There has been an increase in mortality through 'life-style' diseases- diabetes, cancer and cardiovascular diseases. The increase in life expectancy has increased the requirement for geriatric care. Similarly, the increasing burden of trauma cases is also a significant public health problem.

The changed circumstances relating to the health sector of the country since 1983 have generated a situation in which the government has undertaken steps to formulate a new policy framework as the National Health Policy-2001.

The draft NHP-2001 attempts to set out a new policy framework for the accelerated achievement of Public health goals in the socio-economic circumstances currently prevailing in the country.

7.6 TRENDS IN SOCIO-ECONOMIC DEVELOPMENT

Economic Trends

Gross national product (GNP) per-capita increased from Indian Rs. 6340 in 1991/92 to Rs. 13,193 in 1997/98. The annual growth rate of the GNP increased from 0.5% in 1991/92 to 7.0% in 1995/96, but declined to 4% in 2000/2001. The percentage of poor in rural areas increased from 20.5 in 1991/92 to 22.9 in 1992/93 and to 37.3% in 1993/94. Since the early 1990s, overall economic growth has been faster.

The situation regarding balance of payments has strengthened considerably, and the central government's fiscal deficit as a proportion of the gross domestic product (GDP) has declined significantly.

Demographic Trends

The crude birth rate (CBR) declined from 29.5 in 1991 to 26.1 in 1999, while the crude death rate (CDR) declined from 9.8 to 8.7 per 1000 population over the same period. The total fertility rate (TFR decreased from 3.6 in 1991 to 2.85 in 1996-98. The annual population growth rate declined from 1.97 in 1991 to 1.74 in 1999. The population, however, continues to grow, as the decline in the birth rate is not as rapid as the decline in the death rate. Due to the increase in life expectancy at birth (58.7 in 1990 to over 62 in 2001), the number of elderly persons in the population is now increasing, for which specific health facilities will need to be provided. Urban migration over the last decade has resulted in the rapid growth of urban slums, with ad hoc provisions for health care if any. Within the 9th plan steps are proposed to improve urban PHC.

Social Trends

From the 2001 population census, the literacy rate for males is 75.85% and for females is 54.16%. The changing economic situation created by urbanization industrialization and new economic liberalization has transformed the Indian social structure and values from a traditionally agrarian economy to a modern industrial order. The emerging nuclear family is exposed to severe economic and social constraints and changes. The traditional mechanisms for social security and adjustment in times of crisis and conflict are fast disappearing. This transformation has resulted in the creation of several social problems for individuals and groups such as older persons, the disabled, drug addicts, street children child labor, HIV-infected populations, etc. There has also been increased violence individually as well as collectively - especially towards women and young girls, which has assumed a national dimension. The problem of drug abuse is no more confined to a particular section of society but has infiltrated all strata. The large uncontrolled influx of rural migrants to urban areas in search of better earnings and job opportunities leaves them totally vulnerable, particularly the children of these migrant families. The negative influence of the electronic media appears have resulted in an increase in juvenile delinquency, vagrancy, robberies, murders and kidnappings.

There is a plethora of social legislation to safeguard the interest of persons in distress and to deal with the various social problems. Many of the acts have been amended in recent years to give them more teeth in terms of their effectiveness. However, there are wide gaps in the implementation of these acts with regard to coverage, quality and content, which affect social development and the well being of the people. The 9th FYP envisages a more holistic approach to these social problems, with strategies aimed at specific target groups and their problems.

The proportion of newborns weighing less than 2500 grams at birth was reported as 23% in 1995/96. The proportion of children under 3 years whose weight-for-age was less than minus 2 SD below the median was 47% (1998/99). It is estimated that 200 million people are exposed to the risk of iodine deficiency disorders (IDDs) and that 63 million suffer from goitre. Surveys conducted in 275 districts have revealed that 235 districts are endemic for IDDs. In 1991, 87.5% of pregnant women were found to be anaemic (haemoglobin < 11g/dl). The National Institute of Nutrition in Hyderabad reported that 56% of children under five years of age had iron deficiency anaemia. The contribution of vitamin A deficiency to blindness was estimated to be 2% in 1975 and 0.04% in 1990.

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A national IDD control programme was launched in 1992, which covers all states and union territories. The strategy is the use of iodated salt and all aspects of programme implementation are being addressed.

Anaemia contributed to 20% of maternal deaths in 1991. An intervention programme that commenced in 1992 prioritized pregnant women for iron and folic acid administration. During 1994/95, 85.8% of pregnant women were covered with the recommended daily dose of iron folate tablets.

The most susceptible group for vitamin A deficiency blindness is preschool children. The child survival programme seeks to administer five doses of vitamin A to all children under three years. During 1994/95, 72.6% of infants and 54.8% of 1-2 year old children were administered vitamin A.

Other actions include the Integrated Child Development Service (ICDS) programme that provides a package of services to 54 million beneficiaries comprising preschool children, pregnant women and lactating mothers, and the mid-day meal programme for primary school children. The following goals have been set to be achieved by the year 2000: reduction by 50% of moderate and severe protein-energy malnutrition (PEM) in preschool children, reduction of low birth weight to less than 10%, elimination of blindness due to vitamin A, reduction of iron deficiency anaemia among pregnant women to 25%, and reduction of IDDs to less than 10% in endemic districts.

Lifestyle

The proportion of males 15 years and over who were regular smokers in the 1980s has been estimated at 32-74% (rural) and 46-63% (urban), and females 20-50% (rural) and 2-16% (urban). Currently there is an increasing trend in smoking among youth. Other significant changes in lifestyles relate to lack of physical activity among the affluent, increased use of fast foods, substance abuse, and violence, particularly against young women and children.

The government has taken action to promote healthy lifestyles through sports, health education, setting up of no smoking zones, legislation banning smoking in public places, and establishing drug detoxification centers. A major constraint is the government revenue derived from tobacco, sponsorship of activities, especially sports events by tobacco companies, and high-pressure advertising.

5.7 HEALTH AND ENVIRONMENT

General Protection of the Environment

Due to an increase in unplanned urbanization and industrialization, the environment has deteriorated significantly. Pollution from a wide variety of emissions, such as from automobiles and industrial activities, has reached critical levels in many urban and industrial areas, causing respiratory, ocular and other health problems. Monitoring of the urban environment in selected cities in recent years by the pollution control authority has identified 21 critically polluted areas in the country.

Agricultural activities including widespread use of fertilizers, pesticides and weed killers also alter the environment and create health hazards. Water stagnation and the consequent multiplication of vectors has increased the risk of vector-borne diseases. The risk associated with disposal of hospital wastes has added to the overall unhealthy situation.

India is a party to the UN Conference on Environment and Development (UNCED) held in 1992. In the same year, a national conservation strategy and a policy statement on environment were formulated. The policy addresses issues related to sustainable development including health. Thrust has also been given to management of hazardous waste, adoption of clean technologies by industries, establishment of effluent treatment plants, criteria for environmentally friendly products, phasing out of ozone depleting substances, and creating mass awareness programmes.

A very far-reaching notification by the Ministry of Environment and Forests gazetted in 1994 makes it obligatory for almost all development projects to conduct an environmental impact assessment study which has to be evaluated by an impact assessment agency. A Government constituted group at the highest level has identified six priority programme areas, namely urban low cost sanitation, urban waste water management, urban solid waste management including hospital waste management, rural environmental sanitation, industrial waste management and air pollution control, and strengthening of health surveillance and support services. These areas have been addressed in the Dayal Committee

Report that forms the basis for a comprehensive national programme on sanitation and environmental hygiene.

There are many constitutional provisions and laws pertaining to the environment and its protection and improvement. However, the level of enforcement has been extremely poor. Besides, there is no comprehensive legislation on environment and health. In view of the current situation and the Dayal Committee Report, it was proposed that action be taken by the concerned ministries/departments to prioritize the areas and activities that should be included in the 9th plan. During the 9th FYP the Ministry has proposed the following actions :

1. Strengthen environmental health and health risk assessment in the country. A division of environmental health will be established in the Department of Health for this purpose.
2. Establish a hospital waste management programme.
3. Initiate drinking water quality surveillance as a part of disease surveillance.

Water Supply and Sanitation

The proportion of the population with safe drinking water available at home or with reasonable access was 92.6% in 1998/99 for urban areas and 72.3% for rural areas. The proportion of the population with adequate excreta disposal facilities was 80.7% in 1998/99 in urban areas and 18.9 in rural areas.

At the time of formulation of the 8th plan, it was estimated that with regard to water there were about 3000 hard-core 'no source' villages out of a list of 'problem' villages numbering 162,000. Besides this, about 150,000 villages were only partially covered. Regarding urban water supply, the service levels are far below desired norms. During the mid 90s, an accelerated urban water supply programme was initiated for towns having less than 20,000 population. The provision of hygienic sanitation facilities through conventional sewage and on-site low cost sanitation has not been given priority. Though the 8th plan envisaged conversion of all existing dry latrines, the final result is nowhere near the target.

The main constraints with regard to water supply are inadequate maintenance of rural water systems, lack of finances and poor community involvement. Most municipalities do not have any system for monitoring the quality of water, with contamination causing episodes of water-borne diseases even in metro cities like Delhi and Calcutta. Most of the people in rural areas are not aware of the health and environmental benefits of improved sanitation.

Future actions include phasing of the rural water supply programme, more financial support from the state finance commissions, more responsibilities given to local bodies and village panchayats, water supply and sanitation agencies to

have full autonomy in declaring tariffs, improving manpower and equipment support to municipal authorities, and creating public awareness regarding safe water and sanitation.

5.8 HEALTH RESOURCES

Human Resources for Health

The available data regarding health personnel show a national total of 503,900 physicians giving a ratio of 5.2 per 10,000 population. The number of registered nurse/midwifes totaled 607,376. The number of medical colleges has increased significantly over the past decades with the standard of medical education of undergraduates and postgraduates maintained at a high level. The National Institute of Health and Family Welfare (NIHFW) is involved in providing in-service training for all categories of health and family welfare personnel. The curriculum for graduate medical education has recently been revised to provide integrated teaching and more practical learning, as well as greater opportunities for acquisition of skills. The importance of social factors in relation to problems of health and disease are emphasized and a community-based approach is also included in the training. The main constraints are the shortage of funds, particularly for government institutions imparting medical education, and the problem of deployment of medical personnel to rural areas due to inadequate facilities to meet personal and professional needs.

Vacancies continue to exist in the posts of laboratory technicians, radiographers and other paraprofessionals which have serious service implications, particularly for programmes like malaria and tuberculosis. The ratio of nurses to doctors is also below the optimum. Other constraints include the low priority given to in-service training, inadequate staffing of training institutions, quality concerns among trainers, and inadequate facilities in training institutions. As for future actions, the central council for Health and Family Welfare suggested in 1993 that an Educational Commission in Health Sciences be set up to oversee, coordinate and support activities in this area. An omnibus council was also proposed to cover a range of paramedical personnel.

Financial Resources for Health

For the period 1998, the total health expenditure as a percentage of the GDP was 5.1%. Public expenditure on health was 18% of the total expenditure on health. The total government health expenditure as a percentage of the total government expenditure was 5.6%.

Though India was committed to achieve HFA by the year 2000, the range and complexities of health issues have also been substantial. On the one hand the

government has been struggling to combat communicable diseases while on the other having to cope with noncommunicable diseases like diabetes, cancer, cardiovascular diseases, etc.

In the constitutional provisions, health is primarily a state subject. States/ union territories account for 76.26% of the 8th plan health sector outlay as compared to 23.74% from the center. To augment the resources for health care, earmarked outlays are provided to state governments under the Minimum Needs Programme (MNP) with the explicit stipulation that these funds cannot be diverted elsewhere, and in case of diversion the central plan assistance to state governments will stand proportionately reduced. The family welfare/family-planning programme has been a 100% centrally sponsored scheme from its inception. The financial outlay has also been increasing over the successive five-year plan periods.

In the 1996/97 budget, the allocation for health was increased by 21.6%. Efforts have also been made to mobilize resources through various international organizations and UN agencies. The government has encouraged the involvement of private agencies in secondary and tertiary levels of health care.

Financial resources have been a major constraint to developing the primary and secondary levels of health care which are mainly provided by the government. Dependence solely an government resources has been another constraint. For the future, the possibility of moving from strictly government-administered institutions to autonomous institutions or even to joint sector enterprises are options that are being discussed.

Physical Infrastructure

Since early 1990s, the emphasis has been towards consolidation and operationalization, rather than on major expansion of the infrastructure. For this purpose, the following targets have been set :

(a) One subcentre staffed by a trained female health worker and a male health worker for a population of 5000 in the plains and a population of 3000 in hilly and tribal areas. As of 1998, 137,006 subcentres had been established.

(b) One primary health center (PHC) staffed by a medical officer and other paramedical staff for a population of 30,000 in the plains and a population of 20,000 in hilly, tribal and backward areas. A PHC center supervises six subcentres. As of 1998, 23,179 PHCs had been established.

(c) One community health center (CHC) or an upgraded PHC with 30 beds and basic specialities covering a population of 80,000 to 120,000. The CHC acts as a referral center for four PHCs. Up to 1998, 2913 CHCs had been established.

Urban family welfare centres (FWCs) have been set up to provide family welfare/family planning services. In all, 1529 urban FWCs are functioning (1996).

The status of the infrastructure to deliver primary health care appears to be satisfactory but actual programme implementation needs a lot of improvement. Constraints include deficiency of skilled personnel, lack of basic facilities and simple equipment, etc. Also, staff shortages continue to plague the services at all levels. A substantial part of the physical infrastructure has still to be completed. A major factor has been that approved estimates/norms for construction have not kept abreast with the rising estimates of actual construction costs. More than one-quarter of the population now live in urban areas, with about 40-50% of those in the metropolitan and large cities living in urban slums, with primary health care provided by health posts. Very often these health posts are outside slum areas, making access difficult. They also lack basic drugs, equipment and technical support. Consolidation, with attention to specific health needs of the community, will underpin future actions.

Essential Drugs and Other Supplies

No study has been done to assess the availability of essential drugs in remote facilities. The government, in consultation with the states and relevant agencies, has developed a national essential drugs list comprising over 300 drugs classified for use at the different levels of health care. This list serves as a guide to procuring agencies in central and state governments. The drugs available in India as compared to those in other countries are considered cost effective and there is a price control on 78 essential drugs. Budgetary constraints do come in the way of essential drug availability in the public sector. Work is in progress to bring out a compendium on the rational use of essential drugs.

International Partnerships in Health

Various international organizations and UN agencies have continued to provide significant technical and material assistance which has had a positive impact. The various agencies include WHO, World Bank, UNICEF, UNFPA, USAID, Japanese Assistance, ODA (UK), SIDA, NORAD, DANIDA and German assistance. A National Institute of Biologicals has been set up as an autonomous organization, with funding from the Government of India, the Japanese and USAID.

5.9 DEVELOPMENT OF THE HEALTH SYSTEM

Health Policies and Strategies

The health sector in India is characterized by: (i) a government sector that provides publicly financed and managed curative and preventive health services from primary to tertiary level, throughout the country and free of cost to the consumer (these account for about 18% of the overall health spending and 0.9%

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of the GDP), and (ii) a fee-levying private sector that plays a dominant role in the provision of individual curative care through ambulatory services and accounts for about 82% of the overall health expenditure and 4.2% of the GDP. Nationwide health care utilization rates show that private health services are directed mainly at providing primary health care and financed from private resources, which could place a disproportionate burden on the poor.

The provision of health care by the public sector is a responsibility shared by state, central and local governments, although it is effectively a state responsibility in terms of service delivery. State and local governments incur about three-quarters and the center about one-quarter of public spending on health. The responsibility for health is at three levels. First, health is primarily a state responsibility. Second, the center is responsible for health services in union territories without a legislature and is also responsible for developing and monitoring national standards and regulations, linking the states with funding agencies, and sponsoring numerous schemes for implementation by state governments. Third, both the center and the states have a joint responsibility for programmes listed under the concurrent list. Goals and strategies for the public sector in health care are established through a consultative process involving all levels of government through the Central Council for Health and Family Welfare.

The outcomes from meetings of the Central Council for Health and Family Welfare have provided a thrust to various sub sectors within the health sector. The private and voluntary sectors have emerged as an important arm of the health sector. From 1 April 1996 a change has been effected in the family welfare services with targets for contraceptive methods being replaced by a target-free approach. A huge campaign to eradicate poliomyelitis through pulse polio immunization (PPI) was initiated in 1995. The traditional system of medicine is now playing a more significant role due to escalating costs of health care. State health systems/ projects have been formulated to improve efficiency in the allocation and use of health resources through policy and institutional development. Specific efforts have been made to consolidate and strengthen the PHC infrastructure, under the minimum needs programme, by providing enhanced assistance to regions with severe health problems, supporting voluntary organizations, improving IEC activities, etc. The convergence of services to provide a holistic approach to population control has also been promoted. In March 1995 a separate Department of Indian System of Medicine and Homeopathy (ISM & H) was created within the Ministry of Health and Family Welfare.

Intersectoral Cooperation

In order to meet current needs and emerging challenges, a number of working groups were constituted in 1996 to comprehensively review the existing

health situation in its totality. The following areas are included: communicable diseases, health systems and biomedical research development, ISM & H, child development, environmental health, health education and IEC, women's development, and requirements for supportive and diagnostic services in primary, secondary and tertiary care.

Consultations have also been held with NGOs. Two other committees have been constituted, namely an expert committee to comprehensively review the public health system in the country and the National Mission on Environmental Health and Sanitation. The recommendations of these consultations have been discussed by the concerned ministries and were to be submitted as proposals for the 9th FYP.

The active promotion of the *panchayati raj* (local administration) system from the village to the district is a measure directed towards ensuring intersectoral collaboration. Specific health areas that have effectively made use of intersectoral collaboration include malaria control, AIDS control programme, blindness control, nutrition, and water and sanitation to name a few.

Organization of the Health System

The focus of the 8th plan has been to improve access to health care for the underserved and underprivileged segments of society, through consolidation and operationalization of the health infrastructure at all levels with emphasis on primary health care. In view of the high maternal mortality, upgrading of existing maternal health facilities and establishing first referral units (FRUs) have been prioritized. Many states have initiated major projects to upgrade their health services with assistance from funding agencies.

Andhra Pradesh is implementing a Health Systems Project with World Bank assistance, and the states of Karnataka, West Bengal and Punjab are to follow. In support of Safe Motherhood, priority central assistance has been provided to establish FRUs in all 213 districts in six states where the maternal mortality is two to three times more than the national average. States in India have only recently begun to address issues relating to the organization of their health systems. Their capacity to bring about key policy reforms is still lacking. A substantial proportion of specialist posts in CHCs are vacant, and thus affects the functioning of first referral units. Other constraints relate to shortage of paramedical staff, support staff and inadequate involvement of NGOs.

Managerial Process

The process has been initiated for decentralization of authority to the various levels to enable decision making at the right time. Besides this, the *panchayati raj* bodies are also being revitalized. Training facilities for health management are

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being augmented with the NIFHW playing a pivotal role. A consortium of institutions dealing with health management has also been formed. As a further step towards managerial process development, the NIFHW is making efforts to strengthen institutions all over the country, including State Institutes of Health and Family Welfare. A postgraduate certificate course in hospital management through distance learning is in its second year. Through various fellowship programmes, health personnel are being oriented towards newer developments in the field of management and management processes. Networking has also been established between the Nuffield Institute of Health in the UK and NIFHW towards strengthening managerial processes. A recurring constraint has been the appointment of officials to managerial positions who do not have any managerial training or experience.

Health Information System

In pursuance of the national health policy for the establishment of an efficient and effective management information system, a computer-compatible health management information system (HMIS version 2.0) has been designed in collaboration with participating states, the national information center (NIC) and WHO. The system is being implemented in phases. The first phase, involving 13 states/union territories (UTs) commenced in 1992-93 and is at present operational in two states with others in the process of implementation. In addition, each of the disease control programmes has its independent MIS, *e.g.*, the National Programme for Control of Blindness, the National Leprosy Eradication Programme, the AIDS programme, tuberculosis control programme, etc.

Obligations under the International Health Regulations continue to be observed. Morbidity and mortality data in respect of internationally quarantinable diseases (including cholera) are received by CBHI each week. Based on information received, weekly epidemiological reports are prepared and sent to WHO. Surveillance of the principal communicable diseases other than those covered by the international health regulations is also maintained and reported monthly. Health condition reports giving morbidity and mortality data are received annually from states and UTs according to the ICD-9 classification. At present, the states need to be helped to augment their infrastructure facilities for computerization of data.

Community Action

The concept of community participation is contained in national health policy. The broad areas of community participation at grass roots level are seen in the village health services scheme, the *Anganwadi* scheme of ICDS, and the formation of village level committees. Community action has also been

successfully used in disease control programmes such as malaria and in areas such as the provision and maintenance of drinking water schemes and sanitation. The main constraint to community action is the low priority given to health by the community in contrast to schemes that provide direct financial benefit.

Emergency Preparedness

Floods in India affect about 30 million people annually and drought about 50 million. Coastal areas experience two or three tropical cyclones of varying intensity each year. The Himalayan regions are prone to earthquakes. A Health Sector Emergency Preparedness and Response Programme has been in place since 1980. Crisis management groups have been used since 1980 and are constituted at national, state and district levels. In the Ministry of Health and Family Welfare, the Emergency Medical Relief Division is the responsible technical unit.

With WHO collaboration, emergency preparedness and response programmes in the health sector have resulted in : *(a)* preparation of a comprehensive health sector contingency plan at national level, *(b)* institutionalization of health sector disaster preparedness in seven national institutes, *(c)* training activities at institutional and state levels, *(d)* surveys, case studies and research projects, and *(e)* publication of books relevant to emergency preparedness. Limited studies have shown the need to improve competencies of grass-root level functionaries in disaster prone areas, as well as to strengthen monitoring of activities.

From 1995 the following activities are envisaged: transfer of expertise from national to state level institutions, training of target groups including translation of materials into the local languages, strengthening local infrastructure including stockpiling of essential supplies, disease control monitoring and surveillance, and operational research.

Health Research and Technology

India has a long history of biomedical research including health systems research. In several instances research results have directly influenced programme policies or led to modifications in programme strategies. Among the many research institutions, the Indian Council of Medical Research (ICMR), established in 1911, is the lead agency.

In the 8th FYP (1992-1997), ICMR attempted to consolidate significant leads in priority or "thrust" areas that were identified by various scientific expert groups. These areas included emerging health problems like HIV/AIDS, other important communicable diseases like tuberculosis, leprosy, diarrhoeal diseases, malaria, filariasis, Japanese encephalitis, etc., noncommunicable diseases like cancer,

cardiovascular diseases, metabolic disorders etc., contraception, MCH and nutrition.

Efforts have been made to develop a bibliographic database on HSR. With WHO support, nearly 400 HSR studies have been abstracted and a database was developed by the NIHFW in 1996. It is important that research findings have an application in the community. There is a need to sensitize policy makers and administrators about the importance of research and its managerial and programmatic uses. Financial resources also need to be improved. Dissemination of research findings and their utilization for identifying strategies to solve problems have not been up to the desired level.

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5.10 HEALTH SERVICES

Health Education and Promotion

Health education and promotion has been an integral component of all national health and family welfare programmes. The IEC approach uses a community-based strategy. Interpersonal communication at grass roots level is being strengthened by establishing women's health organizations (*Mahila Swasthya Sangh* - MSS) in villages. By 1995-96, 74,000 MSSs had been established. Funds were earmarked for setting up IEC bureaus in eight states in 1995-96. Training of frontline workers and field functionaries in various departments is being strengthened. The sensitization of local leaders is implemented through orientation training camps.

National health programmes are supported with health education and promotion strategies and activities specifically designed to suit programme needs. Such national programmes include those for leprosy eradication, tuberculosis control, malaria eradication, and HIV/AIDS control, as well as the national iodine deficiency disorder programme and the environmental health and sanitation programme.

Interministerial committees at central and state levels meet periodically to review the progress of health education activities. NGOs and other professional organizations have joined with government agencies all around the country to improve health education. The media division of the CHEB has been strengthened to support media promotion activities as well as materials production.

Maternal and Child Health/Family Planning

The proportion of pregnant women attended by trained personnel in 1995/96 was reported to be 65.1%. The proportion of deliveries in 1995/96 attended by trained personnel (including trained TBAs) in the urban sector was 73.5% and in the rural sector 33.5%. The proportion of women of childbearing age using family

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planning in 1998/99 was 48.2%. The crude birth rate (CBR) was 26.1 per 1000 population (1999) and the infant mortality rate (IMR) were 68.0 per 1000 live births (1994–98).

There are wide interstate differences in achievements of health and family planning indicators. Any change in these indicators is dependent on the performance of four states (Bihar, Rajasthan, Madhya Pradesh and Uttar Pradesh). With regard to population growth, unless these states improve their family planning performance, the national growth rate will not change significantly.

High priority has been given to MCH since 1985. The success achieved with EPI is likely to have made a significant contribution to the reduction in the infant mortality rate from 95 in 1987 to 68 per 1000 live births in 1994-98. Perinatal mortality and stillbirth rates remain high, with only a marginal decline in the last decade.

Several socioeconomic variables as well as technical and operational shortcomings constitute the main constraints. Though services are being strengthened and community education promoted, there is a lack of complete involvement by the people. Better coordination with NGOs, professional health organizations, private practitioners and the like is needed if better results are to be achieved.

For future action, a result-oriented action plan has been evolved in consultation between the center, states and UTs. The key features are improving the quality of outreach services, having a differential strategy for poorly performing districts as based on CBR, increasing coverage of younger couples, introducing newer and better quality contraceptives, strengthening family welfare schemes in urban areas, especially slum pockets, revitalizing training for health staff, IEC to focus on quality of life issues and interpersonal communication, and improving intersectoral coordination at all levels.

After four decades, the importance of a holistic multisectoral approach to population stabilization has been realized. A draft revised National Population Policy based on a holistic approach was placed before parliament in 1996. With a view to regulate and prevent the misuse of modern prenatal diagnostic techniques, legislation was passed in parliament in 1994. To ensure strong political commitment to curbing population growth, the 79th Constitution Amendment Bill seeks to incorporate promotion of population control and a small family norm, with an added clause enjoining all citizens to promote and adopt a small family norm. The bill also proposes to add an additional schedule, under which a person shall be disqualified from being elected to hold office as a member of either house of parliament or in a state legislature if he/she has more than two children - but is not to take place with retrospective effect.

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IMMUNIZATION

The proportion of infants reaching their first birthday who were fully immunized according to national immunization policies in 2001 was 49.0%. By individual vaccines the coverage in 1998/99 was as follows: DPT3 52.1% OPV3 59.2%, measles vaccine 41.7%, and BCG 69.1%. Percentage of pregnant women who received two doses of TT was 66.8% (1995/96),. As a result of the immunization programme, the incidence of polio and neonatal tetanus have declined significantly. The strategies to maintain and improve coverage include outreach immunization sessions, intensification in high risk areas, national immunization days (NIDs) and mop-up rounds, strengthening surveillance, intensifying IEC and training, maintaining vaccines and essential supplies, and improving supervision and monitoring. WHO recommended strategies are being followed with regard to achieving the goal of polio eradication, neonatal tetanus elimination and measles control.

PREVENTION AND CONTROL OF LOCALLY ENDEMIC DISEASES

The incidence of malaria remained around 2 million cases per year during 1984-1992. In 1997, 2.7 million and in 1999, 2.3 million cases were reported. The incidence of *P. falciparum* is increasing and reached to 50% in 1999. For filariasis, present estimates indicate that about 420 million people live in endemic areas. There are 206 control units, 198 clinics and 27 survey units. Visceral leishmaniasis, which reappeared in Bihar in the 1970s, is now endemic in 30 districts in Bihar and 9 districts in West Bengal. In 1996 there were 20,466 cases and 260 deaths reported. Japanese encephalitis (JE), though not a major public health problem, has over time been reported from as many as 24 states/UTs during one year, with an estimated 378 million people at risk. Dengue, dengue haemorrhagic fever (DHF) and dengue shock syndrome, all caused by the dengue virus, have been prevalent in India in almost all major urban areas, with periodic outbreaks of dengue fever and DHF. All four serotypes have been detected, and guidelines for prevention and control have been issued to all states.

An expert committee drew up a malaria action programme in 1995. A key strategy is the implementation of short and long term measures in selected high risk areas, high powered boards to expedite intersectoral cooperation, community involvement in antimalarial activities with intensified IEC, and capacity building at the central and grass roots levels through training. The progress of filariasis control is constantly under review and a strategy of selective treatment, vector control and IEC is being implemented. A revised strategy of mass drug administration has been initiated in some districts in Tamil Nadu and Maharashtra states. In view of the seriousness of visceral leishmaniasis, the government has

accorded high priority for its control. Strategies involve early diagnosis and treatment of patients and interruption of transmission by DDT spraying.

Treatment of Common Diseases and Injuries

The national tuberculosis control programme has not achieved the desired results. In 1992 the programme was reviewed and a revised control programme formulated with short term course chemotherapy using the DOTS strategy. The problem of protein-energy malnutrition (PEM) and micronutrient deficiency disorders are quite significant and are being dealt with through a number of national programmes with well defined goals. Diarrhoeal diseases, which are still a major cause of morbidity and mortality in infants and children, are being addressed through the promotion of exclusive breast-feeding, good child feeding practices, and the timely use of ORT during episodes of diarrhoea. Acute respiratory infections (ARIs) are a leading cause of death due to pneumonia in children under five years.

A strategy aimed at early recognition of the signs of pneumonia and timely referral has been very effective in reducing mortality. HIV/AIDS is predicted to be a major problem in India. A total of 22,529 seropositive cases were reported up to March 1996, but this number does not convey the actual magnitude of the problem. Almost 4 million HIV cases are estimated as of June 2000. Of the noncommunicable diseases, cancer and cardiovascular diseases are emerging as major health concerns that will require considerable financial resources for case management.

5.11 TRENDS IN HEALTH STATUS

Life Expectancy

For the period 1996-2001, the life expectancy at birth is estimated to be 62.36 years for males and 63.39 years for females. In 1991 the sex ratio was 927 females per 1000 males which increased to 933 in 2001. To ensure the continued improvement in life expectancy, the health care delivery infrastructure is being expanded, MCH care is being improved, specific programmes such as the expanded programme on immunization (EPI), introduction of oral rehydration therapy (ORT), etc. are being strengthened, and efforts are continuing to contain locally endemic diseases.

There is also an increased thrust in other development and poverty alleviation programmes. The main constraints are the diverse population groups, low literacy and income levels, and sociocultural beliefs and practices which adversely affect health.

MORTALITY

The infant mortality rate (IMR) was reported to be 68 per 1000 live births in 1994-98 and the maternal mortality ratio (MMR) for 1998 was estimated at 407 per 100,000 live births. Estimates for 1996 of the number of deaths per year in children under five years from diarrhoeal diseases was 840,000, from acute respiratory infections 600,000 and from measles 330,000. Deaths from malaria were reported to be 1061 (1995) and 1057 (1999), cardiovascular diseases 2,386,000 (1990), traffic accidents 45,670 (1993), and work accidents 543 (1993). Between 1986 and 1999 the crude death rate (CDR) declined from 11.1 to 8.7 per 1000 population. Between 1980 and 1998 the IMR declined from 114 to 68, the leading causes of death being diseases of circulatory system, infections and parasitic diseases, injury, poisoning, perinatal conditions, and diseases of respiratory system. The number of reported accidental deaths in 1993 was 11,125 and 80,000 in 1998. The main constraints are low literacy and income levels, sociocultural beliefs and practices, and suboptimal utilization of health facilities.

MORBIDITY

The number of reported cases of the following diseases were: leprosy 560,000 (2000), malaria 2,276,788 (1999), measles 26,986 (1991), neonatal tetanus 1896 (1995), polio 142 (2000/2001), and tuberculosis 1,223,127 (1999). The vaccine-preventable diseases (referred to in Section 6) have declined significantly since implementation of the EPI. In India about 14 million people are estimated to be suffering from active tuberculosis and about 0.5 million die of the disease each year. Currently, short term chemotherapy using DOTS has been introduced and accessibility to tuberculosis treatment centres improved. The prevalence of leprosy has declined from about 39 per 10,000 population in 1985 to about 7 per 10,000 in 1995 and further down to 3.7 in 2000. The spectacular reduction in this disease has been due to the new regimen of multidrug therapy. The number of new cases detected annually has, however, remained more or less the same, at about 0.5 million.

DISABILITY

Disability prevalence rates per 100,000 population estimated in 1994 are as follows: physical disability 3574, visual disability 827, hearing 806, speech 510, and locomotor disability 2041. The incidence rates per 100,000 population of these disabilities are: physical 173, visual 45, hearing 27, speech 10 and locomotor disability 105 (national sample survey).

The main cause of blindness is cataract (80.1%), with about 6.5 million (2000) persons blind due to cataract. The national blindness control programme is centrally sponsored with a four-pronged strategy to strengthen service delivery,

develop human resources, promote outreach activities and develop institutional capacity. Due to changing lifestyles, mental disorders are likely to increase in the future. The total number of mental disorders treated in specialized mental hospitals was 48,396 in 1991 and 38,323 in 1992. The majority of cases have been diagnosed as suffering from psychosis (85.7%).

5.12 OUTLOOK FOR THE FUTURE

Overall Assessment and Strategic Issues

Mortality rates, especially the CDR, IMR and to some extent the MMR, have shown a declining trend. There has been an improvement in the expectation of life at birth for both males and females. The vaccine-preventable diseases have started to decline. Guinea-worm disease has been eradicated and leprosy shows a declining trend. Tuberculosis is still a persistent public health problem, but the new short term chemotherapy and DOTS strategy offer some promise. Together with the persistence of communicable diseases, noncommunicable diseases are also emerging as public health problems. The population growth rate though declining, continues to be alarmingly high, with some very populous states continuing to have high birth rates. Socioeconomic and sociocultural factors, the diversity among states, and low literacy remain major constraints.

With regard to health policy, there are well formulated policy guidelines for health, nutrition, education, children, etc. which provide an overall framework for health and development. Health is a state subject and the decentralization envisaged under the Panchayat Raj Act may provide greater opportunities for community participation in development.

The outlay in the health and health-related sectors has been increasing over the five year plan periods, but as a percentage of the total outlay has remained constant over the years. The health care delivery system has expanded, but issues such as consolidation of existing infrastructure and quality need to be given more attention. Though there is an upward trend in economic growth (except for certain period 2000/2001), reducing the gap between the haves and the have-nots is a major challenge. Various international organizations and UN agencies continue to provide significant material and technical assistance for health and family welfare programmes.

Futures Vision

The goal is to achieve optimal health for the people, which would allow them to lead socially and economically productive lives and be in keeping with the principles of the HFA strategy. The health care system envisaged would have a public-private mix, with the latter encouraged to take a greater share of secondary and tertiary health care services. The National Conservation Strategy and Policy

Statement on Environment and Development (1992) aims at ensuring that the demands on the environment do not exceed its carrying capacity for the present as well as for future generations.

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PROPOSED STRATEGIES

(a) *Enhancing equity for health:* Making health services and facilities accessible and available to the people, especially the underprivileged, through the regionalization of health services, rational transfer policies, incentives and career development opportunities, and minimizing inter and intrastate differences.

(b) *Strengthening of health promotion and protection:* Development of an integrated education and health promotion programme with locally relevant content, implementation of an integrated noncommunicable disease control programme (9th FYP), strengthening of intersectoral coordination for implementing preventive and promotive health in an integrated and comprehensive manner, and strict and effective enforcement of available legislation relating to health and the environment.

(c) *Strengthening the health sector through partnerships in health development:* This includes public and private sector involvement, better use of indigenous systems of medicine, etc.

(d) Developing and strengthening specific health programmes.

(e) Developing and using appropriate health technology.

(f) Strengthening international partnerships for health.

5.13 SUMMARY

- Traditional medicine, its nature, axioms and practices, varies from one country to another, or more precisely, from one culture to another. Even its outlook, and that of its practices and products, vary from one place to another depending on the socio-cultural heritage, religious and political identity. From China, India, Indonesia to the African states and the indigenous peoples throughout the Americas, there are a variety of systems that may be termed "Traditional Medicine" - the Ayurvedic, Unani, herbal medicine, etc.
- The history of medical record parallels the history of medicine. Primitive medical records carved in wood and chipped in stone date back to approximately 25000 B.C. In subsequent centuries, hieroglyphics found on parchments recorded scientific progress. These chronicles preserve medical achievement of those eras for later generations.

- In 1958, on the recommendation of Douglas Burdick, Health Division of Planning Commission set out to improve the teaching hospital records. Then the Government of India (GOI) established the Central Bureau of Health Intelligence (CBHI) in the year 1961 to function as the National Nodal Institute of the Director General of Health Services (Dte. GHS), Ministry of Health and Family Welfare (MOHFW), GOI.
- For the period 1998, the total health expenditure as a percentage of the GDP was 5.1%. Public expenditure on health was 18% of the total expenditure on health. The total government health expenditure as a percentage of the total government expenditure was 5.6%.
- The goal is to achieve optimal health for the people, which would allow them to lead socially and economically productive lives and be in keeping with the principles of the HFA strategy. The health care system envisaged would have a public-private mix, with the latter encouraged to take a greater share of secondary and tertiary health care services.

5.14 REVIEW QUESTIONS

1. Discuss the role of colonialism in the development of health system.
2. What was the status of India's healthcare system before independence? Expalin.
3. What is the status of India's human resource in health sector?
4. State the condition of India's health research and technology.
5. Describe India's outlook for the future in health sector.

5.15 FURTHER READINGS

- Ramani, K.V. and Mavalankar, Dileep; ***Health System in India : Opportunities and Challenges for Improvements***, Emerald Group Publishing LTD.
- Arnold, David, 1993. Colonizing the Body; State Medicine and Epidemic Disease in Nineteenth-Century India; Berkeley, University of California Press.
- Bannerman, R.H. 1981. "Discussion on Yoruba Traditional Healers of Nigeria". Social Science and Medicine, Vol. 15B.
- Bibeau, Gilles, 1985. "From China to Africa: the Same Impossible Synthesis Between Traditional and Western Medicines". Social Science and Medicine, Vol. 21, No. 8.