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Sociology of Health and Illness (Elective)

SEMESTER IV

SOCIOLOGY

BLOCK- 2

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BLOCK INTRODUCTION

This is the second block of the paper 'Sociology of Health and Illness' offered in the 4th semester of M.A. Sociology programme of Krishna Kanta Handiqui State Open University.

Here, Unit 8, titled "Health care institutions" focuses on the idea of medicine as a profession, and also attempts to explain how hospital can be seen as a social organisation.

Unit 9, titled "Public Health" highlights the concepts of public health, community health, and social epidemiology.

Unit 10, titled "Social inequality and health" discusses the phenomena of globalisation, medical tourism and social stratification.

Unit 11, titled "Social control of body" provides a detailed understanding of anorexia and bulimia.

Unit 12, titled "State and health" highights the concept of biopolitics, and the health practices in India.

Unit 13, titled "Health policies of government of India" throws light on the trends and debates over health policies.

Unit 14, titled "Global survey of health" highlights the state of health in high-income and low-income countries.

In order to make the text more interesting and informative, a section called LET US KNOW has been provided in the units. This section tries to provide some additional information regarding the content of the unit. Further, in order to enable the learners to continuously check their progress regarding the content, some questions have been put at the end of various sections of a unit with the heading CHECK YOUR PROGRESS. The answers to the questions of CHECK YOUR PROGRESS section have been provided at the end of each unit. In the end of each unit, few MODEL QUESTIONS of long and short type are provided in order to provide an idea of the question pattern to be expected in the examinations by the learners.

UNIT 8 : HEALTH CARE INSTITUTIONS

UNIT STRUCTURE

8.1 Learning objectives

8.2 Introduction

8.3 What is a social organization?

8.4 How is hospital a social organization?

8.5 Understanding the profession of medicine

8.6 Let us sum up

8.7 Further reading

8.8 Answers to check your progress

8.9 Model questions

8.1 LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Understand the meaning of a social organization.
- Explain why hospital is considered as a social organization.
- Comprehend various nuances present in the profession of medicine.

8.2 INTRODUCTION

This unit will provide you brief idea about the nature of health care institutions. In this unit you will be introduced to the idea of social organizations and understand various features of these organizations. Further, it will explain the functioning of a hospital as a social organization. It will introduce you to the historical development in the organization of hospitals and explain its working. A brief explanation of the profession of medicine is also provided to highlight various changes that this profession has undergone since its inception due to the rise in technological advancements.

8.3 WHAT IS A SOCIAL ORGANISATION?

Every society consists of numerous kinds of groups, which interact with each other for the proper functioning of the society or the social system. Each of these groups further have a proper organization within themselves, which basically means that there exists a clear set or pattern of interaction within these groups which facilitate their smooth functioning. The discipline of sociology calls such a pattern of relationship that exist between social groups or among groups and individuals that constitute the group as social organization. Thus, it can be argued that the term organization basically refers to the interdependence of various parts in a group. A group can also be of numerous types. It can vary depending on size, nature and composition such as workers in a factory, members of a family, or nurses in a hospital. In the contemporary scenario, the usage of the word social organization has dramatically reduced. Instead, sociologists prefer using the term 'social system' to refer to the society. For example, Talcott Parsons, G.H Homans, R.K Merton and many others used the term social system to refer to society instead of using social organization. Since the term social organization stresses the importance of interdependence of parts in a group or in a society, it can be best understood by analyzing how a human body operates and functions. All the organs in a human body are arranged in a particular order and located at a particular place and perform a particular function assigned to them. Any discrepancy in any single organ disrupts the equilibrium of the human body resulting in various illnesses. Similarly, the society consists of various groups or parts which are akin to a human organ. The smooth functioning of these parts is extremely essential for the survival of a society. Social organization thus ensures this smooth functioning of the various groups or parts of the society. Since some form of organization is present in every aspect of our society, social organization constitutes an important topic in various sociological theories and research. There are many theorists who have given various definitions of social organizations. Some of these are mentioned below:

Duncan Mitchell : "Social organization means the interdependence of parts which is essential characteristic of all enduring collective entities, groups, communities and societies."

Ogburn &Nimkoff : "An organization is an articulation of different parts which perform various functions, it is an active group device for getting something done."

Eliott and Merrill : "organization is a state of being, a condition in which the various institutions in a society are functioning in accordance with their recognized or implied purposes."

H.M Johnson : "organization refers to an aspect of interaction systems."



LET US KNOW

Social Organization basically refers to the interdependence of various parts in a group. This interdependence is necessary for smooth functioning of the society

Every organization consists of members who have an assigned status in that organization and perform the role relative to their status

There are various characteristics or features of these social organizations. These include a well-defined structure, goal or purpose, division of labor, system of communication within members, sexual composition of the members, leadership, spatio temporal cohesion and many more. These features help in the proper monitoring of various forms of interaction that occur within these organizations. The interaction (called 'role') of individuals within these organizations is dictated by their position which is generally called 'status'. To put it simply, the role of individuals in an organization is based upon the status assigned to them. Since, organizations are made up by interacting individuals and groups, all social institutions are thus organizations. The family, state, church, banks, etc. are therefore various types of social organizations. As

mentioned earlier, these social organizations vary according to their size, members and the goal they serve. To put it broadly, social organizations are of two types. These include Formal and Informal organizations.

Informal organizations are defined as a small group where the members share interpersonal relationship among each other. The interaction between the members consists of informal ways without adhering to any strict norms or rules of behavior. Members of such organizations share companionship with each other and there are no assigned statuses to any member. They share their joy, sorrow, fears with each other. These include friendship, family, bands, etc. On the other hand, formal organizations are those which are characterized by the features listed above. These are: a specific function, division of labor, a hierarchy of authority, rationality and a proper arrangement of statuses and role. The working of these organizations is systematically and carefully planned out. The major difference between these two types of organization is the system or order present in the formal, which is lacking in the informal. This system of order is sociologically termed as bureaucracy. Max Weber is one of the pioneers in the field of sociology who provided the first conception of bureaucracy in his analysis of formal organizations. In his book on 'Theory of Social and Economic organization', Weber notices the increasing rise of formal organizations in the modern, capitalized society and thereby the increasing rationality in these organizations. As the interpersonal relationship between the members diminishes substantially in a formal organization, Weber terms them "iron cages" which take over an individual's life and traps them in a forever vicious cycle of rationality and control. Despite these major differences, the two types of organizations however are not mutually exclusive. Within every formal organization, there exists many informal organizations as well. For instance, a school or a university consists of various groups of friends or debate team, sports team etc. Similar kind of interpersonal relationship exists in all kinds of formal organizations, be it a church, an office and so on. In fact, for the proper functioning of a formal organization, it is necessary that its members share a cordial and friendly relationship

with each other rather than having animosity or hostility towards one another. Such cordial relationship ensures one way of achieving higher efficiency in these formal organizations. Charles Page, in fact argues that due to various forms of association and interaction among members of a formal organization, there emerges a form of informal relationships and roles. Thus, the relationship between formal and informal organization is complicated and complex.

From the above discussion, it can thus be inferred that society consists of varieties of organizations, both formal and informal. The society, as Ogburn and Nimkoff argue, in fact, itself is a larger organization which functions due to the interdependence and interrelationship between various large and small organizations, which consist, as stated above, of both formal and informal ones. Some of these organizations include factories, corporations, banks, schools, prisons, post office, etc. The State can also be categorized as an organization which has a major political goal. A university similarly represents another social organization which shares educational responsibilities. This unit will focus on one specific type of formal organization- the 'hospital'. The next section will explain in detail, the features and functioning of the hospital as a social organization.



ACTIVITY -1

Think how a university is a social organization. What are its functions?

.....

.....

.....



LET US KNOW

A large general hospital, prototype of modern-day hospitals facilitates provision of medical care, space for clinical research and education.

8.4 HOW IS HOSPITAL A SOCIAL ORGANIZATION?

This section would provide an analysis of hospital as a large-scale formal organization that exists in our society. While there exist various kinds of health care institutions, such as a private clinic, small rural hospitals, or the common ones which focus only on patient care, in this section, we will generally be discussing about a particular model of hospital which is a large general hospital typically found in an urban setting (not necessarily though) and which caters to three main functions: health care, teaching and research. While the other models of health care institutions exhibit various attributes of a social organization, it is these large general hospitals which are the closest to the other modern-day organizations and display latest medical trends. In fact, the World Health Organization (WHO) defines hospital as "they are instrumental for care coordination and integration and have a key role to play in supporting other health care providers (including primary health care) and in community outreach and home-based services. They also often provide a setting for education of doctors, nurses and other health care professionals and are a critical base of clinical research." A large general hospital itself is made up of various smaller social organizations which ensure a proper division of labor, leading to higher efficiency. For example, every hospital has a nursing staff, a surgery team, a pathology team (those who conduct various tests), etc. Large general hospitals additionally have other organizations that comprises of its teaching staff, students and its research team as well. One can notice all the attributes of a social organization which have been discussed in the above section in the working of a hospital.

Since, a hospital consists of numerous small organizations, it is highlighted by multitude of interactions that takes place among its members. Each member or actor in a hospital has a designated status and thereby performs his/her role based upon the position/status he/she holds. This designated status is a clear example of the intrinsic division of labor that exists within a hospital. Such a division of labor points to the

intrinsic form of professionalization or specialization that characterizes a hospital. These specializations are references of how work is distributed among the members of a hospital, based on their educational credibility. For instance, a hospital consists of a general physician, surgery specialist, neurologist, neuro surgeon, endocrinologist, cardiologist and so on. This is just a small example of how the doctors are categorized in a hospital and assigned their role. A hospital consists of various members other than doctors; such as nursing staff, non-clinical staff, managing committee, etc. Each of these are further categorized by their own organizational structure. Only when all these smaller organizations or departments within a hospital perform their designated role, the hospital functions smoothly. Robert Wilson, in this context argues that the basic interaction that typifies a hospital takes place between the staff and patient and between the staff themselves. He further asserts that while the patient constitutes an important component in the hospital, he however doesn't belong to it. He is in a state of transition as his identity gets ripped off once he enters the hospital. Thus, the patient, who is one of the most important actors in the hospital, according to Wilson is only a guest, who has a temporary role in the hospital.

The formal structure of a large hospital generally consists of three major forces: the administration, the board of managers or trustees and the medical staff. Beneath these lay the nursing staff, and other kinds of groups like social work, pharmacology, etc. Although the nature of authority is distinctly laid out in the hospital, there however exists certain confusion in its enactment. For instance, ideally, although the administration is the head of the hospital, there exists a clear uncertainty when it comes to the notion of authority between the administration and the medical staff. Wilson is of the view that hospital becomes a complex social organization because of such uncertainties in its authority. Since, administration is comparatively a new aspect in hospitals, it lacks the required occupational prestige that is given to medical staff which is the repository of maximum expertise. This expertise, of course, gives them absolute medical authority. It has been argued that without proper medical assistance, a hospital is

akin to a hotel for sick people. It is only with proper medical care and diagnosis that hospitals tend to perform their major function of providing health care. Hence, the occupational prestige accorded to the medical staff is quite above the administration. However, this is not to say that the medical staff has only limited administrative role. In fact, on various occasions, the line separating medical and administrative role diminishes. Such occasions arise during recruitment processes and compensation of nursing staff. Although these are the functions of an administrator, but the medical staff or the doctor also has a major say in it. Hence, it can be argued that there are two underlying themes that characterize the organization of a hospital: diffusion of authority and struggle for occupational prestige.

The role of hospital as a social organization which is a part of the wider society is not only confined to treatment of patients or provision of health care. The hospital can be regarded as a dynamic institution which has undergone major changes through various phases of history. Such changes are reflected in the social roles that this organization performs today. Cockerham provides a historical model of development of hospital that consists of four phases. Initially, hospital was started by members of the clergy, the nuns who along with providing care were also engaged in charitable services to the 'needy'. During renaissance, these religious centers became secularized and soon turned into places where the poor were fed and provided shelter along with provision of treatment. From the 17th century, there were noticeable developments in technology and medical knowledge, which was followed by an increase in number of hospitals as well as role of physicians in them. It is only in the 19th century that hospitals functioned as institutions solely dedicated for providing medical care, however not with much positive outcome. Finally, by the end of 19th century, as the society had held on to the pace of faster industrialization, the condition of hospitals changed drastically, and they became centers of medical technology and medical care open to all kind of people. This model helps us in understanding the modern-day functions of a hospital.

In the contemporary society, hospitals are providers of medical care, thereby aiding to community life. They also contribute to public welfare by acting as centers of research that bring about various inventions in the field of medicine. Moreover, as institutions that provide medical knowledge to students, they also enact as educational centers or universities. For instance, AIIMS, which is one of the leading hospitals in our country, is also a medical college and center for research bringing about new inventions in the field of medicine. Thus, in this capitalist economy, hospitals can be regarded as one of the largest employers of both clinical and non-clinical staff. As buyers of health care services, products and many other goods, they are also one of the prominent contributors to a country's economy. Hence, there has been a rise in the concept of 'medical tourism', which has been discussed in another unit. Despite these major functions that hospitals perform, they have been subjected to various kinds of criticisms. These include the rising callousness among medical professionals often leading to wrong diagnosis, the extreme rationalization in these organizations which has dampened the humanitarian aspect of it. Goffman criticizes hospitals by referring to them as 'total institutions.' He argues that since, in hospitals (mainly mental asylums) patients lead an administered life away from the society, they form new attachments which are based on these institutions (referring to this process as institutionalization), which makes it difficult for them to reintegrate into society again. He asserts that hospitals by depending on medicines, further this process of institutionalization which is extremely harmful for a patient's wellbeing. In the contemporary society, it is true that hospitals have undergone a drastic change, in fact Wilson calls a "large general hospital is the prototype of the multipurpose organization; it is a hotel and a school, a laboratory and a stage for treatment." However, the process of institutionalization still remains in hospital albeit its intensity has decreased.



Activity-2

Visit your near-by hospital and observe its organizational structure and functions. Write an analysis of it.

8.5 UNDERSTANDING THE PROFESSION OF MEDICINE

The discipline of sociology has always been interested in the concept of profession. There exist various theoretical traditions that provide analysis of professions or professional groups such as the functionalist theory or the neo-Weberian theory. In fact, Talcott Parsons is often regarded as the father of the study of professions. Although, having a single definition of profession is not quite possible, theoretical traditions in sociology have charted out various characteristics for a proper understanding of the idea of profession. Some of these features include provision of a definite, exclusive and necessary social service; possession of intellectual techniques and skills by practitioners of the profession; the methods used in the profession must be well researched and based on theoretical traditions; practitioners must exhibit lifetime commitment to their profession and should never engage in any form of malpractice. Every profession is awarded with social prestige and rewards. Certain level of public trust is attached to a profession. Every profession is attached with ideals of altruism and they also portray self-regulation, which basically means that professionals form their own organization keep a check on their practicing standard and licensing. Based on the above features, this section would analyze the profession of medicine and chart its historical development to understand its prominence in the contemporary society.

Humphry Rolleston has argued that “Medicine, in the ordinary sense namely, the supervision and cure of the sick is not, and probably never will be, an exact science; it is an art aided by the application of several sciences, in which philosophy, religion, and sometimes commercialism also play some part. The degree in which science is applied varies, not only in the hands of different individuals, but also in the various branches or departments of

medicine." Such a notion of medicine points to the fact that in order to understand the development of medicine as a profession, one needs to revisit the history or emergence of idea of medicine. Looking into the history of medicine, one can notice the change that has come up in the society, in its approach of dealing with health and illness. Some of the earliest medical traditions belonged to that of India, China, Babylon and Egypt. Medicine then, did not possess a universalistic feature, instead was quite dependent on the element of culture. The early forms of medicine were generally derived from the principle of 'humourism', also called as humoralism. This principle argues that in every human being, there are four kinds of humours or fluids: blood, phlegm, black bile and yellow bile. These fluids needed to be in equilibrium for a human being to be healthy. Thus, any kind of disease was treated as condition of disequilibrium of the four fluids in the body. The rise of modern medicine owes its discovery to the 'germ theory of disease' which indicated the fact that rather than humors, there are various kinds of germs-bacteria, viruses, fungi, etc., that cause infection in the body. Such discoveries were possible in the 19th century due to advancement in science and technology. Thus, similar to hospitals, the profession of medicine has also undergone through various phases. Today as our society has reached the epitome of technological advancement, the usage of these new technologies in medical care has been ever rising. Small pox has been entirely terminated, and there have been cures for many other deadly diseases. With the growth of modern medicine, various kinds of vaccines also were invented, which led emphasis on the idea of 'prevention' rather than 'cure'. Thus, the notion of "prevention is better than cure" came up. Hence, the role of science or scientific application of medicine is ever increasing in contemporary society. In fact, the extent of this scientific meddling in day to day lives has intensified so much that there have been numerous protests or criticisms against the process of medicalization. Medicalization generally refers to a process whereby any kind of human condition is treated through medical diagnosis only. Health care activists and various scholars have been speaking openly about the dangers of increasing medicalization of human lives. Sociology of medicine is one such

discipline that deals with the issues of medicalization and provides theoretical work based on various cultural and other forms of medicine to criticize it.

One such human condition, which is treated with extreme medicalization is the condition of pregnancy or the process of childbirth. Robbie E. Davis Floyd offers one such criticism of this process. She argues that obstetric rituals are nothing but a process of increased mechanization of the natural process of childbirth. She asserts that such rituals often tend to see women as the weaker sections, who are closer to nature and inferior, and hence are subjected to manipulation by men. Just as this natural world, hitherto considered as supernatural was brought under the control of man due to advancement in science, she argues women, who are closer to nature are also under the control of men and their technologies. She provides various conceptual dilemmas that are ingrained in obstetric rituals which exemplify the fact that these denigrate the female body and consider it as incapable of delivering a child naturally. For instance, the lithotomy position which is considered ideal for giving birth in hospitals is not the correct way or the healthy way for delivering a baby. It is considered the right way as it helps the doctor to be in proper control of the female body. Similarly, there have been numerous instances which have highlighted how every hospital has a designated number of caesareans to perform every day. This means that many times, doctors perform caesarean although there is no need of it, just for the sake of business. Such instances are not only limited to child birth but various other kinds of surgery or diagnosis also. Medicine today has abandoned its goal of altruism and health care and entered the capitalist world where the human body is seen as a commodity, which is under the control of doctor and his/her expertise or knowledge which the laymen lack. As the distrust between doctors and patients have increased today due to wrong diagnosis or surgeries, there has been an increase in the use of alternative medicine. The use of Ayurveda today has increased. In fact, many people have totally withdrawn from scientific medical care and are using alternative methods of Ayurveda, homeopathy along with yoga. Even today, with the advent of modern medicine and practices which apply to all societies, one can still notice the influence of culture in the treatment of

various kinds of medicine. For instance, in India, chicken pox was considered as a possession by the Goddess Sitala of a human body. Thus, the diagnosis involved numerous rituals and sacrifices to the deity Sitala which was believed to cure the disease. Even today, while there exists a scientific treatment of chicken pox, many of these cultural practices of pleasing the Goddess are still carried on in the Indian society. Also, there has been rising cases of home delivery these days, however with the supervision of a medical expert. Thus, today one can see a tendency of an amalgamation of both modernity and tradition in terms of medical care that people resort to.



ACTIVITY-3

Think how medicalization has affected every day life of human beings. Do you think there is an increase in the process of medicalization in the contemporary world?



CHECK YOUR PROGRESS

Q.1. Prison is an example of a social organization. True or False.·

Q.2. What other functions a hospital performs apart from provision of medical care?

.....

Q.3. What are the alternative forms of medicine which are being used in contemporary times?

.....

.....

Q.4. Name one natural human condition which has been extremely medicalized.

.....

.....



8.6 LET US SUM UP

- The term organization basically refers to the interdependence of various parts in a group.
- There are various characteristics or features of the social organizations. Few of these include a well-defined structure, goal or purpose, division of labor, system of communication within members, sexual composition of the members, leadership, spatio temporal cohesion and many more.
- Informal organizations are defined as a small group where the members share interpersonal relationship between each other. The interaction between the members consists of informal ways without adhering to any strict norms or rules of behavior.
- The role of hospital as a social organization which is a part of the wider society is not only confined to treatment of patients or provision of health care. The hospital can be regarded as a dynamic institution which has undergone major changes through various phases of history. Such changes are reflected in the social roles that this organization performs today.
- Goffman criticizes hospitals by referring to them as 'total institutions.' He argues that since, in hospitals (mainly mental asylums) patients lead an administered life away from the society, they form new attachments which are based on these institutions (referring to this process as institutionalization), which makes it difficult for them to reintegrate into society again.
- Medicalization generally refers to a process whereby any kind of human condition is treated through medical diagnosis only.
- Sociology of medicine is one such discipline that deals with the issues of medicalization and provides theoretical work based on various cultural and other forms of medicine to criticize it.



8.7 FURTHER READING

1) Floyd, R. E. (1990). The Role of Obstetrical Rituals in the Resolution of Cultural Anomaly. *Social Science & Medicine*, 175-189.

2) Rolleston, H. (1930). Medicine as a Career. *The British Medical Journal*, 699-702.

3) White, K. (2002). *An Introduction to the Sociology of Health and Illness.* London: Sage Publications.

4) Wilson, R. N. (1963). The Social Structure of a General Hospital. *The Annals of the American Academy of Political and Social Science*, 67-76.



8.8 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No 1 : True

Ans to Q No 2 : Apart from medical care, hospitals also act as educational institutions and centers of medical research. They are one of the leading employers in the capitalist world.

Ans to Q No 3 : Ayurveda along with yoga, Homeopathy

Ans to Q No 4 : Pregnancy or childbirth



8.9 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: What is meant by social organization?

Q 2: Highlight the historical transition in the organization of hospitals.

B) Long Questions (Answer each question within 300-500 words)

Q 1: Explain the rise of modern scientific medicine. Comment on the increasing medicalization of human conditions in contemporary society with an example.

Q 2: Explain how hospital can be considered as a social organization.

*** ***** ***

UNIT 9 : PUBLIC HEALTH

UNIT STRUCTURE

9.1 Learning Objectives

9.2 Introduction

9.3 Meaning of public health

9.4 Emergence of the notion of public health

9.5 Community health

9.6 Meaning of social epidemiology

9.7 Let Us Sum up

9.8 Further Reading

9.9 Answers to Check your Progress

9.10 Model Questions

9.1 LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Know the meaning of public health
- Understand emergence and notion of public health, community health
- Know the meaning of social epidemiology

9.2 INTRODUCTION

In this century it is very easy to point the tremendous progress that is made in the health and life expectancy of the people. It is seen that many dangerous diseases have decreased, mortality rate has reduced and better family planning has started. While discussing health of people it is discussed in terms of the diseases they suffer from. Most people make full recovery from diseases, but some suffer damage to their bodies and may have permanent disability. With the changing health conditions, public health emerged as an important aspect of health care. The basic health services should be provided by dispensaries and health centres. They represent the minimum level of health services that should be

available to the majority of the population. They have also been called ‘essential health services’and are incorporated in the most popular current term ‘primary health care’.

9.3 MEANING OF PUBLIC HEALTH

Public health is the science and art of preventing disease, prolonging life and promoting physical health and efficiency through organised community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organisation of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health. Sir Donald Acheson in 1988 defined public health as: ‘the science and art of preventing disease, prolonging life and promoting, protecting and improving health through the organised efforts of society’. Public health can be defined as the science of protecting the safety and improving the health of communities through education, policy making and research for diseases. The meaning of public health is different for every person. Whether you like to crunch numbers, conduct laboratory or field research, formulate policy, or work directly with people to help improve their health, there is a place for you in the field of public health.

The importance of this field is that it pays attention to social context of health and disease and focuses on improvement of health through social measures such as vaccinations, good drinking water and good policies. Public health is related to health of communities, not an individual’s health. The concept of public health is unique in nature and is changing over time with years because of the health status of the population and the determining situations of health. The definition of health is widely linked with public health as found in the Preamble of the constitution of the World Health Organisation (1948), where health is referred to as “a state of complete physical, mental and social well-being

and not merely the absence of disease."The meaning of public health is to create a right condition to provide better health condition. Public health involves the application of many different disciplines such as biology, anthropology, public policy, mathematics, engineering, education, psychology, computer science, sociology, medicine, business and others.

9.4 EMERGENCE OF THE NOTION OF PUBLIC HEALTH

The history of public health is related to various historical ideas, trial and error, the development of basic sciences, technology, and epidemiology. James Lind's clinical trial of various dietary treatments of British sailors with scurvy in 1756 and Edward Jenner's 1796 discovery that cowpox vaccination prevents smallpox have modern-day applications as the science and practices of nutrition and immunization are crucial influences on health among the populations of developing and developed countries. History is a way of looking into the perspective of health by an understanding of health problems of communities and how to cope with them. Two factors have shaped the modern public health system i.e. the growth of scientific inquiry and research on sources and means of controlling disease and the growth of public acceptance of disease as both possibility and a public responsibility.

Throughout recorded history, epidemics such as the plague, cholera, and smallpox evoked sporadic public efforts to protect citizens in the face of dreaded diseases. By the eighteenth century, isolation of the ill and quarantine of the exposed became common measures for containing specified contagious diseases. During eighteenth century, cities began to establish voluntary general hospitals for the physically ill and public institutions for the care of the mentally ill. Even the physically and mentally ill dependents were cared by their neighbours in local communities. The nineteenth century is a beginning of new era in public health. "The great sanitary awakening" became popular and the identification of filth as both a cause of disease and a vehicle of transmission and the ensuing embrace of cleanliness was a central idea.

Awakening of sanitation paved a new way to see health. Illness came to be seen as an indicator of poor social and environmental conditions, as well as poor moral and spiritual conditions. Protecting health became a social responsibility. Disease control continued to focus on epidemics, but the manner of controlling turned from quarantine and isolation of the individual to cleaning up and improving the common environment. And disease control shifted from reacting to intermittent outbreaks to continuing measures for prevention. With sanitation, public health became a societal goal and protecting health became a public activity. Another major development in public health took place at the close of the nineteenth century. Rapid advances in scientific knowledge about causes and prevention of numerous diseases brought about tremendous changes in public health. Many major contagious diseases were brought under control through science applied to public health. Louis Pasteur, a French chemist, proved in 1877 that anthrax is caused by bacteria. By 1884, he had developed artificial immunization against the disease. During the following few years, discoveries of bacteriologic agents of disease were made in European and American laboratories for such contagious diseases as tuberculosis, diphtheria, typhoid, and yellow fever. During that time public health became an important issue that needed important attention.

The state and local health departments were started during 1890s and began to establish laboratories. These laboratories concentrated on improving sanitation through detection and control of bacteria in water systems. Some of the changes that are seen with the enthusiasm about public health is that people started embracing the new scientific foundation for public health. Scientific measures such as replacing earlier social, sanitary, moral, and religious reform measures to combat diseases were taken into account. Science was seen as a more effective means of achieving desirable social goals regarding public health services. Diseases were taken seriously and it was thought that proper public health service only can achieve good health condition. Use of scientific measures for infectious disease control were taken seriously. The health officers were asked to concentrate on controlling specific routes of disease transmission.

The new methods of disease control were found remarkably effective. The public health became a scientific enterprise, it also became the province of experts. Prevention and control of disease were no longer tasks of common sense and social compassion, but of knowledge and expertise. Health reforms were guided by engineers, chemists, biologists, and physicians. And the health department gained stature as a source of scientific knowledge in health. It became clear that not only public and individual restraint were needed to control infectious diseases, but also state agency, epidemiologists and their laboratories were needed to direct the way.

During twentieth century, new changes started to take over. It was seen that the role of the state and local public health departments expanded greatly. It was understood that individual persons are also a kind of source of disease transmission. Identification and treatment of individual cases of disease were taken seriously and it was believed that treating an individual will be a contribution towards treating the whole community. It is also seen from various data that providing immunizations and treating infectious diseases did not solve all health problems. Despite remarkable success in lowering death rates from typhoid, diphtheria, and other contagious diseases, considerable disability continued to exist in the population. There were still numerous diseases, such as tuberculosis, for which infectious agents were not clearly identified. The public agencies started to move into clinical care and education and from that the orientation of public health shifted from disease prevention to promotion of overall health. Epidemiology provided a scientific justification for health programs that had originated with social reforms. Public health once again became a task of promoting a healthy society. In the twentieth century, this goal was to be achieved through scientific analysis of disease, medical treatment of individuals, and education on healthy habits. From the 1930s through the 1970s, it is seen that the local and state responsibilities towards health increased. The role of state towards health also increased prominently. The strong governments had strong moral values towards public health service. This shows that emergence of

public health has came a long way. The government took interest in both state and local health agencies for providing and planning health services, in health promotion and health education, and in financing health services. The agencies also continued and increased activities in environmental sanitation, epidemiology, and health statistics. Expansion of state activities in health sectors is also seen.

State started expanding their activities in health to accommodate medical care, health promotion and education, and health planning. Maternal and child health, family planning, immunization, venereal disease control, and tuberculosis control are some of the key issues that were taken into account and local health departments were to provide these services. Many people were assigned for better performance of health care service. In current era the efforts are seen towards cost containment. Although health needs and health services have not diminished, political and social values of the time encourage fiscal constraint. Current values also emphasize state responsibility for most health and welfare programs. Changes also have been made in Medicare payment policies to restrain the increase in costs, especially for hospital care. Many new health problems started to surface with time. AIDS, a previously unknown contagious disease, is reaching epidemic proportions. Greater numbers of hazardous by-products of industry are being produced and disposed of in the environment. Many other issues are of growing concern—asbestos exposure, side effects from pertussis vaccines, Alzheimer's disease, alcoholism and drug abuse, and homelessness are just a few.

New health problems continue to be identified, conflicting with concerns about the growth of government and government spending in health. Although science provided a foundation for public health, social values have shaped the system. The task of the public health agency has been not only to define objectives for the health care system based on facts about illness and health, but also to find means to implement health goals within a social structure. The development of a scientific base for public health allowed some consistency in the public health system. Health care included sanitation, laboratory investigation, collecting

vital statistics, regulation of the environment, epidemiology, administering vaccines, maternal and child health, mental health, and care of the poor. How local systems conduct these programs differs greatly from area to area. Changing values over both time and place have allowed great variety in the implementation of public health.

9.5 COMMUNITY HEALTH

Before understanding the meaning of community health, it is important to understand the meaning of community. A community is a collection of people who interact with one another and whose common interest or characteristics gives them a sense of unity and belonging. A community is a group of people in defined geographical area with common goal and objective and the potential for interacting with one another. People belonging to same community have a sense of belongingness and shared identity. Some communities may share almost everything, while other communities (large, scattered and composed of individuals) who may share only their common interests and involvement in certain goals. A community is often defined by its geographic boundaries and is thus called a geographic community. A community demarcated by geographic boundaries becomes a clear target for analysis of health needs to form basis for planning health programs and a geographic community is also easily mobilized for action. Community can also be identified by a common interest or goal. A collection of people, although they are widely scattered geographically, can have an interest or goal that binds the members together, called common interest community.

Community health is the part of medicine which is concerned with the health of the whole population and the prevention of diseases from which it suffers. The process is done taking into consideration the whole community in mind. In this method, firstly, diagnosis of diseases is made at community level, preventive measures are taken, and then suitable control programmes are organized. Limited amount of money is also an issue when it comes to community health care services. The limited

amount of money makes it necessary to work out which among the important and preventable diseases are the priorities, and then to decide on the most effective control programmes that can be afforded. The medical services have traditionally been organized around curative medicine, like that carried out by dispensaries, outpatient departments, and hospitals. These services offer help to sick people who come and ask for it, but they do very little for those who do not come and do not ask. The people who come for medicine can cure some diseases, reduce some suffering, and prevent some deaths, but it can do very little to alter the number of new cases of an illness which occur in the community. To control the number of people who become ill, it is important to start before the people become sick. This is preventive medicine. To practise effective preventive medicine, it is necessary to make some simple health services available to all those who might get sick. Some communities appear to have more sickness and deaths than other communities. Problems such as more children with malnutrition, or more young people with tuberculosis or anaemia are taken care of in community health.Such observations about health and disease patterns in a community and what can be done about them lead to the practice of community health. In the case of individual person's illness, it is necessary to collect some basic information about illness, or what stage the illness that he/she may be suffering from has reached.This is done by history taking, physical examination, and investigations.This is followed by making a diagnosis of what is wrong. Same is with the community. First, it is important to collect information about the whole community and then diagnosis the health-related problem and decide on the most appropriate community health (treatment) programmes; and finally follow up and evaluate the programmes to see if they have done any good in making the community healthier.

9.6 MEANING OF SOCIAL EPIDEMIOLOGY

Social epidemiology is a branch of epidemiology that studies the distribution and determinants of health and disease in populations. Social epidemiology focuses particularly on the effects of socio-structural factors on states of health. Social epidemiology assumes that the distribution of health and disease in a society reflects the distribution of advantages and disadvantages in that society. Social epidemiology proposes to identify societal characteristics that affect the pattern of disease and health distribution in a society and to understand its mechanisms. Social epidemiology is a recent idea, and according to it the social conditions affect health.

Social condition influencing health is not a new concept. Durkheim explains that social norms and conditions affect risks of suicide in the population. Social epidemiology builds and expands on this literature by posing new research questions, utilising new research methods and influencing government policy agenda.Social epidemiology is a very systematic process to understand health, wellbeing, social conditions or problems, diseases and their determinants. In this way social science methods can develop interventions, programs, policies,and health institutions that may reduce the extent, adverse impact or incidences of health or social problems and also promote health. The approach of social epidemiology reflects the understanding that social variables or conditions can lie on either side of the equation determining the factors that affect health and illness.



CHECK YOUR PROGRESS

Q.1. What is meant by public health?

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Q.2. Define community.

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9.7 LET US SUM UP

- Public health is the science and art of preventing disease, prolonging life and promoting physical health and efficiency through organised community efforts.
- The importance of this field is that it pays attention to social context of health and disease and focuses on improvement of health through social measures such as vaccinations, good drinking water and good policies.
- The definition of health is widely linked with public health as found in the preamble of the constitution of the World Health Organisation (1948), where health is referred to as “a state of complete physical, mental and social well-being and not merely the absence of disease.”
- A major development in public health took place at the close of the nineteenth century. Rapid advances in scientific knowledge about causes and prevention of numerous diseases brought about tremendous changes in public health.
- Scientific measures such as replacing earlier social, sanitary, moral, and religious reform measures to combat disease were taken into account.Science was seen as a more effective means of achieving desirable social goals regarding public health services. Diseases were taken seriously and it was thought that proper public health service only can achieve good health condition.
- During twentieth century, new changes started to take over. The role of the state and local public health departments expanded greatly. It was understood that individual persons are also a kind of source of disease transmission.

- State started expanding their activities in health to accommodate medical care, health promotion and education, and health planning. Maternal and child health, family planning, immunization, venereal disease control, and tuberculosis control are some of the key issues that were taken into account.
- New health problems continue to be identified, conflicting with concerns about the growth of government and government spending in health.Although science provided a foundation for public health, social values have shaped the system. The task of the public health agency has been not only to define objectives for the health care system based on facts about illness and health, but also to find means to implement health goals within a social structure.
- A community is a collection of people who interact with one another and whose common interest or characteristics gives them a sense of unity and belonging.
- Community health is the part of medicine which is concerned with the health of the whole population and the prevention of diseases from which it suffers. The process is done taking into consideration the whole community in mind.
- Social epidemiology is a branch of epidemiology that studies the distribution and determinants of health and disease in populations. It asserts that health is affected or influenced by social conditions.



9.8 FURTHER READING

1) Greifinger,Robert (2007), Public Health Behind Bars : From Prisons to Communities, Springer Publication, New York.



9.9 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No 1 : Public health is the science and art of preventing

disease, prolonging life and promoting physical health and efficiency through organised community efforts.

Ans to Q No 2 : A community is a collection of people who interact with one another and whose common interest or characteristics gives them a sense of unity and belonging.



9.10 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1 : What is meant by being healthy?

Q 2 : What is social epidemiology?

B) Long Questions (Answer each question within 300-500 words)

Q 1: Explain the emergence of the notion of public health.

Q 2: Write about community and community health?

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UNIT 10 : SOCIAL INEQUALITY AND HEALTH

UNIT STRUCTURE

10.1 Learning Objectives

10.2 Introduction

10.3 Equity and Inequality in Health: A Stratified Reality

10.4 Globalisation of Health and Diseases

10.5 Medical Tourism : Its Impacts in a Globalised World

10.6 Let us sum up

10.7 Further reading

10.8 Answers to check your progress

10.9 Model questions

10.1 LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Understand 'health' and its relationship to social inequality.
- Understand 'health' in the context of globalisation.
- Understand medical tourism as one facet of health in globalised world.

10.2 INTRODUCTION

Sociological studies in the field of health and diseases which come under the rubric of medical sociology or health sociology, attempt to look at the social causes and consequences of health and illness. Out of many aspects of this branch of study, a very important aspect is its understanding of the relationship between the social factors and the health of individual or groups or a larger society. Social conditions are an important determining factor of illness and prevention and can either enhance or hinder access to proper health care or even a healthy environment. Eero Lahelma explains that it is an inherent starting point of any medical sociological analysis that health and illness are embedded not only in the biological but equally in the social context. Therefore the

issue of how people's social environments contribute to the onset, course, and consequences of their illness and disease forms a key area of medical sociology. The question of how health, illness and death are socially produced and hence linked to the concepts of social stratification are made the focal point. In this domain, different forms of stratification such as socio-economic class, education, gender are all termed important in understanding the disparities in terms of providing health care and receiving the same. Eero points out that social stratification related to health is typically called socioeconomic inequalities in health or health inequalities. In this unit, we will learn briefly about the forms of stratification and how it affects health. Also we would look at the context of globalisation and a very popular trend of medical tourism to understand the relationship between social inequality and health.

10.3 EQUITY AND INEQUALITY IN HEALTH : A STRATIFIED REALITY

As given by World Health Organisation (WHO), " 'equity' in health implies that everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided". The policies and goals tend to focus on the concept of 'equity' and avoid possible biases so that no group or individual face any kind of disadvantage. Margaret Whitehead while discussing the concept and principles of 'equity' suggests that the aim of policy for equity and health is not to eliminate all health differences so that everyone has the same level and quality of health, but rather to reduce or eliminate those which result from factors which are considered to be both avoidable and unfair. Any approach using the notion of equity aims for equal access to available care for equal need, equal utilization for equal need and equal quality concern for all. Whitehead argues that in most of the discussions on equity, confusion arises since another concept 'inequity' gets implicated. 'Inequities' could be in the level and quality of health of different groups

in the population or inequities in the provision and distribution of health services. The term 'inequity' has a moral and ethical dimension too. Very similar but slightly different is also the term 'inequality' which in the context of health is used to indicate systematic, avoidable and important differences.

Students of sociology will be familiar with the system of stratification prevalent in a society. Scholars like Dipankar Gupta distinguishes between 'difference' and 'inequality'. He argues that differences between individuals are inevitable but to discriminate an individual or a group on the basis of their difference is 'inequality'. Systems that produce and re-produce inequality marginalise certain section of people and thus they often fail to get access to any kind of policies or rights even though the policies were intended to work on the principles of 'equity'.

Social stratification is a system based on inequalities. It divides society into different layers called strata and rank them in a hierarchy. Categorisation and division into groups is done on the basis of birth, race, gender, caste, class, ethnicity and so on. Stratification on the basis of caste, class (socio-economic), race and gender, are some common examples.



LET US KNOW

Social Determinants of Health (SDH) are the conditions in which people are born, grow, live, work and age".

In studies on community health, there has been an increasing focus on Social Determinants of Health (SDH). World Health Organisation's commission on Social Determinants of Health defined SDH as "the conditions in which people are born, grow, live, work and age" and "the fundamental drivers of these conditions." The 'social determinants' is used to denote factors which are available in one's social space, health-related features of neighbourhood, which can influence health-related

behaviours. Socio-economic factors such as income, wealth, education serve as fundamental causes of a wide range of health outcomes. Thomas Mckeown draws causal explanation between dramatic increase in life expectancy since 19th century and improved living conditions, including nutrition, sanitation, and clean water. When a group or individual fail to get proper access to these basic human needs, it ultimately leads to vulnerable health hazards. Large inequalities in health according to social class have also been documented in various studies and reports. For example, Whitehead in her article cites that in Finland, 42% of people with lower incomes suffer chronic illness, as opposed to 18% of the high-income group. She further sites another study carried out in the United Kingdom of people who died prematurely in different neighbourhoods. According to this report, men and women in poorer areas were likely to have been chronically ill or disabled for longer before death and to have suffered a greater number of distinct health problems than their counterparts in more affluent localities.

Bruce Link and Jo Phelan discussed how and why social inequality is a fundamental cause of health disparities. They also argue that the unequal distribution of socio-economic resources inevitably leads to health inequalities as those with more resources use them to obtain and act on new and better information. Other factors like racial discrimination, gender, education etc all contribute to health disparities.

In India where there is low female-male ratio, the mortality and morbidity indicators are unfavourable to the females. Maternal mortality in developing countries including India is unacceptably high. There is a failure of achievement of Millennium Development Goals in relation to maternal mortality and gender equality and empowerment of women. Global Gender Gap Index 2016 indicates that India is at 142nd rank in health and survival.

Social inequalities or forms of stratification hinder equal distribution of basic resources which then leads to non-accessibility to certain resources, health care and government policies to provide equal healthcare.



ACTIVITY 1

Q.1. Can you think of some forms of stratification and how it affects health?

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CHECK YOUR PROGRESS (A)

Q.1. How true is the statement "differences in health across the social groups reflect the fact that the better off lives a healthier lifestyle"?

a. Both lifestyle and social grouping interact to influence risk of ill-health

b. Absolutely true. The differences totally reflect lifestyle differences

c. Lifestyle and social group independently predict health

b. Absolutely untrue. The differences are unrelated to lifestyle.

10.4 GLOBALISATION OF HEALTH AND DISEASES

Generally, globalisation refers to the increasing interconnections among societies, regions, nations in terms of their economy, culture and other values at a global level. The world gradually moves towards becoming a signle whole where something happening at one place has an effect in most of the places since they are all interconnected. In terms of health, globalisation indicates an aspect of this phenomenon. World Health Organisation (WHO) has been working in this field where their attempt focusses on assisting countries to assess and act on the cross-border risks to public health security. They support collective action since domestic action often remain inefficent and thus ensure cross-border health risks. Scholars have been asking whether health-care is becoming more alike as globalisaiton connect the economic, political and social systems at a global level. Many have also approahced this with comparative study of health systems of different countries or regions

which serves as a reflection of a new academic interest re-inventing itself in a gobal context. Looking at globalisation's impact on health which can be easily fast-tracked through media exposure and technological informaiton resources, Mechanic and Rochefort described threads of connection derived from global shifts and called it 'emerging convergences'. It means that due to fast growing global links cross-national and dependent imperatives are growing in the case of

- Expansion of access to health care
- Financing of care
- Government roles
- Patient choice

Globalisation is affecting diseases equally. Paul Farmer has shown how global social inequalities are at the centre of many emerging diseases. According to his study, those in power use structural violence to erase history by discouraging scrutiny of the political-economic factors that bring humans into contact with pathogens. Globalisaiton, along with two other inter related factors- urbanisation and disease emergence, affect the disease and health.

George Armelagos and kristin Herper suggests that globalisation has a deep imapact on the use of anti-biotics. Common notion about anti-biotics is that a new one can be developed when a pathogen becomes resistant to a specific anti-biotic. But this should have been foretold that resitant anti-biotics were inevitable. There is a massive use and production of anti-biotics. Just as infectious diseases have been subjected to globalisation, antibiotic resisitance has met the same end. Globalisation thus, increases the vulnerability of disease threats from other countries and the anti-biotic resistant pathogens they carry. The pattern of anit-biotic resistance has been compared in China, Kuwait and the United states with the purpose of understanding the global threat of the phenomenon. Many have even put out strategies and collective actions for containing resistance. With globalisation going in full swing, international convergence of anti-biotic resisitance seems like a possibility. Emergence of diseases, which are resisitant to at least one anti-biotic and some

resistant to many antibiotics is a challenge in the era of globalisation. Globalisation is also coupled with unprecedented urbanisation and global warming which poses different kinds of threats.

WHO's initiative regarding globalisation and health mentioned earlier becomes very important where the world is collectively facing lots of health issues. One important part of their program is Global Public Goods (GPG) where they provide a framework for assesing and resolving problems of collective action at the global level. The concept of GPG offers a powerful lens to analyse and promote the health of the poor.

Since medical tourism offers an example to underestand globalisation of health and its related issues, the phenomenon of globalisation would be discussed extensively with the case of medical tourism in the next section.



CHECK YOUR PROGRESS (B)

Q.1. Define globalisation.

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ACTIVITY 2

1. Think of the major ways in which globalisation is affecting health and diseases.

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2. Do you agree that the governments should come together to face the global challenges in health? Think of reasons why you think so.

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10.5 MEDICAL TOURISM: ITS IMPACTS IN A GLOBALIZED WORLD

Medical Tourism is an emerging concept in the tourism industry. It refers to any form of tourism undertaken with the purpose of addressing a health concern at the same time receiving equal to or greater care than they would have in their home country. Medical Tourism has become an attractive option for potential economic growth in many countries across the world. Some of the countries that actively promote medical tourism include Belgium, Costa Rica, Cuba, Hungary, India, Jordan, Malaysia, South Africa and Thailand. The following are responsible for increased consumption for health care beyond borders.

a) Desire of healthy life

b) Advanced technology

c) Cost saving

d) Increasing availability of information and communication to consumers worldwide

The first ever recorded instances of medical tourism date back thousands of years to when worshippers of Asclepius, the Greco-Roman god of medicine, would make pilgrimages to his temple in Epidaurus, where they would undergo healing through “incubation rituals,” which were rooted in prayer, fasting, and ceremony. In later centuries, as travel and tourism increased, spas and health resorts in countries worldwide often attracted clientele from overseas. In India also, the hotsprings like Rajgir and Bakreshwar have been drawly visitors since time memorial. Since late 1970s health tourism has been widely accepted as an international phenomenon for individuals travelling, in which patients travel foreign countries. The practice of travelling internationally for surgery, however, is a relatively recent phenomenon. That growth appeared to parallel the worldwide boom in medical tourism that took place in the early 21st century.

Now, travel for medical treatment has enormously expanded and hence, many travel from developed countries to low or middle income

countries, often to avoid high costs and long delays.

Globalization is regarded as a new phase of world integration with increased density and frequency of international or global social interactions relative to local or national ones. The globalization of healthcare, which includes medical tourism, has become a reality which has assumed increasing importance for developing countries, particularly in Asia.



LET US KNOW

Types of Medical Tourism

Outbound : This type of medical tourism occurs when patients travel from the home country to a foreign country to receive medical treatment.

Inbound : This type involves patients traveling from a foreign country to the home country in search of medical care.

Intrabound or Domestic : Refers to patients traveling to another part of their own country. No international travel happens.

The increasing privatization of health care and globalizing processes such as trade liberalization have enabled this industry to operate and grow, with corporations developing chains of medical facilities and other manufacturing and service activities that compliment medical tourism practices. Standardized information technology in the form of the internet, mobile phones, free web browsers and social networks means that more people are sharing information online about an expanding spectrum of their lives. Standardized information technology enables more businesses to offer information about their products and services in forms that other people can recognize, understand and use. These inexpensive communication technologies are creating global markets and collaboration among people located around the world. In addition, falling prices of air travel mean that it is increasingly fast, convenient and relatively less expensive to travel globally than ever before.

Liberalization of financial services enables people to pay for goods

around the world much more easily than ever before. Growing demand for health services is a global phenomenon, linked to economic development that generates rising incomes and education. Demographic changes, especially population ageing and older people's requirements for more medical services, coupled with epidemiological change, i.e. rising incidence of chronic conditions, also fuel demand for more and better health services. Waiting times and/or the increasing cost of health services at home, coupled with the availability of cheaper alternatives in developing countries, has led new healthcare consumers, or medical tourists, to seek treatment overseas. The correspondent growth in the global health service sector reflects this demand. The globalization of healthcare is marked by increasing international trade in health products and services, strikingly via cross border patient flow.



LET US KNOW

Intrinsic Factors (Push from home country)

- Demographic changes
- High cost of health care services
- Poor quality
- Long waiting lists
- Poor accessibility
- Inadequate insurance coverage
- International agreement

Impact of Globalization on Medical Tourism :

As Global competition is highly emerging in the health care industry, today, constraints and long waiting lines at home, as well as the ease of global travel, make medical tourism more appealing. The medical services industry hasn't been global historically but is becoming so now. There are several reasons that globalization can manifest itself in this industry :

- Patients with resources can easily go where care is provided. Historically doctors moved from Africa and India to London and New York to provide care. Now, it is the reverse which is true.

- High quality care, state-of-the-art facilities, and skilled doctors are available in many parts of the world, including in developing countries.
- Health care insurance companies within industrialized nations have begun considering medical tourism as a potential cost-saving measure, and are seriously considering the provision of round trip airfare to tourists for this kind of travel.
- Medical tourism holds the promise of reducing health care costs for individuals, companies, and governments, as the latter will likely offer discounts or rebates to their employees and constituents to prompt them to choose the medical tourism option and, in turn, reduce the insurer's and self-insurer's growing costs of providing quality health care.

There are also many companies that can help arrange patients' surgeries, travel arrangements and tours. Many of these companies partner with specific hospitals, thereby arranging a cheaper price for their patients than one could arrange on their own through the hospital directly. The emergence of a private sector that thrives by servicing a small percentage of the population that has the ability to afford medical care has changed the character of the medical care sector.



LET US KNOW

Extrinsic Factors (Pull to home country)

- Cheaper health care service
- No or Short waiting list
- High quality service
- Advance technology
- Ease of access to care
- Better transportation facilities
- Organised facilitators
- Social media and networking
- International agreements

POSITIVE IMPACTS

- **Social Impact :** When established as an industry, medical tourism is significantly instrumental in moulding the society. It contributes not just in terms of enhanced, speedier or affordable healthcare, but also lends itself to infrastructural betterments, more employment opportunities with an increased propensity towards overall wealth creation.
- **Financial Impact :** Manufacturing industries, foreign investments, business exports, agricultural, mineral products or information technology services, are currently among the most prominent and largest contributors to any nation's Gross Domestic Product (GDP). It has enormous potential as a service-sector industry and private hospitals stand to gain the most from it, provided they invest in the appropriate medical infrastructure and adequately promote their capabilities. As more and more foreigners troop into the country to avail cheaper, better and faster remedies for their illnesses, the chances of financial gain with a higher return on the basic investment is then guaranteed.
- **Industrial Impact :** Several industries, closely associated with the world health tourism sector are significantly impacted by its growth and development. These closely allied industries which are promoted as a result of the surge in medical tourism get a new foundation and recognition in the global sphere and are forever retained in memories, standing a chance of benefiting through future investments.
- **Tourism :** All medical tourists do not visit a country with the only purpose of a treatment or surgery. They also intend to tour the country's other historical or natural attractions. This trend is growing as tourists tend to invest the amount they save in healthcare, in sight-seeing. This serves as significant revenue for the tourism industry and forms a portion of total profits of the industry.
- **Pharmaceutical :** The pharmaceutical industry is very closely associated with the field of medical science. When one undergoes treatment or surgery in one country, he/she is bound to take over-the-

counter drugs sold in the same area. This increases the sale of medicines in a directly proportional manner such that, the number of surgeries or treatment conducted directly adds to the profits of the pharmaceutical company of the country that is a prominent medical tourism destination.

- **Medical Tourism Facilitator :** Because of the complexity of this decision-making process, some medical tourists seek help from travel agents or the international patient departments of hospitals, or concierge service providers.
- **Public and Private sectors :** The medical tourism industry is served both by private as well as public sector industries. While the public sector contributes to the overall infrastructure and associated processes like permitting medical visa, clearing foreign passports, facilitating foreign exchange etc; the private sector totally takes over the comfort & hospitality department as well as the healthcare facilities.

  The kind of medical care and amenities provided by private sector industries is generally far more superior to that offered by government establishments. Under such situations, a public private partnership tends to equalize profits, adds to overall infrastructural benefits and caters to the needs of the foreign medical tourist, in a balanced manner making the overall procedure smooth, rapid and economical.
- **Intellectual Impact :** A country that prospers in the healthcare tourism industry will experience less of the Brain-Drain phenomenon which commonly portrays the exit of trained professionals from their home country to a foreign nation availing better employment and financial opportunities. This phenomenon quite frequent among the medical community, is easily plugged because medical tourism pays ample impetus to the treatment of rare global disorders. Many intelligent or expert medical professionals generally look up to such challenges, as they get the required job satisfaction and financial fulfilment even when stationed in their native country.
  - ***Political Impact :*** When one country serves as a major tourism destination for another and there is constant exchange

of treatment and revenue between them, the political links between those nations are affected in a positive manner. Stronger bonds between those nations are forged when the host nation provides the foreign tourists with several amenities besides conducive medical treatment.

NEGATIVE IMPACT

- **Healthcare impact :** With patient travels, there is significant risk of corresponding bacterial travel. All industry professionals must understand the negative impact of communicable diseases. Hence, good strategies should be developed by global organizations to protect spread of such diseases. It is true that medical tourism escalates the per capita rates of the host country but it escalates several other detrimental factors as well. For infrastructural growth, the natural greenery or forest cover of a region is compromised in order to accommodate more buildings, hospital facilities, roads, treatment or diagnostic centres etc. To supplement the above, there is a continuous discharge of polluted air, solid -toxic medical waste, litters of sewage consisting of oil and chemicals. Architectural, noise and visual pollution also has a direct negative impact on the atmosphere.

  Health tourism also creates a dearth of local resources like power, food stock, fuel and other unredeemable natural resources, which could already be in short supply within the host country. Water, another non-replenishable natural resource, is commonly misused in hotels, spas and swimming pools through careless personal use by tourists.

  With an increased number of health tourists, the hospital adopts the policy of being paid in accordance to an overseas system. Such a structure, even though economical to a foreigner, tends to be expensive for the native. As a result, all sections of people within a particular nation are not able to avail the advanced treatment options available within the country. This creates a negative impact on the health infrastructure of a country.

- **Economic Impact :** Healthcare tourism in most countries runs through private institutions. Currently the private sector in most developed countries accounts for a larger number of surgical procedures, treatment operations, and ultimately in the overall number of patients from all over the globe. Thus the revenue generated by this sector is much greater compared to that generated by the government or the public sector. The latter shows low expenditure in healthcare sector, poor management of resources, corruption, infrastructure shortfalls, slower growth, etc., to name a few. The uncontrolled growth of the private sector leads to inequalities and profit imbalance across both sectors.
- **Ethical & Legal Impact :** Many medical tourism hospitals would tap into unethical practices to grab international patients, such as restricted regional treatments or several other medical services which are restricted, regulated or controlled in one region. Another issue in medical tourism concerns the illegal trafficking of organs. Countries with indigent or vulnerable populations frequently have a greater availability of organs for medical use, since members of these populations are often tempted to risk their health and give up an organ with the promise of monetary compensation. Combined with the lack of adequate resources for donor care, the practices surrounding organ obtainment have been targeted as an aspect of medical tourism in need of greater regulation and oversight. Likewise, the exploitation of medical procedures for which efficacy is unproven or for which safety is unknown is a point of discussion for standardization and regulation. Legal issues are also likely to rise as this industry presents unique problems and challenges for both consumers as well as providers.

  Inconsistency in quality of care is a major source of criticism for the medical tourism industry. One of the primary mechanisms implemented for the standardization of international health care is accreditation. Accreditation attempts to ensure that medical tourism facilities meet basic safety standards, are staffed

with trained personnel, and have appropriate medical equipment to perform the procedures offered. Those organizations charge fees to clients who want to have their facilities surveyed for accreditation, and each organization maintains a list of accredited hospitals to help persons wishing to travel internationally for health care select a facility that will meet their needs.

In sum, medical tourism does have both positive and negative impacts on healthcare, economic, social and environmental sectors in the globalized world which creates both opportunities and risk factor for this growing industry.



ACTIVITY 3

Q.1. What are your views about medical tourism?

.....

.....

.....



10.6 LET US SUM UP

- As given by World Health Organisation (WHO), " 'equity' in health implies that everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided".
- Social stratification is a system based on inequalities. It divides society into different layers called strata and rank them in a hierarchy.
- Social inequalities or forms of stratification hinder equal distribution of basic resources which then leads to non-accessibility to certain resources, health care and government policies to provide equal healthcare.
- In terms of health, globalisation indicates an aspect of this phenomenon. World Health Organisation (WHO) has been working in this filed where their attempt focusses on assisting countries to

assess and act on the cross-border risks to public health security.

- Globalisation is affecting diseases equally. Paul Farmer has shown how global social inequalities are at the centre of mnay emerging diseases.
- George Armelagos and Kristin Herper suggest that globalisation has a deep imapct on the use of anti-biotics.
- Medical Tourism is an emerging concept in the tourism industry. It refers to any form of tourism undertaken with the purpose of addressing a health concern at the same time receiving equal to or greater care than they would have in their home country.
- Liberalization of financial services enables people to pay for goods around the world much more easily than ever before. Growing demand for health services is a global phenomenon, linked to economic development that generates rising incomes and education.
- When established as an industry, medical tourism is significantly instrumental in moulding the society of a nation. It contributes not just in terms of enhanced, speedier or affordable healthcare, but also lends itself to infrastructural betterments, more employment opportunities with an increased propensity towards overall wealth creation.
- Medical Tourism also has negative impacts like spread of diseases, inequality in access to good health care facilities, etc.



10.7 FURTHER READING

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2) Davey Smith, G. 1996. "Income inequality and morality: Why are they Related? *British Medical Journal* 312: 987-8

3) Hummer, R.A. 1996. "Black-White Differences in Health and Mortality: A Review and Conceptual Model" *Sociological Quaterly*, 37: 105-25



10.8 ANSWERS TO CHECK YOUR PROGRESS

A. Ans to Q No 1 : (b) True. The differences totally reflect lifestyle differences.

B.

Ans to Q No 1 : Globalisation refers to interconnectedness among societies, nations, etc. in terms of economy, culture etc., at a global level.



10.9 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: Highlight the relationship between social inequality and health?

B) Long Questions (Answer each question within 300-500 words)

Q 1: How does globalisation affect health at a global level and how can one solve these problems?

Q 2: What is medical tourism? Briefly explain its merits and de-merits.

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UNIT 11 : SOCIAL CONTROL OF BODY

UNIT STRUCTURE

11.1 Learning Objectives

11.2 Introduction

11.3 Anorexia : Meaning and Causes

11.4 Consequences of Anorexia

11.5 Defining Bulimia

11.6 Consequences of Bulimia

11.7 Preventive measures of Anorexia and Bulimia

11.8 Let us sum up

11.9 Further Reading

11.10 Answers to Check your Progress

11.11 Model Questions

11.1 LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Understand Anorexia, its causes and consequences
- Understand Bulimia, its causes and consequences
- Know about the Preventive Measures of Anorexia and Bulimia

11.2 INTRODUCTION

Bodies are socially constructed in material and cultural worlds, which means they have both physical and symbolic significance. Though physical appearance plays an important role for both men and women, it is of much central importance when it comes to evaluating a woman. Women over the centuries have continuously tried to adapt and fit into the social construction of beauty. Body weight has long been a marker of social status. In most places, where food is scarce, corpulence signals high rather than low status. In these cultures, plumpness in women is especially prized. A young girl's girth is physical evidence of her father's and later her husband's wealth. Being fat signifies that her labour is not

needed, making fat women the ultimate “trophy wives.” Similarly, up until the early twentieth century, women in the United States and Europe strived to be fat, not thin at a time when food was scarce and plumpness signalled wealth, while thinness suggested illness Yet, while thinness was regarded as ungainly in these contexts, especially in women, it did not reflect on one’s moral character nor were individual women personally blamed for being too thin. Thus, one can see a transition in the notion of beauty, from preferring plump body to desiring a thin body. We also see that beauty is a social construct that varies depending on factors like class, race, ethnicity, etc. Thus, cultural values have all along shaped the construction of social problems and, in turn, reproduced social inequalities.

However, women have over the years fallen prey to this socially constructed idea of ‘beauty’ and ‘attractiveness’. They have all along been held by the hegemonic discourses of beauty standards that are socially prescribed and nearly unattainable for most women. The cultural ideology saturates our idea of ideal beauty. The mass media offer important primary sources for cultural and social research. Television, radio, magazines, newspapers, and Internet content provide a sensitive barometer of social process and change. Once created, these texts remain unchanged and available for analysis, making them ideal for the study of attitudes, concerns, ideologies, and power relations, and how they shift over time. Aware of these strengths, early feminist work examined the fashion media, demonstrating how fashion magazines and advertisements convey the audience on the importance of slenderness and the shame of fatness for women. Anthropologist Mimi Nichter (2000) has argued that such images contribute to negative body image and eating problems among young girls.This aspect has directly led to a boom in cosmetic industries, surgeries and dieting which has led to various lifestyle changes in women. In an era where thin body is celebrated and is often associated with ‘femininity’, dieting occupies a prominent place in lives of women who are repelled and terrified by the stigmatized stereotype circling fatness. Fat people are often, thought of as being self-induced, self-indulged, lazy and lonely. Obesity has significant associations with ill-health and

shortened life expectancy. Thinness on the other hand is associated with beauty. Thus, there is a constant desire among women to be thin, and a constant fear of becoming fat. Therefore, dissatisfaction with ones weight and shape is prominent from childhood which continues through to adulthood. This makes us question why eating and body weight are radicalized and gendered. Therefore, feminist scholars have avoided the term “eating disorder” because it situates “disorder” within individuals rather than in complex social structures. We do not use “overweight,” “obesity,” or “eating disorders” because we endorse a medical or public health framing, but because we seek to establish how these particular terms have been constructed in the news media.

Sociologists note that the body has today been reduced to a ‘site’ that people work on. Giddens (1991) argues that in contemporary society individual identity has been reduced to something on which people ‘work at’. People today often use their bodies to consciously construct an image which they want to present to others as their real ‘selves’. Giddens calls this ‘reflexive mobilization’. Chris Shilling (2003) found that people are increasingly seeing their bodies as ‘unfinished products’, or projects for improvement. Amidst such a scenario women are more at risk of eating disorders not only because of the cultural pressures of having a thin body, but perhaps they are also biologically at risk as a result of this change in neurochemical responsiveness. Compared to men, women are held to higher standards of thinness and suffer if they fall short, in terms of marriage prospects as well as employment, due to them being fat.

Dieting appears to be the key which unlocks this important biological consequence. Dieting is also the most preferred option among women as a means of losing weight as it provides an expensive means and little or almost no physical exercise is required.What is mobilized is a decision to diet. However, dieting has a role in the evolution of anorexia and bulimia. The consequences of dieting, which are mostly the product of physiological and psychological effects of starvation, are important perpetrators of the illness and serve to intensify dieting and so weight loss.

Due to such a socio-cultural emphasis on thinness among women,

there has been a proliferation of anorexia or anorexia nervosa and bulimia or bulimia nervosa among young women. They are mostly accelerated due to eating disorder and dieting.Several factors have been identified as possible risks for the development of these eating disorders. Girls at the onset of puberty have higher chance of anorexia, while girls who are transitioning to adulthood may be more prone to bulimia.

Anorexia nervosa is defined by the persistent restriction of energy intake, intense fear of gaining weight and disturbance in self-perceived weight or shape. Individuals may control food and weight as a means of controlling areas of life that feel out of control, or as a way of expressing complex or concerning emotions. What characterizes anorexia nervosa is their strength, degree of personal significance and inflexibility. But looking at the connection between dieting and eating disorders, one may view anorexia nervosa as an extreme case of dieting. This willful refusal to eat, leading to extreme emaciation, is a circumstance which many find mystifying and beyond their own life experience. Thought most anorexics may gain back some weight within five years of becoming ill, it is one of the deadliest mental disorders which is seeing a rise among women. Even when an eating disorder is described as beginning with a choice, that is by starting a diet, the choice is depicted as a “normal” response to cultural pressures, rather than as an irresponsible or self-indulgent behaviour. This encourages more women to take up dieting which is socially accepted as normal and are mostly never discouraged.

We can view this from the identity theory that links identities to the role relationships and role- related behaviour of individuals. The self contains collection of identities, each based on the occupation of a particular role and having a role set of associated meanings and expectations for the self. An individual’s role identities are said to influence his/her behaviour, making him/her behave in a way that is expected of a person occupying his/her role. According to identity theory, women and men who adopt the stereotypical feminine and masculine gender role in Western culture will be influenced by the meanings and expectations of those particular roles. Depending on how deeply these expectations are

internalized, people will likely modify their behaviours so that they coincide with the behaviours expected of culturally determined, stereotypical female or male.



LET US KNOW

A careful assessment of a person's history on mental health, eating habits and behaviour is the prime pre-requisite to be taken in case of eating disorders like anorexia nervosa and bulimia nervosa.

Most individuals suffering from Anorexia and Bulimia do not consider themselves ill. They believe there is nothing going wrong with their eating habits and that they are leading a normal life.

Bulimia Nervosa is a psychological and severe life-threatening eating disorder described by the ingestion of an abnormally large amount of food in short time period, followed by an attempt to avoid gaining weight by purging what was consumed. Methods of purging include forced vomiting, excessive use of laxatives or diuretics, and extreme or prolonged periods of exercising. Often, in these binge/purge episodes, a person suffering from this disorder may experience a loss of control and engage in frantic efforts to undo these feelings.

Both anorexia nervosa and bulimia nervosa were first clinically described in 1979. Moreover, it is widely agreed that the number of sub-clinical eating-disordered individuals is now vast, and that the cases identified and treated are only the tip of the iceberg of eating pathology. People are usually diagnosed with anorexia and bulimia during their teenage years or early adolescent years. It can affect men and women of all ages, with women being more prone to such illness.

11.3 ANOREXIA : MEANING AND CAUSES

Anorexia also known as Anorexia Nervosa, is a syndrome of self-imposed starvation and relentless pursuit of thinness. Anorexics suffer from a fear of fatness and relentless effort of thinness. It is thus a

complex emotional disorder characterized primarily by an obsession with food and weight. Anorectic refers to persons who restrict their diet and do not exhibit symptoms of bulimia. Many theories have been postulated to understand the origin of anorexia nervosa. An anorexic patient is seen as being preoccupied with food and eating, yet obsessed with maintaining their weight. They are hence notoriously prone to sever diet regimes and food fads. While anorexia and obesity may both fall under medical categories related to body weight and eating, they however have strikingly different social and moral connotations. The social-cultural theory argues that the pressures on women to have a slim body is responsible for anorexia nervosa among them. However, what it fails to account for is why only a small proportion of women are exposed to such pressures which eventually develops into illness. The family pathology theory is of the opinion that anorexia is caused by interpersonal problems which must be understood under the family communication network. Even peer pressure can affect adolescent diet patterns. For example, high school and college students may resist treatment if their peers are actively involved in dieting or eating-disordered behaviour. The individual psychodynamic theory, on the other hand, focuses on the individual's struggle with their self-esteem and identity. Medical theories like the developmental psychobiological theory focuses on the need to stop the changes of puberty through starvation and to further avoid the turmoil of growing up. The primary hypothalamic dysfunction theory proposes a biological disorder of unknown origin as responsible for the illness. Anorexia nervosa is no more than a variant of affective disorder or depression. In spite of all these theories it seems unlikely that any single theory would adequately explain the causes in all cases.

Common to all these theoretical models is the fundamental role that dieting has in the evolution of anorexia. Moreover, the consequences of dieting, many of them direct products of the physiological and psychological effects of starvation, are important perpetrators of anorexia and serve to intensify dieting and in turn weight loss. One of the prominent symptoms of anorexia nervosa is the denial of illness and insistence on

becoming thin.



LET US KNOW

A person with an eating disorder will very often also suffer from depression, anxiety and a lack of self-worth.

11.4 CONSEQUENCES OF ANOREXIA

Anorexia nervosa causes an increase in Serotonin. Serotonin is a chemical produced by our body for the nerve cell and the brain to function. However, excessive production of serotonin may lead to mild shivering, diarrhoea, muscle rigidity and high fever and will need immediate medical attention. Excessing dieting and eating disorder also leads to change in behaviour, emotional and cognitive change.Due to intensified and extreme dieting, self-induced vomiting, and preoccupation with shape and weight, as well as binge-eating, the body is denied the essential nutrients it needs to function normally. These include cognitive changes, altered behaviour and changes in emotional state. There are serious mental disorders with significant morbidity and mortality. Based on genetic and neuroimaging studies, anorexia nervosa appears to have a biological basis, analogous to what is observed in other serious mental disorders such as schizophrenia, bipolar disorder and addictive diseases. Eating disorders are associated with impairment in emotional and cognitive functioning that greatly limits life activities.

Anorexia can also be said to be a struggle with one's own identity, competence, and effectiveness. Anorexia is a life-threatening illness and is associated with numerous medical complications. Mortality rates for anorexia nervosa are the highest of any psychiatric disorder.

11.5 DEFINING BULIMIA

Bulimia or Bulimia nervosa (serious eating disorder) also known as bulimarexia is a dietary chaos syndrome, which involves the ingestion

of a prodigious quantity of food in one or more eating “binges” which is usually followed by attempts to purge oneself so as to rid the body of food. Bulimia, which is derived from a Greek word, is characterized by an episode of overeating or binge eating in which a person may consume food more than the recommended daily food allowance. Purging is mostly done through vomiting, laxative or diuretic abuse. Thus, two of the most prominent behaviours of bulimia are bingeing and purging. The cycle the bulimarexic endures can be physically damaging. It can also take a tremendous emotional toll and leads to severe, life-threatening conditions and hence it is also a mental health disorder that causes several mental health concerns. For the person who is struggling to meet unrealistic goals by imposing severe and ascetic control over herself/himself the binge is a release.

Bulimia Nervosa is mostly facilitated by dieting which is mostly related to the social emphasis on slimness. Therefore, bulimia is directly the result of rejection and societal pressure to be thin, which is high among women. Bulimia can also result from anorexia nervosa. This behavior of restricting food intake, bingeing and purging alters the brain structure, metabolism and neurochemistry which makes it difficult for individuals to discontinue the behaviors. Moreover, the binging brings about a union between the mind and body. There is a complete loss of control over oneself when indulged in binging. However, the giving over of one’s self to this kind of experience results into guilt. Socialization and cultural pressures intrude to initiate the purification rites, purging or fasting. The purging relieving the guilt produced by. Thus binging carries with it the threat of ego dissolution and social humiliation. Moreover, it can turn out to be a vicious circle where the already frustrated woman may further her binging as an escapism from the social standards of beauty set by the society to which she is made to live up to.

Unlike anorexia, bulimia doesn’t necessarily have symptoms of significant weight loss. It is important to be noted that Bulimia was identified relatively recently as an eating disorder separate from anorexia. It is to be noted that while everyone is exposed to similar societal pressures to

be thin, only a small percentage develop eating disorders. Those who succumb typically are prompted by extreme career pressures most often in cases of actors and models who are exposed to more emotional and physical vulnerability.



LET US KNOW

Patients with bulimia nervosa may hide their binging and purging and have no overt signs. Primary care physicians may be the first to suspect potential problems, including a patient's fixation on food, weight, dieting, physique, and exercise. Sometimes, patients who have struggled in silence for years turn to their trusted physician for support and understanding.

11.6 CONSEQUENCES OF BULIMIA

The regular binging and purging caused by bulimia can have an impact on the entire digestive system which leads to electrolyte and chemical imbalances within the body that affect the heart and other organ functions. Bulimia can lead to an imbalance in electrolyte that causes irregularity in heartbeats and failure of the heart. This can cause an irregular heartbeat (arrhythmia), and in some severe cases, a weakened heart muscle and heart failure. Electrolyte imbalance is caused by dehydration and loss of potassium, sodium and chloride from the body as a result of purging behaviour. Frequent purging can cause dehydration which makes the muscles week and causes extreme fatigue. Bulimia also causes low blood pressure, a weak pulse, and anaemia. In women, bulimia can interfere with the menstrual cycle or stop it altogether. Research indicates that while anorexia nervosa is associated with increased serotonergic functioning, bulimia nervosa is associated with reduced serotonergic functioning.

As bulimia is also a mental health disorder it also leads to depression, anxiety, apparent or obsessive-compulsive behaviours.

Changes may come about due to lack of vitamins or behaviours that come along with bulimia.

Eating disorders probably result from a combination of emotional, physical and psychological factors that are encouraged by the society that values appearance above all. Once believed to be a problem largely among young women, the disorders are being found increasingly among children, young athletes, men, and elderly women. Often accompanied by depression, anxiety, and personality disorders, eating disorders may be difficult to diagnose. Patients with anorexia nervosa often deny that they have a problem, despite obvious physical signs. The first step in treatment is to address the medical complications caused by the unhealthy eating habits. Once nutritional health has been restored, patients need to reverse their entrenched and distorted body-image ideas.

11.7 PREVENTIVE MEASURES OF ANOREXIA AND BULIMIA

The aspect of prevention of anorexia and bulimia has received very little attention. This is ironic because many researchers and health care workers suggest that anorexia and bulimia become difficult to be treated if they become an individual's lifestyle. Most would agree that helping individuals avoid being affected by the factors perpetuating eating disorders like starvation which deprives one of the nutritional benefits, is the prime step towards preventing eating disorder from taking a toll on an individual. Psychological factors like striving towards perfectionism, feelings of ineffectiveness and interpersonal distrust may also lead to eating disorders.

Primary prevention should focus on eliminating the causes or predisposing factors. Here the primary goal of reducing anorexia and bulimia is by understanding what causes eating disorders in the first place. Few of the primary reasons for the inception of such disorders may be due to the societal pressure especially among women to be thin. Cultural attitudes towards weight are inculcated in a child from a very

young age by their family members which later leads to the development of eating disorder among women. Thus it is important for the family to examine their own perception towards societal construction of food, weight, shape so that their children do not become victims of anorexia and bulimia in the process of becoming thin. Individual factors like low self-esteem and insecurity mostly accelerated due to the cultural attributes of weight by their own family members may also lead to such eating disorders.



LET US KNOW

Many people with eating disorder usually eats faster than normal. They prefer eating in solitude so others do not judge their eating habits.

The secondary prevention, on the other hand, should focus on reducing the cause that perpetuates eating disorders like dieting and purging.

Thus, early detection and intervention is an important aspect for secondary prevention. However, doing the same is not an easy task as the individual with anorexia and bulimia most often attempt to conceal their problem. Therefore, it is of crucial importance to review every sign shown by an individual known to have an eating disorder and who shows higher risks of developing anorexia and bulimia. The individual should immediately be made to approach someone for help like a family member, peer or a health care professional, who may instrumentally help the individual to tackle the problem.



Activity

What are the causes of increase in eating disorder among women? Think.

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_____

_____

_____

_____



CHECK YOUR PROGRESS

Q.1. What are the two most prominent behaviours in bulimia?

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.....

.....

Q.2. What is the difference between anorexia and bulimia?

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.....

Q.3. Anorexia is a result of obesity. True/False

Q.4. Bulimia does not always have symptoms backed by weight loss. True/False



11.8 LET US SUM UP

- Bodies are socially constructed in material and cultural worlds. Though physical appearance plays an important role for both men and women, it is of much central importance when it comes to evaluating a woman.
- Anorexia and Bulimia are psychogenic illnesses and are kinds of eating disorder, which pose great concern to the society.
- Women have all along been held by the traditional and hegemonic discourses of beauty standards that are socially prescribed and nearly unattainable for most women.
- This has in turn led to a boom in cosmetic industries, surgeries and dieting which have led to various lifestyle changes in women. While fatness is usually associated with ill-health and shortened life

expectancy. Thinness, on the other hand, is associated with beauty, 'femininity'. It blames an individual for being overweight and obese, thus reflecting and reinforcing negative stereotypes on fatness.

- Thus, women from the inception of their teens are exposed to this idea of thinness, and thereby become a victim of it. They thereby practice dieting, which is seen as the easiest means of losing weight from a young age. This has led to a rampant increase in eating disorder like anorexia nervosa and bulimia nervosa among women.
- Anorexia nervosa is an eating disorder and an illness where an people see themselves as overweight, regardless of them being thin. This false belief justifies extreme cases of abstinence from food, to the extent of having serious health complications and forced treatments.
- Due to intensified and extreme dieting, self-induced vomiting, and preoccupation with shape and weight, as well as binge-eating, the body is denied the essential nutrients it needs to function normally. These include cognitive changes, altered behaviour and changes in emotional state. There are serious mental disorders and significant morbidity and mortality.
- Bulimia nervosa is an eating disorder in which people see themselves as massively overweight. While unlike in anorexia nervosa the individual may consume a vast quantity of food and purge later by vomiting. Frequent purging can cause dehydration which makes the muscles week and causes extreme fatigue.
- Bulimia also causes low blood pressure, a weak pulse, and anaemia. In women, bulimia can interfere with the menstrual cycle or stop it altogether.
- Thus, as a preventive measure to anorexia and bulimia early detection is important. This can be made possible through constant support from an individual's family, friends and concerned medical or clinical intervention at the earliest.



11.9 FURTHER READING

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11.10 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No 1 : Binging and Purging

Ans to Q No 2 : Anorexia is an eating disorder wherein in an individual fear weight gain and avoids eating as a result. Those with anorexia have a tendency to skip meals, adopt highly restrictive and unhealthy diets, obsess over thinness and food, and present abnormal eating habits due to the fear of gaining weight. Bulimia on the other hand, is an eating disorder wherein individuals go through a cycle of binging or overeating, followed by purging, often either by vomiting or using laxatives. It is also possible for a person to suffer from both disorders

Ans to Q No 3 : False

Ans to Q No 4 : True



11.11 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: What causes Anorexia?

Q 2: Why are women more prone to eating disorders like anorexia and bulimia?

B) Long Questions (Answer each question within 300-500 words)

Q 1: "Bodies are socially constructed in material and cultural worlds." Explain.

Q 2: How can you prevent an individual from developing an eating disorder?

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UNIT 12 : STATE AND HEALTH

UNIT STRUCTURE

12.1 Learning Objectives

12.2 Introduction

12.3 Concept of Bio-politics

12.4 Health Practices in India

12.5 Let Us Sum up

12.6 Further Reading

12.7 Answers to Check your Progress

12.8 Model Questions

12.1 LEARNING OBJECTIVES

After going through this unit, you will be able to:

- understand the concept of Bio-politics
- know about the health practices in Indian state to practice control over citizens

12.2 INTRODUCTION

India has 1.15 billion people which represent around 17% of the world's population.An assessment of performance of the country's health sector has pointed out some health-related indicators such as an uneven progress in health across regions, uneven health progress between male and female and also regional variation in heath.Bridging the gap needs extra attention from the government. Government should provide accessible, affordable, equitable health care and launch programs and schemes. The country is living under shadows of many familiar and unfamiliar diseases, the familiar one is infectious diseases like malaria, tuberculosis, etc and non-infectious are chronic diseases like cancer and coronary diseases. Available analysis on qualitative and quantitative data shows extremely uneven health and development progress in various parts of the country. Even within the reasonably well performing states,

there are regions where little has changed since Independence. The centralized pattern of government sector has many problems associated with it. The lop-sided planning, inadequate and unbalanced financial outlays, lack of accountability, low moral values and dereliction of duties by medical and nursing professionals are some of the issues faced by the health sector of the country. Recent trend shows that there is an unprecedented growth of the private sector, in both primary and secondary health care all over the country. As per the current ethical standards of the medical profession and free market technology-driven operational principles, the private sector generally does not provide quality health care at a reasonable cost.

At independence the private sector in India had only 8% of total health facilities. Currently 93% of all hospitals, 64% of all beds, 80-85% of doctors, 80% of outpatients and 57% of inpatients are in the private sector. The medical education and training, medical technology and diagnostics, manufacture and sale of pharmaceuticals, hospital construction and ancillary services and the provision of health services are mostly dominated by the private sector. Problems associated with compliance, contribution and collaboration has an immense impact on health sector despite the introduction of various new approaches. The health indicators of country are still not in good condition. India has to go a long way to achieve the required goals for good health service.

12.3 CONCEPT OF BIO-POLITICS

The concept of bio-politics was defined by Michel Foucault in1978. He talked about how the life and its mechanisms enter the explicit calculations of government. To understand the concept of bio-politics, it is important to be clear about what author meant by biopower. According to Foucault biopower is a double-edged technology that operates through two mechanisms and their intermediate relations i.e. “anatomo-politics” and “bio-politics”. Anatomo-politics refers to the configuration of the human body as a productive machine. In this sense it encompasses those

disciplines targeting the body and human anatomy. In the original formulation, such disciplines have the two fold sense of disciplines within knowledge, for example medicine, and practices of discipline which include forms of self-discipline and self-care. Biopolitics designates the regulations and interventions targeting the human population. In this framework of biopower, biopolitics assumes at its core the human body at the level of species, and therefore takes the shape of knowledge, practices, and forms of control relating to longevity, natality, mortality, morbidity, health, and hygiene. Modern medicine, reproductive control, national statistics, censuses, urban sanitation, and social hygiene are all examples of such interventions born with the modern state and its concern with governing life and population.

Bio-politics as a concept has been used and developed as a social theory even after Foucault. To understand the strategies and mechanisms through which human life processes are managed under regimes of authority over knowledge, power, and the processes of subjectivation are still undergoing process. As Thomas Lemke points out, a great deal of the inconsistency with which the concept of biopolitics has been deployed in more recent decades results depending upon whether one takes as their starting point the notion that life is the determining basis of politics, or alternatively, that the object of politics is life. Meanwhile, as Nikolas Rose and Paul Rabinow point out, the original interests in and conceptions of biopower drawn out by Foucault, quite usefully, do not grapple with these opposing positions- something that has remained underappreciated by many theorists who have worked to develop alternative conceptions of biopower to match more contemporary phenomena. As Lemke states most clearly, Foucault avoids this conflict by taking as his starting point the assumption that “life denotes neither the basis for the object of politics. Instead, it presents a border to politics- a border that should be simultaneously respected and overcome, one that seems to be both natural and given but also artificial and transformable.”

In the book “The Birth of Biopolitics”, Foucault theorized liberalism as a practice and as a critique of government. He further argued that the

rise of biopolitical technologies of governance, which have extended political control and power over all major processes of life itself, through a transferral of sovereign power into “biopower”- that is, technologies and techniques which govern human social and biological processes. Despite writing about many important concepts in academic writing, the concepts of “biopower” and “biopolitics” are the most compelling concepts of Foucault. Within his published work, these concepts featured only in the last chapter of the first volume of History of Sexuality. But the concept of biopolitics and biopower was dominant within broader conceptualisations and genealogies of power and governmentality of his lecture series at the Collège de France. Biopolitics and biopower occupies a significant role in his discussions on modern forms of governance and modes of subjectivation.

Before understanding the concept of biopolitics and biopower in the boarder context of Foucault’s work, a brief understanding of the concepts is important.Biopolitics can be understood as a political rationality which takes the administration of life and populations as its subject: ‘to ensure, sustain, and multiply life, to put this life in order’. Biopower thus names the way in which biopolitics is put to work in society, and involves what Foucault describes as ‘a very profound transformation of mechanisms of power’ of the Western classic age. As Foucault writes: power that exerts a positive influence on life, that endeavours to administer, optimize, and multiply it, subjecting it to precise controls and comprehensive regulations.In this instance Foucault talks about power, which he later identified as biopower and it has influence on life of people.In the last chapter of The Will to Knowledge named ‘Right of Death and Power over Life’, Foucault provides a brief genealogy of biopolitics. Foucault’s concept was a concept which is often associated with a tradition in continental history and philosophy. The notion of biopolitics has become an important word recently. It was not known to many people few years ago, but today many disciplines use this concept for discourse. Beyond the limited domain of specialists, it is also attracting increasing interest among the general public. The term is used to discuss political asylum policies, as well as the prevention of many diseases

and demographic change. Biopolitics may refer to issues as diverse as financial support for agricultural products, promotion of medical research, legal regulations on abortion, and advance directives of patients specifying their preferences concerning life-prolonging measures. There is a range of diverse and often conflicting views about both the empirical object and the normative evaluation of biopolitics. Through this archaeology of knowledge and power, Foucault tried to understand discourses and practices that worked as agents of transformation of human life. Topics like health, illness, and behaviour from a human and social sciences perspective are more approachable through this concept. Foucault's impact on this field was achieved through his research on the disciplines and institutions of psychiatry, medicine, sexuality, and imprisonment. Biopolitics is present in many contemporary research arenas like regimes of government and apparatuses, sociality and citizenship, etc.

Mark Duffield has analysed how the international agendas of human development and human security constitute forms of global biopolitics targeting health, demographics, territory, and power. The anthropologist Paul Rabinow considered the reversal of the two poles of biopower technologies he saw as a post-disciplinary rationality forming modes of bio sociality and bio-identity. In this way many scholars have their own way of understanding and interpreting biopolitics in different disciplines. Due to the conceptual richness of the concept of biopolitics it is open to research. In future new research on this concept will emerge with continuation of presented research. The deepening and substantive meaning of biopolitics will probably shift into new areas and use research methods from analytical to biographic and ethnographic studies. Such areas may well include and reinterpret issues of : political economy; global health; moral philosophy, subjectification, embodiment, and bodily transformation; reproduction and kinship; reconfigurations of age and life course; boundaries of health, enhancement, and performance; surveillance and monitorization; biosecurity and bio geographies; biostatistics and classification. When it refers to bio politics plural and divergent meanings will evolve as the term signifies.

12.4 HEALTH PRACTICES IN INDIA

The National Rural Health Mission (NRHM) launched in 2005 was a major landmark in the health system of India. It improved hospital care, decentralization at district level to improve intra and inter-sectoral convergence and effective utilization of resources in the system. The challenges the government is facing includes population growth, poverty, unexpected natural and manmade disasters, global pandemic of AIDS or influenza (H1N1), poor coverage in rural and remote areas and the constant threat of biomedical warfare. Many new lifestyles are emerging that have an impact on health of the people. Their rising incidence adds to the stress related to urbanization and industrialization. Due to population overgrowth and the limited opportunities people have to struggle to achieve their basic health needs. Increased cost of medical education has increased the cost of health care. These problems are related mainly to the physical infrastructure, medicines, funding, limited resources and accessibility to health services, etc. Issues regarding human resources are shortage of key cadres in rural areas, lack of motivation or will to serve in rural areas, absenteeism and irregular staff attendance, non-transparent transfer and posting policy, weak or non-existent accountability framework, inadequate systems of incentive for all cadres especially in difficult area postings, lack of career progression and standard protocols, etc.

Another new condition arising in India is Public-Private Partnership that emerged as one of the options to influence the growth of private sector with public goals in mind. It will help to change the landscape of healthcare in India.Other important issues associated with private sector are varied quality of service delivery, absence of formal accreditation systems, low penetration of Insurance, inadequate buying of services by Government and the fact that private sector is driven by curative and investigative care. Public distribution system became an important part of government development policy and government tried to implement in rural areas also. One of the main problems with this system is the

inefficiency in the targeting of beneficiaries and the resulting leakage of subsidies.

With the growth of the Indian economy after 1991 economic reforms, the country has worked in the area of human development. Life expectancy and literacy rates have increased, poverty levels have declined and large-scale famines have all but disappeared. Many people in India live below poverty line, this has an impact on them. Heath is also a parameter to understand the level of poverty in India. Because of poverty, there is wide spread malnutrition and chronic hunger among them. Major disparities exist between urban and rural areas, regions, social groups and between men and women. Thus, while some western and southern states have regularly touched double-digit growth rates, many states in the north have continued to lag behind on most development indicators. While India's engagement with economic liberalisation and restructuring creates prosperity in the aggregate, it similarly presents the country with the continuous challenges of how to deal with multiple and overlapping forms of inequality and exclusion – spatial, social, economic and gendered. They inadequate amount of investments in health and education made by the Indian government has a limited capacity in lifting millions of people from notional poverty line, who still lack the basics for a decent life. There has been a process of political emphasis on empowering women, on removal of female disadvantage and unlocking the power of women's active role in society to reform both health care and education from the part of government.

Neo-liberal ideas and reform have extensively spread across many types of welfare and development regimes and policy sectors. The NRHM is one such initiative, focusing on health and human-resource development in rural areas. NRHM is one important manifestation of the new techniques of governance, centred crucially on this notion of 'the citizen', and epitomises the broader shift in Indian development policy from a perception of development as a welfare activity of the government, to recognition of basic development as a right of citizens. The current health policy of India seeks to create aware and active citizens out of rural poor and

marginalised groups through new technologies of governance. But the tension between policies as formulated and policies as practised, between neo-liberal and welfare ideas and between participation and compliance are still going on.

Foucault's concept argued that individuals, under neo-liberal regimes, are taught to govern themselves. Neo-liberal health reforms directed their attention towards changing individuals and individual behaviours. Human rights have, under neo-liberal reform, become a global standard or norm with reference to which states, health systems, health workers, communities,families and mothers may be evaluated and disciplined. But it is with respect to these same human rights norms that individuals increasingly also evaluate themselves, and change their behaviour in order to conform (at least officially) to the norm. This form of power creates a set of rules and standards that result from a constellation of discursive structures, and the (scientific) knowledge and practices that accompany them. Power, in this sense is positive, as it produces behaviour that is in conformity with the dominant standard of normality or acceptability mediated by a dominant view of what constitutes normality or deviance. Explicitly, Foucault draws our attention to how neo-liberalism as a political rationality induces dynamics of depolitisation of the public health regime, thus transforming political actors into clients, consumers and technologists of themselves.

Although the rights regime can individualise and de-politicise social struggle, the language of rights is also frequently used for mobilisation and structural change. The disciplinary power provokes counter tendencies, exercised within historically and geographically contingent forms. The NRHM focuses particularly upon the health of poor women and their children. The government focusses on the poorest segment of the population. NRHM is one such approach of government and is a specific-purpose grant funded and planned by central government to induce health system reform in the individual states to address these challenging health indicators. Within the new Indian state, citizenship is being constructed, invoked and substantiated as ways to soften – if not eliminate – gender,

class and caste inequalities. Since Indian independence, social reforms have referred to the nuclear family as the new foundation for the developing state. To the modern state,traditional large family structures are a hindrance to political democracy, development and social justice, all of which have been and still are India's national goals. Citizenship thus does not refer only to formal inequality but also to how citizens should behave to move forward and/or upward and become full citizens of the polity. The two-child norm introduced in some states of India through the Panchayat Raj institutions in the 1990s clearly demonstrates how the nuclear family is an effect of responsible citizenry. Health bureaucrats interpret, enact and form policies at all levels in the system. In addition, NRHM is widely acknowledged as an outcome of the grassroots pressure generated by India's vibrant democracy, which is capable of influencing government policy in pro-poor directions.Rather than understanding policies as instructions flowing down from above, policy implementation should be understood as practises that must be situated in the broader domains of knowledge and power in which they are embedded.



CHECK YOUR PROGRESS

Q.1. Mention indicators of health.

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Q.2. Define biopower.

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12.5 LET US SUM UP

- An assessment of performance of the india's health sector has pointed out some health-related indicators such as an uneven progress in health across regions, uneven health progress between male and female and also regional variation in heath.
- The centralized pattern of government sector has many problems associated with it. The lop-sided planning, inadequate and unbalanced financial outlays, lack of accountability, low moral values and dereliction of duties by medical and nursing professionals are some of the issues faced by the health sector of the country.
- The concept of bio-politics was defined by Michel Foucault in 1978. He talked about how the life and its mechanisms enter the explicit calculations of government.
- According to Foucault, biopower is a double-edged technology that operates through two mechanisms and their intermediate relations i.e. "anatomo-politics" and "bio-politics".
- Anatomo-politics refers to the configuration of the human body as a productive machine. In this sense it encompasses those disciplines targeting the body and human anatomy.
- Biopolitics designates the regulations and interventions targeting the human population. In this framework of biopower, biopolitics assumes at its core the human body at the level of species, and therefore takes the shape of knowledge, practices, and forms of control relating to longevity, natality, mortality, morbidity, health, and hygiene.
- Bio-politics as a concept has been used and developed as a social theory even after Foucault. To understand the strategies and mechanisms through which human life processes are managed under regimes of authority over knowledge, power, and the processes of subjectivation are still undergoing process.
- In the book "The Birth of Biopolitics", Foucault theorized liberalism

as a practice and as a critique of government. He further argued that the rise of biopolitical technologies of governance, which have extended political control and power over all major processes of life itself, through a transferral of sovereign power into “biopower”- that is, technologies and techniques which govern human social and biological processes.

- The National Rural Health Mission (NRHM) launched in 2005 was a major landmark in the health system of India. It improved hospital care, decentralization at district level to improve intra and inter-sectoral convergence and effective utilization of resources in the system.
- Due to population overgrowth and the limited opportunities people have to struggle to achieve their basic health needs. Increased cost of medical education has increased the cost of health care. These problems are related mainly to the physical infrastructure, medicines, funding, limited resources and accessibility to health services, etc.
- Other new condition arising in India is Public-Private Partnership that emerged as one of the options to influence the growth of private sector with public goals in mind. It will help to change the landscape of healthcare in India.
- Public distribution system become an important part of government development policy and government tried to implement in rural areas also. One of the main problems with this system is the inefficiency in the targeting of beneficiaries and the resulting leakage of subsidies.
- Neo-liberal health reforms directed their attention towards changing individuals and individual behaviours. Human rights have, under neo-liberal reform, become a global standard or norm with reference to which states, health systems, health workers, communities, families and mothers may be evaluated and disciplined.



12.6 FURTHER READING

1) Thomas Lemke (2011), Biopolitics: An Advance Introduction, New York University Press, New York.



12.7 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No 1 : An assessment of performance of the country's health sector has pointed out some health-related indicators such as an uneven progress in health across regions, uneven health progress between male and female and also regional variation in heath.

Ans to Q No 2 : Biopower means the way in which biopolitics is put to work in society, and involves what Foucault describes as 'a very profound transformation of mechanisms of power'



12.8 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: What is meant by biopolitics?

Q 2: What is NRHM?

B) Long Questions (Answer each question within 300-500 words)

Q 1: Explain about the health system in india.

Q 2: What is the difference"anatomo-politics" and "bio-politics"?

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UNIT 13 : HEALTH POLICIES OF GOVERNMENT OF INDIA

UNIT STRUCTURE

13.1 Learning Objectives

13.2 Introduction

13.3 Introduction to health policies of India after independences

13.4 Introducing the National Health Policy (NHP) of 2017

13.5 Debates on the National Health Policy of 2017

13.6 Let us sum up

13.7 Further Reading

13.8 Answers to check your progress

13.9 Model Questions

13.1 LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Understand the history of health policies and programmes in independent India
- Know the need for a National Health Policy (NHP) at various points of time
- Understand the details of the National Health Policy 2017

13.2 INTRODUCTION

The state of health of people in a country is directly influenced by the governments approach towards the health sector. This aspect has been in earlier units. In this units, emphasis will be laid on health policies adopted by government of India since independence, with particulars focus on the National Health Policy.

13.3 INTRODUCTION TO HEALTH POLICIES OF INDIA AFTER INDEPENDNCE

Health after independence

Health and development of healthcare have not been priorities for the Indian government since independence. This is evident from the low expenditure and investment on health – only 1 percent or even less from the Gross Domestic Product (GDP) has been allocated to the health sector in the five-year plans. The social areas like health, water supply,and education were low in importance after independence was achieved. Industrial growth and economic development were the priorities.

Therefore, the first National Health Policy (NHP) was released only 36 years after independence. However, this does not mean that the health sector was not regulated or had no planning involved at all. It was monitored through the five-year plans. Till 1982, India had no formal health policy and health was part of the five-year planning process. Every five-year plan had specific programs and schemes that were designed to take care of the health sector.

The Central government designs programs which the states then accept and implement at their levels. The government at the centre ensures that the states follow and implement these programmes through the budget. Modern medicine and health care were introduced and developed in India during the period when India was under British rule. After the end of colonization, it was the Indian government's duty to nurture and expand this healthcare system. The result, however, has not been wholly positive. The post-colonial era has seen the growth of the private medical sector, even in villages and towns as a consequence of the expansion of the socio-economic infrastructure. But the private medical industry remains inaccessible to the poor and the marginalized as it is expensive. One thus feels that planning should have given equal emphasis to social services like health, water supply, sanitation, education, and housing along with industrial development.

Health in five-year plans

In the 1950s and 1960s, the primary function of the health sector was to manage epidemics as there were frequent outbreaks. There were mass campaigns to eradicate various diseases like malaria, smallpox, tuberculosis, leprosy, cholera, polio, etc. This was an extension of the

colonial policy that believed in removing the germ to get rid of a particular disease. However, many of these diseases were rooted in the social structure, i.e., inadequate nutrition, lack of clothing, housing and proper sanitation and a clean environment. But these causes were ignored,and this was one of the drawbacks of the health programs. Many of these programs were also dependent on international organizations like the World Health Organization (WHO) and the Rockefeller Foundation for funds for the supply of necessary medicines and vaccines. But the aid did not come for free. Along with support, these organizations also exercised political and economic power over India's health sector.

The first two five-year plans had a common structural framework. Urban areas got over three-fourths of medical care resources and the rural regions received 'special attention' under the Community Development Programme (CDP).The aim was the betterment of environmental hygiene, including the provision of water, proper disposal of waste, control of epidemics and provision of medical aid. However, this special attention was hardly received as the health sector has a dismal performance in rural parts of the country. While epidemics were controlled, the other goals like provision of sanitary environment, clean water and sanitation were not achieved.

There was a shortage of medical personnel and facilities in rural areas. Many villages did not even have proper hospitals and villagers had to travel miles to access primary healthcare. Hospital facilities were mainly unavailable in rural areas. While many villages did not even have hospitals, the ones that had, did not have medical staff. In many places, the team was not equipped to handle critical issues. Majority of the hospitals did not have beds, medicines, and instruments. Compared to this, the situation in urban areas was slightly better.

India was one of the first countries to implement a state-sponsored family planning programme in 1951. The country was facing a growing birth rate and a declining death rate,and therefore, family planning was seen as a necessary planned objective for the state. Thus family planning became an independent department in the Ministry of Family Planning.

This emphasis on family planning was also an influence of developed countries that had low rates of population growth. Population control was seen as a pre-requisite for development.

The third five-year plan (1961) looked into the problems that Primary Health Centres (PHCs) were facing. It directed attention to delay in construction of PHCs, lack of health personnel, lack of life-saving drugs, vaccines, etc. The fourth plan (1969) continued from the third one, with the focus on infectious diseases and the PHCs. The PHCs were given a special allocation in the fourth plan just like in the third one.

The fifth plan marked a significant change from the previous plans in the sense that the government admitted that the health sector had not achieved the desired results that it had hoped for in the rural areas. Therefore in the fifth plan, the government decided to focus on health in rural areas. The goal was to enhance the availability of health services in rural areas through the Minimum Needs Program (MNP) and correcting regional imbalances between urban and rural areas while eradicating communicable diseases. Water supply and sanitation were given priority too. Many illnesses that had plagued the populace in both rural and urban areas were water-borne –cholera, jaundice, diarrhea, typhoid, and dysentery. Therefore, providing clean drinking water became an essential target of the government to improve healthcare.

The sixth five-year plan was greatly influenced by the Alma Ata declaration of Health for All by 2020, and thus the plan suggested a community-based health system. It prioritised rural areas and training of health workers in PHCs. Although there has been progressive thinking on the part of the government, there has been inadequate action, and that is why in spite of health being a part of the five-year plans, the sector has not developed as well as it should have. And this is why the NHP was announced in 1983. The need was felt for a nation-wide health policy that could rejuvenate the dilapidated condition of the health system in the country and govern the public health sector. The NHP is based on the Directive Principles of State Policy of the Constitution of India recommending universal health for everyone.

After the NHP was introduced, rural healthcare received special attention,and the work of building PHCs was continued. Decentralisation and professionalism within the medical sector have been achieved to a limited level, but India is still lagging in community participation which the NHP 2017 wants to correct. The private sector received a boost after the 1983 NHP as it suggested privatisation of curative care. It talked about "healthcare that people can afford" which meant, health services were no longer free.

This also marks a shift in India's economic policy from one based on a welfare economy to one based on capitalistic principles.The private sector expanded phenomenally post NHP,and the state has played a major role in this, helping by giving subsidies for medical education, soft loans to set up a medical practice, etc.

The 1983 policy, however, did not achieve its goal of universal and comprehensive primary health coverage, especially in rural regions. The seventh five-year plan, therefore, wanted to correct this regional imbalance by building specialties and super-specialties, especially in rural areas. Population control was also another goal. Along with communicable diseases, the plan also directed attention towards other diseases like AIDS, cancer and heart diseases.



LET US KNOW

Modern medicine and health system was introduced by the British to India during the colonial era.

Health was not a priority area after independence and only received 1% of GDP allocation.

The focus of the five-year plans before 1982 was on communicable diseases.

The need for a NHP was felt to rejuvenate the health system that was not performing well.

India has had three NHPs – 1983, 2002 and 2017.

The eighth five-year plan was a departure from India's goal of

"Health for All" as the country was facing a severe economic crisis and the underlying slogan was changed to "Health for the Underprivileged." The ninth five-year plan reviewed the 1983 NHP and recommended the need for another NHP. Therefore, a new and the second NHP was introduced in 2002.

The NHP 2002 focuses on the requirement for increased funding and organizational restructuring of the national public health facilities to ensure equitable access. It focused on diseases like TB, malaria, blindness and HIV AIDS. The marginalized population like women, children, tribals and senior citizens were the target. The idea is to meet minimum health needs of the people. The policy has been widely criticized for not adhering to the concept of "Health for all" and not involving the states in drafting the document. It also received flak for not substantively talking about population control, as it is still a burning issue.

The five-year plans after the 2002 NHP have tried to implement the recommendations that had been made by it. Epidemics were more or less controlled, and so were diseases like malaria, polio,and leprosy. There has also been a reduction in crude birth rate, crude death rate,and infant mortality rate. The NHP 2002 encouraged further decentralization and professionalism in the health sector. But with time, the need for a new NHP was felt,and this is why the NHP 2017 came out. We will be discussing the NHP 2017 in detail in the next section.



CHECK YOUR PROGRESS (A)

Q.1. Who introduced modern medicine and health system in India?

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Q.2. When was the second NHP announced?

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13.4 INTRODUCING THE NATIONAL HEALTH POLICY OF 2017

The government of India has released three national policies till today – the first in 1983, the second in 2002 and the latest in 2017 on 15th March. The focus of the 1983 policy was on the provision of primary healthcare to all by 2000, whereas the 2002 policy focussed on the requirement for increased funding and restructuring of organizational public health facilities for ensuring equitable access to them.

The 1983 NHP was critical of the curative model of healthcare and stressed the need for a preventive, promotive and rehabilitative approach to primary healthcare. It recommended decentralization in the health system, community based participation and expansion of a private curative health system to support the public facilities. Both the 1983 and 2002 NHPs were not very effective and did not meet the goals that they had set out to reach. In this unit, we will be assessing the 2017 National Health Policy and debates that it has raised.

The two former health policies have guided the Indian health sector,but the need for a new policy was felt as health priorities are changing. Some of the reasons why a new National Health policy was needed are –

- Increase in non-communicable diseases like diabetes and cardiovascular diseases. The focus of the previous two NHPs was on communicable diseases.
- A growing healthcare private industry
- Expenditure on health care costs which leads to further impoverishment of the poor
- Mental health issues on the rise

The main aim of the National Health Policy 2017 is to inform, clarify, strengthen and prioritize the government's role in shaping health systems in all its aspects – investment, organization, prevention of diseases, promotion of good health, access to technologies, developing human resources, building a human base, strengthening regulation and health assurance. The goal of the policy is the attainment of the maximum

possible level of health and well-being for all age groups, through a preventive and promotive healthcare orientation. Thus, the policy believes in providing universal quality healthcare and also acknowledges the importance of Sustainable Development Goals (SDGs). The emphasis is on providing primary healthcare.

The policy also proposes to provide free medicines, free diagnostics, and free emergency and necessary healthcare services in all public hospitals to provide access to everyone and financial protection to the poor. Some of the best healthcare systems are those of the UK, Canada, and the Scandinavian countries, countries in which the state leads the system. The US, which has a market-based healthcare system, therefore, has an expensive healthcare system and is unaffordable for many citizens. The NHP intends to build the ordinary person's belief in the public healthcare system to make it patient-centric, affordable and efficient. A health policy is an expression of what the health care system should be so that it can meet the health needs of the people.

Some of the fundamental principles of the policy are –

- Professionalism, integrity,and ethics
- Equity
- Affordability
- Universality
- Patient-centered
- Accountability
- Pluralism
- Decentralization

Some of the critical targets of the National Health Policy are –

- The policy suggests raising public health expenditure to 2.5% from 1.5% of the Gross Domestic Product (GDP) in a time-bound manner. This target is anticipated to be met by 2025.
- It intends to increase life expectancy at birth from 67.5 to 70 by 2025.
- It proposes to reduce Total Fertility Rate (TFR) to 2.1 at the national level.

- It plans to lower infant mortality rate to 28 by 2019.
- The policy aims to achieve the global HIV 2020 target.
- Eliminate leprosy by 2018 and tuberculosis by 2025.
- To reduce premature death from diabetes, cancer, cardiovascular diseases,and chronic respiratory illnesses by 25% by 2025.
- Increase utilization of public health resources by 50% by 2025.
- Access to safe water, hygiene,and sanitation to all by 2020 (under the Swachh Bharat Mission).
- Enhance the share of individual states on health to more than 8% of their budget by 2020.



ACTIVITY 1

1. How many National Health Policies are there in India?



CHECK YOUR PROGRESS (B)

Q.1. How does the NHP 2017 differ from the other two National Health Policies?

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Q.2. What are some of the critical targets of the NHP 2017?

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13.5 DEBATES ON THE NATIONAL HEALTH POLICY 2017

- **Public vs. private :** One of the most heated debates that have resurfaced from the National Health Policy 2017 is the argument on

the role of the public and the private sectors in providing healthcare. The public system is heavily criticized as it is unable to provide quality healthcare. People who have financial resources have the choice to seek help in the private healthcare sector, but for most people, they do not have that option. However, there are also many incidents of blatant profit-making, wrong treatment and bad practice in the private sector. The question, therefore, that arises, is should the public sector be strengthened or should the private sector be encouraged? Should the focus be on improving the public healthcare system or of enhancing and supporting the private healthcare system?

One answer is that the public healthcare system can only be improved if the middle-class people start accessing it regularly. Or else, any programme that just the poor and the marginalized uses is at the risk of being poor in quality. While private sector healthcare can supplement and complement the public system, it cannot be the leading service provider. Technical and financial support under the National Health Mission (NHM) is provided to the states and union territories (UTs) for strengthening their public healthcare systems for the provision of universal, accessible and affordable health care. The private sector mostly provides curative healthcare services, and the state sector gives preventive and promotive health facilities.

- **Unavailability of life-saving drugs :** In 2016-2017, many diseases have remerged, like diphtheria. Several new epidemics also broke out like Nipah virus. There are also several occurrences of diseases like snake bite, rabid animal bite,and scorpion bite, especially in rural areas. In most cases, the hospitals, be it public or private ones, are not prepared to deal with such outbreaks and emergencies. There are shortage and unpreparedness of hospital staff and unavailability of life-saving medicines. This highlights the need for providing life-saving drugs, which is the principal responsibility of the state.
- **Universal Health Coverage (UHC) :** The third debate that the NHP has raised is about universal health coverage. It suggests that

universal health should be given for both communicable and non-communicable diseases (NCDs). It recommends the building of health and wellness centres, and support from community health centres and district hospitals.

It proposes an 'assurance based approach' instead of a 'right based approach.' However, just building health centres and hospitals for NCDs is not enough. Treatment of NCDs like diabetes and hypertension needs a community-based approach and patients also require counselling. These diseases need lifestyle modification and discipline which need support from both the family and the community apart from medical treatment.

To provide UHC, the public sector will provide free primary care, which will be complemented by strategic buying of secondary care hospitalization and tertiary care services from both public and non-government areas to fill the existing gaps.

The concept of UHC is not new. The Health Survey and Development Committee Report or the Bhore Committee Report had prepared a detailed plan of a National Health Service for the country in 1946 before independence which had proposed universal health coverage to the entire population free of charge. But the recommendations of the Bhore Committee was not implemented properly,and the standard of health remains very low.

- **Assurance based approach to health :** The National Health Policy 2017 proposes an assurance based approach to health instead of a rights-based approach. It advocates an assurance based approach with assured funding to create an environment for raising healthcare as a right in the future.This has raised many arguments from critics, who have criticized the government's decision to not look at health as a fundamental right. This is seen as contradictory to the government's admittance that healthcare expenditure is a significant cause of poverty.
- **Focus on male sterilisation :** The NHP calls for a better focus on male sterilization to stabilize population. The government aims to

increase the proportion of male sterilisation from less than 5% to at least 30% and much higher. The male sterilisation rate is meager – 0.3% - according to National Family Health Survey (2015-16) compared to the female sterilisation rate which is 36%. Therefore, the hour requires to promote male sterilisation to stabilize the population.

- **Keeping in mind the global context :** Many of the critical targets of the NHP have been criticized for being backward and not keeping in mind the global and the South Asian settings. For instance, one of the policy goals is to increase life expectancy at birth to 70 by 2025. But this ultimate objective is seen as low, as Sri Lanka and Bangladesh, India's neighbouring countries have already achieved it. Another example is that the policy targets are reducing child mortality rates for the age group 0-5 to 23 deaths per 1000 live births and neonatal mortality rates to 16 deaths per 1000 live births by 2025. However, Sri Lanka is already doing better than these set target rates – 9.8 for infant mortality rate in the age group 0-5 and 5.4 for neonatal mortality. The targets of the NHP, therefore, are seen as backward.



CHECK YOUR PROGRESS (C)

Q.1. What kind of approach does the NHP 2017 follow?

.....

.....

.....

Q.2. How does the NHP talk about population control?

.....

.....



13.6 LET US SUM UP

- Till 1982, India had no formal health policy and health was part of the five-year planning process. Every five-year plan had specific programs and schemes that were designed to take care of the health sector.
- In the 1950s and 1960s, the primary function of the health sector was to manage epidemics as there were frequent outbreaks. There were mass campaigns to eradicate various diseases like malaria, smallpox, tuberculosis, leprosy, cholera, polio, etc. This was an extension of the colonial policy that believed in removing the germ to get rid of a particular disease.
- The first two five-year plans had a common structural framework. Urban areas got over three-fourths of medical care resources and the rural regions received 'special attention' under the Community Development Programme (CDP).
- There was a shortage of medical personnel and facilities in rural areas. Many villages did not even have proper hospitals and villagers had to travel miles to access primary healthcare.
- India was one of the first countries to implement a state-sponsored family planning programme in 1951. The country was facing a growing birth rate and a declining death rate,and therefore, family planning was seen as a necessary planned objective for the state.
- The third five-year plan (1961) looked into the problems that Primary Health Centres (PHCs) were facing. It directed attention to delay in construction of PHCs, lack of health personnel, lack of life-saving drugs, vaccines, etc.
- The fourth plan (1969) continued from the third one, with the focus on infectious diseases and the PHCs. The PHCs were given a special allocation in the fourth plan just like in the third one.
- The fifth plan marked a significant change from the previous plans

in the sense that the government admitted that the health sector had not achieved the desired results that it had hoped for in the rural areas. Therefore in the fifth plan, the government decided to focus on health in rural areas.

- The sixth five-year plan was greatly influenced by the Alma Ata declaration of Health for All by 2020,and thus the plan suggested a community-based health system. It prioritised rural areas and training of health workers in PHCs.
- The seventh five-year plan focussed on the regional imbalance by building specialties and super-specialties, especially in rural areas. Population control was also another goal. Along with communicable diseases, the plan also directed attention towards other diseases like AIDS, cancer and heart diseases.
- The eighth five-year plan was a departure from India's goal of "Health for All" as the country was facing a severe economic crisis and the underlying slogan was changed to "Health for the Underprivileged."
- The ninth five-year plan reviewed the 1983 National Health Policy (NHP) and recommended the need for another NHP. Therefore, a new and the second NHP was introduced in 2002.
- One of the most heated debates that have resurfaced from the National Health Policy 2017 is the argument on the role of the public and the private sectors in providing healthcare.
- The public system is heavily criticized as it is unable to provide quality healthcare. On the other hand, there are also many incidents of blatant profit-making, wrong treatment and bad practice in the private sector.
- The NHP suggests that universal health should be given for both communicable and non-communicable diseases (NCDs). It recommends the building of health and wellness centres, and support from community health centres and district hospitals. It proposes an 'assurance based approach' instead of a 'right based approach.'
- Many of the critical targets of the NHP have been criticized for

being backward and not keeping in mind the global and the South Asian settings.



13.7 FURTHER READING

1) Duggal, Ravi. 2001. Evolution of Health Policy in India.CEHAT.

2) National Health Policy 2017. 2017. Ministry of Health and Family Welfare. Government of India.



13.8 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No A :

1. The British
2. 2002

Ans to Q No B :

1. The NHP 2017 focuses on non-communicable diseases and private sector.
2. Universal Health Coverage, increasing life expectancy and reducing premature death from non-communicable diseases.

Ans to Q No C :

1. Assurance based approach
2. Male sterilisation



13.9 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: What were the needs of National Health Policy?

Q 2: What was the focus of the five year plans before the NHP of 1983?

B) Long Questions (Answer each question within 300-500 words)

Q 1: How has health been percieved in the Five Year Plans in India?

Q 2: Discuss the National Health Policy of 2017.

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UNIT 14 : GLOBAL SURVEY OF HEALTH

UNIT STRUCTURE

14.1 Learning Objectives

14.2 Introduction

14.3 Health and Society

14.4 Relationship between health and socio-economic factors

14.5 High income and Low-income countries and the health scenario

14.6 Let Us Sum up

14.7 Further Reading

14.8 Answers to Check Your Progress

14.9 Model Questions

14.1 LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Understand the relation between Health and Society
- Understand Socio-Economic dynamics affecting Health
- Compare Health in different economies

14.2 INTRODUCTION

This unit will introduce you to the concepts of Health, Society and how they are inter-related with each other in the larger context of the well-being of a person. This unit will enable you to understand how socio-economic factors affect the well being of a person as a member of the society. It will also help you to understand how to view health as a social phenomenon and make you ready to engage with political values associated with it and the process of policy making to address the issues pertaining to health.



LET US KNOW

Health is as much a social phenomenon as it is an individual phenomenon. According to World Health Organization (WHO), "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." This definition means that a person to be healthy, it ought to have proper functioning body, as well as his relationships with his fellow peers and societal members at large should be amiable. This definition also entails that the person is also at peace within itself and not at unease leading to strenuous effects on the mind and causing stress, anxiety, or depression in the individual that leads to a negative and desensitized image of the person in their self.

Health means:

- Physical Well-being
- Mental Well-being
- Social Well-being
- Not merely absence of Disease

14.3 HEALTH AND SOCIETY

Society can be, loosely, viewed as of people inhabiting a geographical terrain sharing various spheres of life with each other as individuals and groups. Therefore, the wellbeing of the individual also depends upon, to a greater extent, the society in which the person lives. The social values attributed to health, the economic expenses on healthcare and health facilities, political will towards the well-being of the individual are some determinants.

To understand this, let us consider the case of vaccination. Vaccination strengthens our body's immunity against the diseases against which our body is vaccinated. Vaccination has helped humanity to eradicate diseases like cowpox, small pox, Whooping Cough, Measles, etc. Now

vaccination as process requires both society as an agent to engage as well as the state as an actor to facilitate the process through policy making and fund allocation, awareness campaigns and programs to impart education on such issues. Another good example are the state-run programs regarding sex education and Sexually Transmitted Diseases through various modes of advertisements and media communications. This shows how health is an intricate aspect requiring various societal aspects to play in.

Health historically has had an important part in the well-being of the individual. From the ancient Greeks to Leonardo da Vinci to Michel Foucault to recent Genome Projects, how society views health as a subject has changed over the period of time. In the modern era, various thinkers have attempted to study health, not merely from a medical perspective but also from the sociological perspective and political economy of the health.

According to the WHO, for an individual to be completely healthy, the individual ought to be socially, mentally and physically well.

Let us look at each of the three points in the above mentioned definition :

- **Physical Health :** There are various old sayings adhering to the importance of the health. One such saying says “jo jaage so pave, jo sove so khove” i.e. one who awakes gains, one who sleeps loses. Health has been regarded as wealth, virtues in various cultures across the worlds. The physical health enables a person to contribute to the physical labor towards the well-being of self and the society at large.
- **Mental Health :** The recent times have seen increase in the individuals exhibiting symptoms, of deteriorated mental health, like Stress, Anxiety, Depression, and these escalating to severe implications. The increasing crisis of job mentality, consumerist behavior, hyper-individualism leads to the individual feeling disembedded in the larger society resulting in a feeling of alienation.
- **Social Health :** This one deals with the ability of an individual to

fulfill social obligations and duties towards kith and kin, and the society at large. This can be affected by improper physical health and mental health. This exhibits that the society is becoming stagnant, and the growth and progress is slow.

Hence, we now know that the health in itself is a very serious concern for the society as it can determine the course of the evolution of the society both spiritually as well as socio-politically.

14.4 RELATIONSHIP BETWEEN HEALTH AND SOCIO-ECONOMIC FACTORS

The individual as a part of the society bears the brunt of socio-economic factors upon the well-being of the individual. This can be seen in the fact that some people have a better chance of living a long and healthy life and some have poor chances. This is a manifestation of the social advantages enjoyed by some and disadvantages borne by others. When health becomes an object at the intersection of the individual and the socio-economic environment the individual exists, it excites the imagination of a sociologist. Health then becomes a larger structural phenomenon having a bearing upon the individual as well.

- **Health Inequalities and Health Inequities :** According to Hillary Graham, Health inequalities can be understood with respect to three meanings :
  - Health Differences between individuals
  - Health Differences between Population groups
  - Health Differences between groups occupying unequal positions in society.

  However, one thing to understand according to Braverman is 'Health disparities/inequalities do not refer to all differences in health. A health disparity/inequality is a particular type of difference in health. It is a difference in which disadvantaged social groups – such as the poor, racial/ethnic minorities, women, or other groups who have persistently experienced social disadvantage or discrimination –

systematically experience worse health or greater health risks than more advantaged social groups.'

- **Socio-Economic Determinants :** Humans are members of society which has evolved over time. In this course of time, the society evolved structures and hierarchies that have resulted in disadvantages to some people and advantages to others. In the US, the racism is one such structural phenomenon, gender hierarchy is one such, in several countries. Indian society is affected by caste hierarchy, and the larger class structure.

  Individuals are slotted in such structures which prescribes roles and obligations with respect to that position and in fulfilling these structural roles people end up reproducing the structure. The people who benefit from the structure accumulate resources and the people disadvantaged by the structure are left without the resources and are struck by a resource scarcity. This resource scarcity creates problems in the disadvantaged people to have access to chances of living a longer and healthier life.

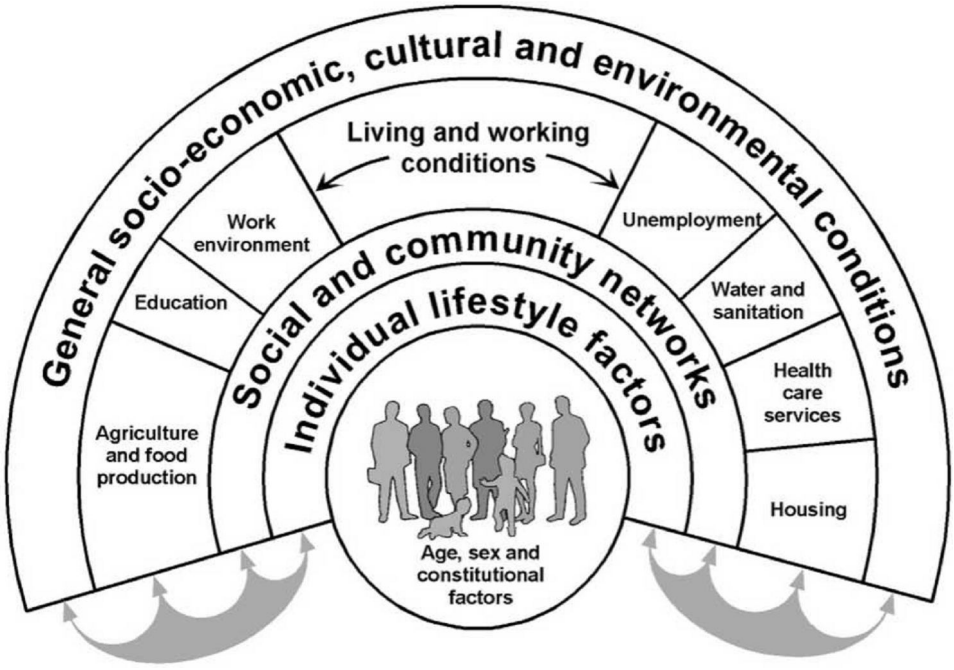


Figure 1 The main determinants of health

Private healthcare is one such aspect of health care that disadvantaged people cannot gain access due to lack of resources in their hands.

To people who are disadvantaged, the public health institutions under the supervision of the state are the options to go since they can not afford the private health care. To aid such citizens, the state allocates funds, programs, campaigns, health care schemes.

Let us understand the following instance. In China, in 2002, a person called Yong Lu was diagnosed by a form of leukemia and was advised to use the drug “Gleevec” produced by a Swiss Pharmaceutical Company. The cost of the drug being very high, it was unaffordable for many patients. To make it available to a network of patients Yong Lu started importing Indian variant of the same drug at a much cheaper price and made it available to the patients at cheap prices bearing most of the cost from the profits he would earn from his business. However, he was arrested on charges of forgery and a lawsuit was filed against him by the Swiss company against which a plea was filed on behalf of the public to regulate the price of the Anti-cancer drug “Gleevec” which was being produced by the Swiss pharmaceuticals. The case was delivered in the favor of the public and the state reformulated its policy on drugs research and pricing. It is one of the land mark cases in the history of medicine in China where state was compelled to change its views on the policies and issues of drug allocation.

The case above is an example of how health requires attention not only from the society itself but, it requires larger socio-economic factors. Inn the age of globalization, and neo-liberal world, bigger institutions are involved in the funding and awareness programs like World Bank, IMF, etc. to safeguard the rights of the citizen. It is the obligation of the state to keep a check on the regulation of the prices of drugs that are available for the masses. This might require the state to enforce laws and regulations.

14.5 HIGH INCOME AND LOW-INCOME COUNTRIES AND THE HEALTH SCENARIO

Having discussed the impact of socio-economic factors on the health of an individual, let us see how the situation varies with respect to the economy of the country. For this exercise we will engage with the comparative analysis of high income and low-income countries. Before we go into comparative analysis, we will try to understand what does the term mean.

The evidence at the disposal of medical sociology argues that people's health is closely linked in determination by their social circumstances. The evidence base is heavily tilted towards richer countries in which only a minority of the world's population live. In part, this is because these countries have more comprehensive data collection systems. For example, England and Wales have National Registration for births and deaths since 1837.

The lack of evidence on health inequalities in poorer countries cannot be wholly explained by the limitations of their national data collection systems. It is also due to the targeting of research funding at the world's richest and healthiest populations. It has been estimated that, of the total volume of global health research funded by the public and private sector, less than 10 per cent is devoted to improving the health of 90 per cent of the world's population. This has been termed the '90/10' gap (Commission on Health Research for Development,1990).

According to the World Bank, a high-income country is one that had Gross National Income Per Capita of $12,056 in 2017.

The Low-Income Country is one that had Gross National Income per Capita of $995 or less in year 2017

But what is Gross National Income?

According to Todaro and Smith, it comprises of the total domestic and foreign output claimed by residents of a country, consisting of gross domestic product (GDP), plus factor incomes earned by foreign residents, minus income earned in the domestic economy by nonresidents.

Now we move to understanding the correlation between health and income. Below is a table depicting how the life expectancy at birth and Under-5 mortality varies with income group of the country.

Table 1 Life expectancy at birth and under-5 mortality in low-income, middle-income and high-income countries, 2001

Life expectancy at birth	Under-5 mortality	(deaths per 1000)
Low income	59	121
High income	78	7

Source: *adapted from World Bank, 2003, table 2.20*

As we see from the above table the difference between the life expectancy is 19 years between the two groups while the child mortality gap shoots up in low income group by addition of 114 children dying before their 5th birthday.

According to the study of Colin Mathers and Dejan Loncar, in sub-Saharan Africa, the region of the world with the lowest life expectancy, it is estimated that 18 per cent of the average life span is spent living with disabilities; in countries where life expectancy is high, like Japan, the proportion is around 8 per cent. But how does income relate to health? This is answered by the research published in 1975 arguing how the income disparity affects health in various countries through Preston Curve as shown below.

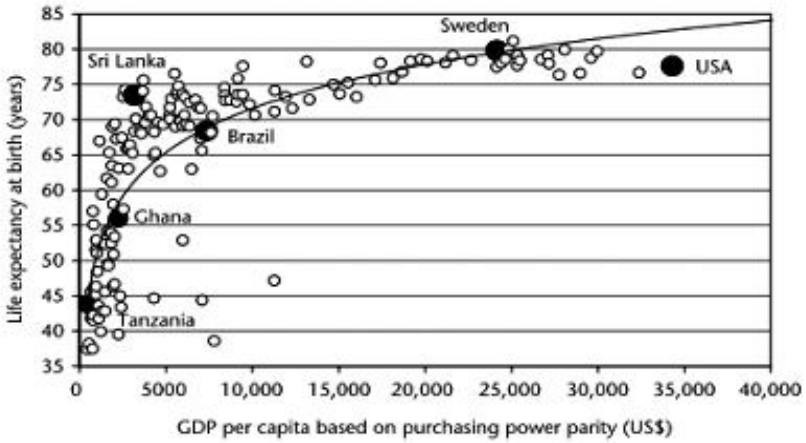


Figure 2 Gross domestic product per person in US dollars (adjusted for purchasing power parity) and life expectancy in 159 countries, 2001

Source: World Bank, 2003

The curve attempts to understand how income parity affects the health in the corresponding income group. When GDP is low, increases are strongly associated with improvements in life expectancy: at this point in the income distribution, the line linking income and health is almost vertical. Among richer countries, the curve flattens out, with higher incomes bringing diminishing health benefits. As this suggests, the marginal health gains of extra income are far greater at the lower end of the income range. It is a conclusion which lends support to the view that 'redistribution of income towards the poor will improve their average health by more than the loss of health among the rich.' (Deaton, 2003:115)

However, does this link between health and income explains exceptions? For example, according to World Bank (2003), a country where levels of health do not match its levels of wealth is the USA. In the early 2000s, the world's richest country had a lower life expectancy (77.0 years) than countries with much lower GDP, like Sweden (79.7 years) and Japan (80.7 years), and an infant mortality rate which was more than twice as high as these countries. This anomaly is explained by the receded regulation of the state in the labor market and Welfare Provision. This also features in how much proportion of GDP is allocated towards the health care provisions. The US allocates lesser GDP to healthcare as compared to other high-income group countries. Another

exception in contrast to the case of the US is Sri Lanka, Sri Lanka's GDP is half that of Brazil, but it has a higher life expectancy (73.1 years compared to 68.1 years in Brazil). Sri Lanka also has a lower infant mortality rate (17 vs 31 per 1000) and a lower rate of under-5 mortality (15 vs 35 per 1000) (UNDP, 2003; World Bank, 2003).

In the case of Sri Lanka, the issue has been resolved by allocation of a good proportion of the national wealth towards poverty alleviation, emanating from their equity-oriented policies.

In Indian context, Kerala state has been deemed as a sub-national example by Amartya Sen in his works. According to Thakkappan (2001), the modus operandi of the Kerala state has been along the similar lines regarding the equity-oriented approach by providing a land redistribution system allowing the allocation of land to the poorest as well as food distribution at a subsidized price along with public funded service expansion to women education and healthcare.

As the examples of the USA, Sri Lanka and Kerala suggest, the relationship between national wealth and population health is not a direct and simple one. Rather, the relationship appears to be mediated by government policies.

Since the 1970s, globalization has become 'shorthand for global capitalism' (Birdsall, 2006: 22), with trade liberalization and financial deregulation enabling companies based in high-income countries to extend their reach into the economies, and the populations, of poorer countries. Global financial institutions, like the World Bank, International Monetary Fund and World Trade Organization, have played an important role by negotiating what are called 'structural adjustment programmes' with poorer countries, often as a condition of financial aid and debt rescheduling (CSDH, 2005; Labonte and Schrecker, 2006; Sáinz, 2006). Actively promoted through the1980s and 1990s, the programmes required that domestic markets were opened up to foreign investment and public expenditure was cut, with private companies taking over what were formerly publicly provided services.

In India, the structural adjustment programmes have been seen

to have more far-reaching effects, with resources directed away from primary health care towards private hospitals and a sharp rise in the costs of health care, particularly for poorer groups (Qadeer, 2000; Thankappen, 2001). Analyses suggest that the programmes have impacted negatively on Kerala, making it hard for the Indian state to sustain the principle of universal access to health care and threatening the survival of its redistributive model of welfare (Kutty, 2001; Thankappen,2001). As this suggests, politics and policies matter for people's health.

Taking the case further we see the table below for our further analysis.

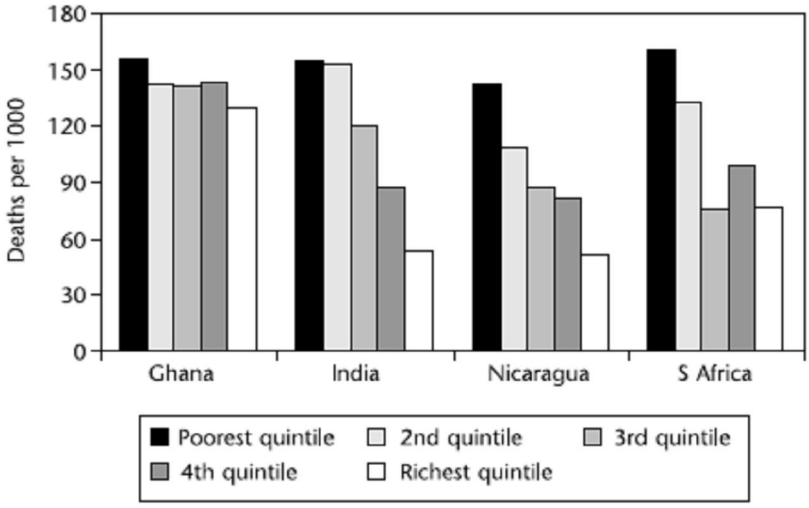


Figure 3 Under-5 Mortality

In the figure above, we have a middle-income country, South Africa (per capita GDP of $3500 in 2003), and three low income countries: Ghana, one of the poorest countries in the world ($350), India ($550) and Nicaragua ($750) (UNDP, 2005). The steepness of the socio-economic gradient varies, with death rates falling much more rapidly with rising household income in India, Nicaragua and South Africa than in Ghana. But in all four countries, death rates are at their highest in the poorest households. In rich societies, overall standards of health are much, much higher. But high overall standards mask the unequal distribution of health between more and less advantaged groups.



CHECK YOUR PROGRESS-(A)

Q.1. Which of these is included in WHO's definition of Health?

a). Being privileged b).Being rich

c). Political Power d). Mental Health

Q.2. Write two important factors that affect the health of an individual.

.....

14.6 LET US SUM UP

- According to World Health Organization (WHO), "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."
- A health disparity/inequality is a particular type of difference in health. It is a difference in which disadvantaged social groups – such as the poor, racial/ethnic minorities, women, or other groups who have persistently experienced social disadvantage or discrimination – systematically experience worse health or greater health risks than more advantaged social groups.
- The lack of evidence on health inequalities in poorer countries cannot be wholly explained by the limitations of their national data collection systems. It is also due to the targeting of research funding at the world's richest and healthiest populations.
- Global financial institutions, like the World Bank, International Monetary Fund and World Trade Organization, have played an important role by negotiating what are called 'structural adjustment programmes' with poorer countries, often as a condition of financial aid and debt rescheduling.
- In India, the structural adjustment programmes have been seen to have more far-reaching effects, with resources directed away from primary health care towards private hospitals and a sharp rise in the costs of health care, particularly for poorer groups.



ACTIVITY 1

Try finding out initiatives of Indian government regarding mental health

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_____

_____



CHECK YOUR PROGRESS - (B)

Q.1. Which country has a high income per capita?

a). Brazil b). the US

c). India d). Bangladesh

Q.2. The Criteria for a country to be High Income is:

a). Rich Natural Resources b). $12,056 income per capita

c). wealthy politicians d). Poor people

Q.3. World Bank Defines High-Income and Low-Income Countries. True/ False

Q.4. For better health of the population, policy needs to be

a). profit oriented b). equity oriented

c). capitalist oriented d). none of the above



ACTIVITY 2

Find about the health care initiatives in your locality

_____

_____

_____



CHECK YOUR PROGRESS - (C)

Q.1. Why does the US have higher mortality rate?

.....

Q.2. Why does Sri Lanka have higher life expectancy?

.....

Q.3. The state referred to as the sub-national example is

a) Manipur b) Meghalaya c) Gujrat d) Kerala

Q.4. Write two important works mentioned in the chapter above done in Kerala for better health.

.....

.....



14.7 FURTHER READING

1) *The Sociology of Health and Illness* (Routledge Student Readers) by Michael Bury

2) *Key Concepts in Medical Sociology* (Sage key concepts series) by Jonathan Gabe and Lee Monaghan

3) *The New Medical Sociology : Social Forms of Health and Illness*, by Bryan S. Turner

4) Unequal Lives : *Health and Socio-Economic Inequalities*, by Hillary Graham



14.8 ANSWERS TO CHECK YOUR PROGRESS

A.

Ans to Q No 1. Mental Health

Ans to Q No 2. Social and Economic factors

B.

Ans to Q No 1. the US

Ans to Q No 2. $12,056 per Capita

Ans to Q No 3. True

Ans to Q No 4. Equity Oriented

C.

Ans to Q No 1. The US has higher mortality rate because of lack of Institutions, and minimal allocation of GDP for health care.

Ans to Q No 2. Sri Lanka has a higher life expectancy because of their equity-oriented policies and allocation of more portion of GDP for health and mass welfare.

Ans to Q No 3. Kerala

Ans to Q No 4. Land redistribution to the poor and availability of food at subsidized rates for the masses

14.9 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: What is the definition of Health as given by World Health Organization (WHO)?

Q 2: What factors affect the health of an individual apart from the environmental factors?

B) Long Questions (Answer each question within 300-500 words)

Q 1: What is the role that policy plays in providing masses the access to health care?

Q 2: What do you think could be reasons why low-income countries fare poorly in healthcare?

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