Sociology of Health

DSOC614

Edited by
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Unit 01: Sociology of Health

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Objectives

After completing this Unit, you shall be able to:

- To understand what sociology of health is
- To know definition of Sociology of Health
- To know the scope , nature and importance of the Sociology of Health
- To know about relationship between sociology with health and well-being and how the interplay of structure and agency is there.

Introduction

Sociology is a discipline customised to have a scientific approach to understanding the people in society. In Simple terms, it focuses on social structure and how the structures interact to modify human behaviour, actions, and opportunities, and how the patterns of social existence engender social problems. Social Institutions play a key role in society, where H. E Barnes mentions as social institutions are 'the social structure and machinery through which human society organizes, directs and executes the multifarious activities required to society for human need.' They are broad conceptual frameworks that look into and govern a particular aspect of societal life i.e. these institutions works as pillars that hold up society because they are the integral parts of the society and these parts are interdependent and interrelated with specialised functions for the survival of society. Due to this reason, human society is often referred to as a social system. Every institution performs some functional requirements. The family as an institution functions in procreation and socialising its member to become part of the society. Similarly, the economic institution contributes in production and distribution of goods and services. But, at the same time both family and economic system is complementing each other's, whereas the Heath Institution is mechanised in providing the wellbeing and survival of human beings.

Social scientists define basic needs as food, water, and shelter from the traditional days onwards but as the years moved the societies became advanced and the modern references cite it as where minimum consumption of the basic needs not only food, water, clothing and shelter but along with that sanitation, education, and healthcare (Denton, 1990). Contemporary society addresses health as a social problem and it is vital for human survival in society. As Weber (1995, p. 9) defined social problems "as a social phenomenon that is destructive to the society or its members, is perceived as such, and is socially remediable." i.e. as any issue that threatens the well-being or survival of the society is regarded as a social problem. The twenty-first century has witnessed various contagious diseases like Influenza, Nipah virus, Ebola Virus Disease, and Coronavirus disease and how they hard hit society and made life up and down. At this juncture, the sociology of health and well-being became crucial to the social scientist to understand and analyse the changing situation in the arena of health and how that impacts society need to be addressed.

1.1 Sociology of Health: Definition

WHO (The World Health Organisation) defined "Health" in the Constitution of the World Health Organization, 1948 as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, as it adds that the enjoyment of the maximum achievement of standard of health is one of the fundamental rights of every human being irrespective of race, religion, political belief, economic or social condition. This announcements underlines that health is not a private affair but it is the responsibility of the society as well. Professor William Cockerham of University of Alabama, observes "it is clear that most diseases have social connotations i.e the social context can shape the risk of exposure, susceptibility of the host, and the disease's course and outcome- regardless of whether the disease is infectious, genetic, metabolic, malignant or degenerative (Cockerham, 2007:2). Thus looking closer one can understand the health and society is interconnected, here comes the responsibility and scope for the study of sociology of health. As Michael Bury (1997) mentions, "Sociology can relate to health and illness in two different ways. On the one hand, a sociological perspective can be applied to the experience and social distribution of health and health disorders and to the institutions through which care and cure are provided. Keeping this perspective, medical sociology can have an applied orientation to understanding and improving health, and can be seen as one of many disciplines that might appropriately be studied by providers of health care, i.e. the sociological study of health, illness and institutions of health care can stand alongside analysis of other significant social experiences and institutions, as a means of understanding the society under study.

1.2 Significance Sociology of Health

The significance of the Sociology health is described as below

- Sociology of health examines the interaction between society and health
- It is important to differentiate between sociology in Health and Sociology of health.
- Good health is defined as a condition, where both our body as well as our mind are working properly.
- Our body becomes free from various forms of disorders, so that we get longer life and create a good society.
- We can live without suffering from aches, pain or discomfort in society.

1.3 Scope Sociology of Health

The scope of the sociology of health is discussed by sociologists, anthropologists and historians on the social basis of health and illness in a wide range of studies, including ethnographies of specific communities. They have discovered issues of health care, the performance of 'the sick role', the construction of mental illness as a disease, the wider creation of medical belief systems and the relationship between these and the exercise of power and social control. The sociology of health is concerned with the social origins and influences on disease, rather than with exploring its organic manifestation in individual bodies. The sociology of medicine is concerned with exploring the social, historical and cultural reasons for the rise to dominance of medicine – especially the biomedical model – in the definition and treatment of illness. These fields are closely related, since how professional (or orthodox) medicine defines and manages illness reflects wider social dynamics that shape the perception and experience of the disease.

Sociology of health (Sociology of wellness, sociology of health and wellness) studies and analyses the relationship between society and health in a structural way. It is a specialized field of sociology which is interested in all aspects of life, i.e. contemporary as well as traditional aspects and connects that to understand the impact and modify our health and wellbeing (Nettleton, 2013), (White, 2002). The development of the sociology of health and illness has to be understood in terms of its relation to the dominant paradigm of western medicine called Biomedicine. Many of the central concerns of the sociology of health and illness have emerged as a reaction to, and critique of this paradigm. As it underlines that health and diseases are socially patterned, health status is the consequence of factors other than biology, and this is evidenced by the fact that it does not occur at random. The pattern of mortality and morbidity, or a person's life chances are related to the social structure and vary according to gender, social class, race and age. Health, or lack of health, was once merely attributed to biological or natural conditions. Sociologists have proven that the spread of diseases is deeply influenced by the socioeconomic status of individuals, ethnic traditions or beliefs, and other cultural factors. Where medical research might collect statistics on a disease, a sociological perspective of an illness would provide insight into what external factors caused the demographics that contracted the disease to become ill.

Social medicine is a social science discipline which focuses on understanding how social and economic conditions are influencing health, disease, and the practice of medicine and it tries in improving to lead a healthier society. It uses social science as well as humanities research techniques to improve the practice of medicine, the delivery of treatment, and the development of healthcare. As it focuses on the wider determinants of health or upstream factors which include housing, education, income, poverty, transportation, healthcare organisations, and environmental and genetic influences. By aiming these factors which can help in preventing the illness from happening and so save costs of lives. Social medicine focuses on areas including social epidemiology, social pathology, medical geography, medical sociology, health economics, etc. whereas Public health works apply the findings of social medicine to improve the services and healthy population. In most cases, social medicine is considered an academic arm of public health while some will address as it a bridge between medicine and public health.

Medical sociology is a sub-discipline of sociology that studies the social causes and consequences of health and illness (Cockerham 2004), i.e. it deals with a sociological analysis of medical organisations and institutions. The production of knowledge, selection of methods, the actions and interactions of healthcare professionals, and the social or cultural effects of medical practices. This discipline came in the late 1940 and early 1950 in an intellectual climate far different from traditional sociology's specialisations but became in strength only in the mid-twentieth century as an applied field in which sociologists could produce knowledge useful in medical practice and developing public policy in health matters.

But certain other studies mention as both medical sociology and sociology of health and illness got emerged as independent disciplines under sociology in the anglophone world, i.e. among the English-speaking people whereas they referred to Medical sociology (as the sub-discipline was first named and which term is still preferred in the United States), or the sociology of health and illness (the term preferred in Britain and Australia), was primarily concerned with systematic empiricism using the measurement of objective variables estimated as quantifiable. As in the beginning stage of development, to be accepted as a quasi-scientific discipline applied to a scientific discipline (that is, medicine), medical sociology adopted largely positivist values which to some extent are still evident, although more so in the United States than Britain and Australia. As a result, often medical sociology could best have been described as a derivative of social medicine rather than as a sub-discipline of critical sociology (Jordanova, 1983; Mechanic, 1993; Scambler, 1987).

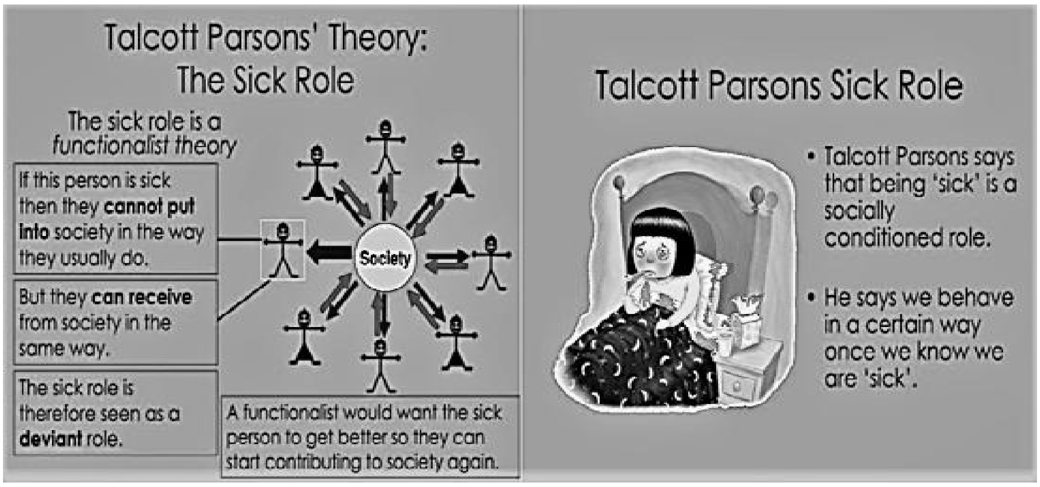
Theoretical approach to the Sociology of Health

Sociology of health is understood by analysing three theoretical perspectives, they are

A. Functionalist perspective

According to the functionalist perspective, health is vital to the stability of the society, and therefore sickness is a sanctioned form of deviance. Talcott Parsons (The Social System, 1951) was the first to discuss this in terms of the sick role: patterns of expectations that define appropriate behaviour for the sick and for those who take care of them.

According to Parsons, the sick person has a specific role with both rights and responsibilities. To start with, they have not chosen to be sick and should not be treated as responsible for their condition. The sick person also has the right of being exempt from normal social roles; they are not required to fulfil the obligation of a well person and can avoid normal responsibilities without censure. However, this exemption is temporary and relative to the severity of the illness. The exemption also requires legitimization by a physician; that is, a physician must certify that the illness is genuine. The responsibility of the sick person is twofold: to try to get well and to seek technically competent help from a physician. If the sick person stays ill longer than is appropriate (malingers), they may be stigmatized.



Talcott Parsons' Theory: The Sick Role

The sick role is a *functionalist theory*

If this person is sick then they **cannot put into** society in the way they usually do.

But they **can receive** from society in the same way.

The sick role is therefore seen as a **deviant** role.

A functionalist would want the sick person to get better so they can start contributing to society again.

Talcott Parsons Sick Role

- Talcott Parsons says that being 'sick' is a socially conditioned role.
- He says we behave in a certain way once we know we are 'sick'.

Image 1.1

Parsons argues that since the sick are unable to fulfil their normal societal roles, their sickness weakens the society. Therefore, it is sometimes necessary for various forms of social control to bring the behaviour of a sick person back in line with normal expectations. In this model, doctors serve as gatekeepers, deciding who is healthy and who is sick—a relationship in which the doctor has all the power. Moreover, medical providers function as dispensers of resources for the healing of the sick. But is it appropriate to allow doctors so broad discretion in deciding who is and is not sick? And what about people who are sick, but are unwilling to leave their positions for any number of reasons (e.g., personal/social obligations, financial need, or lack of insurance).

The theory was not much welcomed by the critiques, the major criticism to the theory was initiated by Ann Oakley (1974), who had suggested that the rights of the sick role were not afforded to women in the same way they are for men. When a woman is ill they are rarely excused from their 'normal social role' of being the housekeeper / mother. Another criticism on Parson's theory is with regards to health could be said to be the Interpretivists. They have argued that building an ideal type model of all doctor-patient interactions with only one type of relationship (led by the 'expert' doctor) is both unrealistic and misguided. For Interpretivists it is very rare that both the patient and doctor live up to the expectations as set out by Parsons.

B. Conflict perspective

Theorists using the conflict perspective by suggestingthat issues with the healthcare system, as with most other social problems, are rooted in capitalist society. According to conflict theorists, capitalism and the pursuit of profit lead to the commodification of health, i.e. the changing of something not generally thought of as a commodity into something that can be bought and sold in a marketplace. In this perspective, people with money and power—the dominant group—are the ones who make decisions about how the healthcare system should work. They, therefore, confirm that they will have healthcare coverage, while simultaneously ensuring that subordinate groups stay subordinate through lack of access. This creates significant healthcare—and health—disparities between the dominant and subordinate groups.

Alongside the health disparities created by class inequalities, there are several health disparities created by racism, sexism, ageism, and heterosexism. When health is a commodity, the poor are more likely to experience illness caused by poor diet, living conditions and work in unhealthy environments, and are less likely to challenge the system. Keeping the situation of Indian health care system, it have both the public as well as private services which is access to the commoners. The private health care system is mainly located in the urban centres, whereas the government health care services apart from government hospitals, it works in three phases as Sub-centres, community medical centres and primary health centres. As per WHO records of the 2007, India has been raked 184 out of 191 countries in the amount of public expenditure spent on healthcare out of total GDP. But the situation is not same as in the other places, as in the United States, a disproportionate number of racial minorities also have less economic power, so they bear a great deal of the burden of poor health. It is not only the poor who suffer from the conflict between dominant and subordinate groups. For many years now, homosexual couples have been denied spousal benefits, either in the form of health insurance or in terms of medical responsibility. Further adding to the issue, doctors hold a disproportionate amount of power in the doctor/patient relationship, which provides them with extensive social and economic benefits.

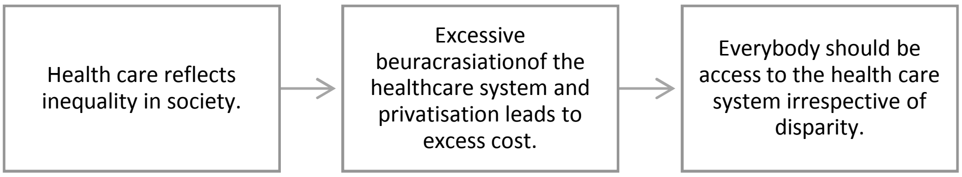


Image 1.2

While conflict theorists are accurate in pointing out certain inequalities in the healthcare system, they do not give enough credit to medical advances that would not have been made without an economic structure to support and reward researchers, a structure dependent on profitability. Additionally, in their criticism of the power differential between doctor and patient, they are perhaps dismissive of the hard-won medical expertise possessed by doctors and not patients, which renders a truly egalitarian relationship more indefinable.

C. Symbolic Interactionism

According to symbolic Interactionists, health and illness are both socially constructed. As interactionists focus on the specific meanings and cause people to attribute to illness. The term medicalization of deviance refers to the process that changes "bad" behaviour into "sick" behaviour. A related process is de-medicalization, in which "sick" behaviour is normalized again. Medicalization and de-medicalization affect who responds to the patient, how people respond to the patient, and how people view the personal responsibility of the patient (Conrad and Schneider 1992). Under this perspective, as our perception of a condition changes, so do the social consequences of that condition.

An example of medicalization is illustrated by the history of how our society views alcohol and alcoholism. During the nineteenth century, those who drank too much were considered bad, lazy people. They were called drunks, and it was not uncommon for them to be arrested or run out of town. Drunks were not treated sympathetically because, at that time, it was thought that it was their fault that they could not stop drinking. During the latter half of the twentieth century, however, people who drank too much were increasingly defined as alcoholics: people with a disease or a genetic predisposition to addiction who were not responsible for their drinking. With alcoholism defined as a disease and not a personal choice, alcoholics came to be viewed with more compassion and understanding. Thus, "badness" was transformed into "sickness".

There are numerous examples of de-medicalization in history as well but the more recent example is homosexuality, which was labelled a mental disorder or a sexual orientation disturbance by the American Psychological Association until 1973. Similarly, the Indian judiciary after the judgement of section 377 followed by discussions made by the Indian psychological association has declared underlined that homosexuality is not an illness. While interactionism does acknowledge the subjective nature of the diagnosis, it is important to remember who most benefits when behaviour becomes defined as illness or condition. Pharmaceutical companies make billions in treating illnesses such as fatigue, insomnia, and hyperactivity that may not be illnesses in need of treatment.

Sociology with Health and well-being-Interplay of structure and agency

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

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

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

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

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

- **Neo-material perspective**: It refers to explanations of class and health inequality that emphasise unequal distribution of resources such as housing, income and access to education. Thus, there are consistent and persistent differences in class and health in contemporary society. Such differences are part of the array of inequalities to do with wealth, income and other recourses. Perhaps it is in health that the social division of class is most evidently visible, with the bodies of people affected and changed by their location in society. As discussed earlier the bodies of working-class people are more likely to age quicker, be more susceptible to illness and be much more likely to encounter limiting long-term conditions than those located higher in society.

1.4 Ethnicity, Race and Health

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

There has been much research on ethnicity and health over the years. What much of the research indicates is that there is a burden of ill-health among ethnic minority groups in the UK. Many people from ethnic minority groups report poor health and long-term limiting illnesses. This is even more notable as ethnic minority groups tend to have a younger age profile than the white majority population. Researchers in the past often favoured explanations that drew attention to either genetic or cultural reasons for ill health. The implication was that there was something wrong with the biology of ethnic groups, which predisposed them to certain types of ill-health or that the culture of the ethnic group was to blame. An indicative example of this older approach can be noted in research on 'South Asians and coronary heart disease (CHD) (Nazroo1998). The work by Gupta et.al. (1995) inferred that it was something to do with either the genetic make-up of 'South Asians' that predisposed them to CHD, something in cultural practices such as cooking with ghee, or exercising or not making the best use of medical services. In the past few years, however, the work of other researchers, such as Ahmad (2000), Nazroo (2006) and Smaje (1996), have put forward a more challenging and sophisticated explanation of the complex way in which ethnicity, society and health interact.

Thus it can be summarised, that variations in ethnicity and health and ill-health, 'arise from the coalescence of complex factors such as migration, cultural adaptation, racism, reception by the host community, socio-economic influences, and prevailing societal ideologies'. Reviewing a range of research and reports, Chahal (2004) concluded that medical and health care services can be problematic for Black and ethnic minority people, with negative experiences of medical and health services being a common problem. This is particularly evident with mental health services. Black people are overrepresented in mental illness statistics, more likely to be placed in secure wards and to receive different if not poorer –treatment and care than Whites. Thus, class and socio-economic differences affect the health of ethnic minority groups. Even within the same ethnic minority group, there are differences in health, with those from the non-manual occupation class having better health than those in manual occupation classes. Moreover, the psycho-social effects of racism can have a strong impact on the health of ethnic minority groups.

1.5 Health Promotion and Sociology

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

- Health promotion is the attention that it gives to the facilitation of healthy lives: the idea that it is not just telling people that they should change their lifestyles but also altering their social, economic and ecological environments' health.
- The promotion aims to work not only at the level of individuals but also at the level of socioeconomic structures and to encourage the creation and implementation of 'healthy public policies such as those concerned with transport, environment, and agriculture and so on.
- Promotion aims to work not only at the level of individuals but also at the level socioeconomic structures and to encourage the creation and implementation of 'healthy public policies' such as those concerned with transport, environment, agriculture and so on.

- The promulgation of healthy lifestyles and the discourse of health promotion and the ‘new public health more generally are important and topical subjects which, although retaining some continuities with past health policy, can increasingly be viewed as representing a new paradigm of health care (Nettleton, 1995).
- An aetiology and distribution of health and illness which reveal that adequate health policies must take structural and environmental factors have been analysed and focused on. The political and ideological bases of health education and health promotion activities have also been debated.
- The dominant strand of the sociology of health promotion is its concern to analyse the phenomena as a characteristic of the much wider set of socio-economic and cultural processes associated with late modernism.
- Sociological analyses of health promotion; develop analyses on matters concerning health promotion which are of interest to contemporary sociology, including risk, the body, consumption, and processes of surveillance and normalization; and develop critiques of health promotion which are of interest to health and medical practitioners, including issues of gender and race in the implementation of health programmes, cultural dimensions of lifestyles and health behaviours, and the marketing and consumption of health-related activities.

Some major contributions of Sociology of Health and illness

- On the social psychological level, Mechanic has extended the early work on the sick role to consider illness behaviour and what constitutes trust. Parsons (1951) made a major contribution in identifying the components of the sick role in terms of what was expected of the patient. Over the years, others criticized and expanded this model to include expectations of those with chronic illnesses and disabilities.
- Mechanic (1962) made contributions in considering what it meant to be ill and how one experienced and expressed illness. This work led him to reconsider the doctor-patient relationship and, on a more macro level, what illness meant in society. This stream of research has laid conceptual building blocks and theoretical foundations that make discussions of trust and social justice more sophisticated. As Mechanic (1989) points out, trust is the social glue that makes diagnosis and treatment possible on the individual level and social policy possible on the community and societal levels.
- On the organizational level, studies of national health care services, multiple hospital systems, assisted care facilities, hospices, support groups for those with HIV/AIDS and the environment within which these organizations operate have led to important findings about how the organization of health care directly impacts the cost, access and quality of care. This work is now expanding to important sets of cross-national studies that are examining the essentials of effective health care systems, how different organizational models may produce similar results and how the mix of populations served to interact with the organizational structures of the delivery system to yield variable results. In other words, the organization of health care needs to be tailored to the needs of the population and local culture and environment. That is why there is a persistent interest in the comparative health care system.
- Inequality in health has also been a dominant theme of the sociology of health and illness which has evolved from a consideration of differences in behaviour and material circumstances to a complex consideration of how health behaviours and material and social resources interact to produce differences in health outcomes both on the individual and community levels. Researchers in this area have illustrated the importance of social capital in dealing with health issues.
- Social capital refers to the social resources and networks available to individuals that help them define and cope with health problems. Consistent findings show that larger amounts of social capital are predictive of less disability, more support and a higher quality of life.
- Research on social equity has also highlighted the need to do multi-level analysis; to consider individuals in their environments and as members of a community and nation. Each layer of relationships is likely to explain some of the health outcomes and considering individuals in context permits a more fine-grained analysis of health and disease realities.

- Health-related quality of life research has directed attention beyond issues of mortality and morbidity to how people are living (Levine, 1987, 1995). This concept is applicable across the lifespan and groups of individuals.
- Investigations into quality of life have led to important distinctions between objective and subjective indicators of well-being. AlbrechtandDevlieger (1999) discovered, for example, that there was a disability paradox raised by the apparent discrepancies between the quality of life of disabled people as perceived by the general public and those living with the disability. About 50 per cent of the people with serious and persistent disabilities in the study reported that they had a good or very good quality of life even though outside observers might deem otherwise. This type of result suggests that clinical and policy decision-makers need multiple sources of data to understand the desires, wants and experiences of vulnerable and disable people. As a consequence, quality of life is being incorporated into most judgments of treatment outcomes. Much progress is being made in this area.
- The work on health-related quality of life has also drawn renewed attention to the concepts of normalcy and deviancy (Phelan et al., 2000).
- The women's movement and interest in international health have illustrated how white male norms established at one point in history in post-industrial countries do not serve as useful reference points for the behaviour of all people.
- Most research has been traditionally done on men by men and for men. Yet, recent research clearly demonstrates that women's health experiences and issues are different from those of men, requiring considerable changes in the conceptualization and delivery of health care for women and children. In fact, one of the major factors in improving the health of a nation is to educate women and make health resources available to them, for women are usually the people who care for children, older parents and disabled people.

Summary

Sociology of health is a discipline of sociology which was emerged in the latter half of the twenty-first century and studies society and health. Health sociology uses the insight to critique long-established ideas around the human body as a mechanical entity alongside disrupting the idea that the mind and body can be treated as distinct spaces. The sociology of health is concerned with the social origins of and influences on disease, rather than with exploring its organic manifestation in individual bodies. This hold close connection with the Sociology of Medicine, Sociology of body, and sociology of diseases.

Keywords

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

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

Biomedicine- It is a branch of medical science that applies biological and physiological principles to clinical practice

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

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

SelfAssessment

1 Health is ……………….

A. Weight of body according to height

B. Absence of disease or infirmity

C. State of complete physical, mental and social well-being.

D. None of these.

2 Who proposed Sick role theory?

A. Robert K. Merton

B. Clifford Geertz

C. Jeffrey C. Alexander

D. Talcott Parson

3 In Antony Giddens, theory of structuration, primary is granted

A. Structure

B. Agency

C. Habitus

D. Structure and Agency

4 Conflict theory emerged as a ……

A. Critique of feminist theory

B. Alternative to Anthony Giddens's structuration theory.

C. Alternative to structural-functionalism.

D. Critique of postmodernism.

5 Sociology of health examines the interaction between …………

A. Society and wellness

B. Structure and agency

C. Society and health

D. Health and illness

6 ………..is considered an academic arm of public health

A. Social medicine

B. Social epidemiology

C. Social pathology

D. Public health

7 According to ………..sickness is a form of deviance.

A. Functionalists

B. Conflict theorists

C. Symbolic interactionists

D. Positivists

8 If we promote equality we must………….

A. Treat everyone the same

B. Treat people based on their status

C. Treat everyone with equal respect but take account of individual needs and make accommodation to meet these needs.

D. Ignore their differences

9 ………is an analogy between society and biological organism.

A. Functionalism

B. Social conservatism

C. Social constructionism

D. Conflict theory

10 Who determines which illness are stigmatized?

A. Therapists

B. The patient themselves

C. Society

D. All of the above

11 Antony Giddens's ……………concept is used in explaining Health sociology

A. Structuration

B. Structure and Agency

C. Third way

D. Double Hermeneutic

12 According to symbolic Interactionists, health and illness are both ……constructed.

A. Political

B. Socially

C. Cultural

D. Emotional

13 …………is called the state affected by diseases

A. Morbidity

B. Mortality

C. Abortion

D. Ophthalmology

14 According to………..Capitalism and the pursuit of profit lead to the commodification of health.

A. Conflict theorists

B. Positivism

C. Functionalists

D. Post modernists.

15 What does the term 'mortality' refer to?

A. Birth

B. Death

C. Illness

D. None of these

Answers for SelfAssessment

1.	C	2.	D	3.	D	4.	B	5.	C
6.	A	7.	A	8.	C	9.	A	10.	C
11.	B	12.	B	13.	A	14.	A	15.	B

Review Questions

1. Distinguish between Medical sociology and Social epidemics.
2. Analyse the functionalistic understanding on sociology of health.
3. Why sociology consider sickness as deviance?
4. How structure and agency explained in context of Sociology with Health and well-being?
5. What is symbolic interactionist's perspective and how that helps in explaining sociology of health?

Further Readings

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Unit 02: Social Epidemiology

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Objectives

After completing this Unit, you shall be able to:

- To understand what is Epidemiology?
- To know definition of Sociology of Health
- To know the scope , nature and importance of the Sociology of Health
- To know about relationship between sociology with health and well-being and how the interplay of structure and agency is there.

Introduction

In the year 2019- 2020 coronavirus pandemic spread had upended life on a global level. The highly infectious coronavirus disease 2019 (COVID-19) is caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has been reported. As per the reports, Wuhan, Hubei, China where its outbreak was first identified in December 2019. After almost 3 months, on March 11, 2020, the World Health Organization recognized it as a pandemic considering its significant ongoing spread in multiple countries across the world. When it reaches April 11, 2020, approximately 1,741,621 cases of COVID-19 have been confirmed in over 210 countries and territories resulting in around 106,670 deaths. The most countries, airports all the modes of transportation were blocked. The people were requested to stay at home on the one hand people across India and around the globe are largely confined to their homes with businesses and educational institutions all shut down in an attempt to contain the virus, and on the other hand doctors, healthcare workers, and medical staff members are leading the battle against COVID-19 from the front. This was not the situation in India but all around the world, many vulnerable experiences have been shared. As the number of those infected is increasing at this point only the Health workers and the medical practitioners were only hoping but they also have a limitation as they are unable to identify what was the reason for this widespread new disease with new symptoms. At this juncture, Epidemiologists and virologists, microbiologists, and biotechnologists came to the forefront in understanding the pandemic in detail and find out a solution to handle the pandemic and also make things normal by inventions of vaccines. Thus this chapter details who are Epidemiologists, Social epidemiologists and how they take part in the various roles in identifying the various diseases over the time and also this is the history of human kind and their development of advancement in the field of diseases as epidemics.

2.1 Epidemiology of Diseases

Public health is concerned with preventing health problems, promoting health and extending life. Epidemiology is one of the subfields of public health along with biostatistics and health service. It is commonly referred to as the foundation of public health because it is a study that aids our understanding of the nature, extent and cause of public health problems and provides essential information for improving people's health and social conditions. Epidemiology has a population focus in that epidemic investigations are concerned with the collective health of a group of individuals who share one or more observable personal or observational characteristics. I.e. it is the study of the determinants, distribution, and frequency of disease (who gets the disease and why).

The origin of Epidemiology traces back to the time of Hippocrates, who tried to explain the causative factors of diseases. But it flourished rapidly during the last three decades of the present century and contributed extensively to the field of medicine and community health. As science and academic field, epidemiology not only helps in understanding health concepts, the natural history of disease and disease causation, but it also helps in planning, implementing and evaluating effective and efficient healthcare services. During the late 19th century and the early 20th century, the study of frequency, distribution and determinants of infections and communicable diseases and their prevention and control were the primary focus of epidemiologists. There has been a considerable reduction in the morbidity and mortality from these diseases as a result of epidemiological studies and improved methods of diagnosis, prevention and control. However, the threat of communicable disease is still present, especially in developing countries, because of substandard environmental conditions, poor socio-economic status and inadequate resources.

Epidemiology is often described as the basic science of public health, and for good reason. First, epidemiology is a quantitative discipline that relies on a working knowledge of probability, statistics, and sound research methods. Second, epidemiology is a method of causal reasoning based on developing and testing hypotheses grounded in such scientific fields as biology, behavioural sciences, physics, and ergonomics to explain health-related behaviours, states, and events.

However, epidemiology is not just a research activity but an integral component of public health, providing the foundation for directing practical and appropriate public health action based on this science and causal reasoning. Epidemiologists categorise the discipline into two broad types, Descriptive epidemiology and Analytic epidemiology, whereas descriptive epidemiology focuses on examining the distribution of disease in a population and observing the basic features of its distribution, and on other side analytic epidemiology focus on investigating a hypothesis about the cause of disease by studying how exposures relate to disease.

Significance Epidemiology

The current medical approach must scrutinise the application of clinical epidemiology in health establishments and patients; in general, epidemiologic research with its analytical designs and clinical trials allows the progress in treatments and management, as well as defining the quality of auxiliary exams ever more sophisticated through the test of tests design and its cost-benefit approach. On the other hand, field epidemiology is applied through descriptive studies of the population’s health situation with their analytical approaches to the Situational Health Analysis (SHA), the study of epidemic outbreaks and evaluation of the respective answer of the community interventions. This way, it allows carrying out integral management of the epidemiology, both communal and individual, which will finally result in preventive medicine and public health.

2.2 Nature and History of Diseases

In the early phase of civilization both for humans, the origin of diseases and illness, the influence of Demonic theory was marked. During that period, Religion, philosophy and medicine were an integral part of the early part of civilization. Religion recognized the multiplicity of Gods, both good and evil. Philosophy accepted the influence of inanimate bodies such as the sun, moon and stars on living bodies. Thus a correlation between these health and disease was established in primitive ages. One concept prevalent was that the evil spirit entered the body directly and pursued nefarious actions. Another concept was the evil spirit as a messenger of God giving warnings in the form of diseases. Some other concept was a human enemy with supernatural powers, sending evil spirits to harm others. The souls of dead ancestors influencing his family members were another belief. Demonic possession is held by many belief systems to be the control of an individual by a malevolent supernatural being. Expressions include erased memories or personalities, convulsions, "fits" and fainting as if one were dying, access to hidden knowledge and foreign languages, drastic changes in vocal intonation and facial structure, the sudden appearance of injuries (scratches, bite marks) or lesions, and superhuman strength. Many cuneiform tablets contain prayers to certain gods asking for protection from demons, while others asked the gods to expel the demons that invaded their bodies.

The demonic theory, followed by the period has marked the reference existence of the punitive theory. Its origin in religion with the belief that one's attitude toward the deity is responsible for the cause of sickness. From a period centuries before the Christian era down to the present time, there have been beliefs that disease was a punishment meted out by an outraged God for the sins of the individual or the race. There are recorded statements in biblical writings where punishment is meted out for a sin of David, with a devastating plague in which the whole nation suffered and which was stayed only by David's repentance and the making of a sacrifice. Such references are abundantly available in Hindu mythology also especially those related to eruptive fevers such as Smallpox, Chicken Pox etc.

After this, the most celebrated theoretical explanation was the Humoral theory. As the Greeks rejected supernatural theories and looked up to disease as a natural process. With the contributions of the ancient Greek Hippocrates, they advocated that matter is made up of four elements- Earth, Air, Fire and Water and these elements have the corresponding qualities of being Cold, Dry, Hot and Moist. With this concept, they hypothesized that these qualities are represented in the body by four humors- Phlem, yellow bile, black bile and blood. According to this theory, the equilibrium among these humours characterizes health (eucrasia), and disequilibrium (dyscrasia) characterizes the disease. I.e. These humours (blood, bile, black bile and phlegm) were each produced within the body, and their proper balance constituted health. If there was too much or too little of one or more of them, disease ensued, and the doctor's task was to restore the balance that was best for the individual patient. This model was challenged by two doctors, Paracelsus (c.1494-1541) and JB van Helmont (1579-1644), who conceived disease as an external 'thing' which could attack any organ of the body. By separating the patient and the disease, they offered a new way of thinking about illness. But although each man had his followers, their ideas did not convince many doctors to abandon Hippocratic humoral principles. These observations remained poorly defined, but they opened the way for the disaggregation of persons and diseases. Hippocrates moved medicine from magic and metaphysics to give it a scientific basis. He introduced logic into medical thinking, elaborated the theory of humours and recognized the importance of the environment in health. He also suggested that an excess of one of the humours would result in various idiosyncrasies - hematic, phlegmatic, choleric and melancholic. The theory of humours was known in India, China, Egypt and Greece and has dominated Western medicine for two millennia.

Following this period, a new way of classifying disease (disease classification is called nosology), was also elaborated by a doctor with no knowledge of 'germs'. Thomas Sydenham (1624-89) is sometimes called the 'English Hippocrates' because he provided careful descriptions of specific diseases. In a famous passage, he argued that the symptoms of the disease are the same in Socrates and a simpleton and that diseases could be classified just like botanists classify plants, which also differ individually. Sydenham did not follow up on this idea in any detail, but it offered a starting point for later doctors worrying about the names they gave to medical diagnoses.

During the age of enlightenment and the industrial revolution, several individuals began to investigate and their contributions eventually paved the path for the germ theory would eventually help to explain and control those that could often become epidemics, racing through a community or whole country. Plague, smallpox, typhus, scarlet fever and measles were among the curses that affected the devastated populations. Explaining them was a way to try to prevent their arising and spreading.

During that period, two main theories were prevalent, that is

1. **Miasma**– The miasmatic theory is based on the inference that the air arising from certain kinds of ground, especially low, swampy areas, was a cause of disease. Certain places were thus given a very evil reputation because the ground was said to exude some invisible, insensible vapour,

called miasm, which produced the disease.The invention of miasma was really beginning to be scientific medicine. People were searching for material and natural causes, instead finding shelter in god or the devil. Rational thinking that something can come out of nothing was the basis of this concept. The fact that malaria was prevalent in the vicinity of swampy land, and some evidence that people who ventured out in these swampy places were more likely to get the disease, lent plausibility to this theory. It was the belief in the air as the causative agent that gave malaria its name, mal aria ('bad air' in Medieval Italian). Hahnemann was fascinated with this concept and further studied the cause of chronic diseases. He observed suppression of diseases with heroic treatment available at that time was a major basis for many chronic diseases. He brought out a new concept that suppression of itch to a miasm called Psora and venereal diseases to Sycosis and Syphilitic miasms.

2. **Contagion** – Some Hippocratic writings recognized that consumption (tuberculosis) is contagious. However, contagion played little role in medical explanations of disease until the work of Fracastoro who published his major treatise on contagion. Girolamo Fracastoro (1478-1553), an Italian physician, contended that there is a large class of diseases caused by contagion rather than humoral imbalances. This was based on the observation that persons could contract infections even if their humors are normally balanced. Fracastoro defined a contagion as a "corruption which develops in the substance of a combination, passes from one thing to another, and is originally caused by infection of the imperceptible particles”. He called the particles the seminaria (seeds or seedlets) of contagion. Fracastoro was unable to say much about the nature of these suspected particles; bacteria were not observed by van Leeuwenhoek until 1683, and their role in infection was not appreciated until the 1860s.Fracastoro nevertheless discussed the causes and treatment of various contagious diseases. He described how contagion can occur by direct contact, by indirect contact via clothes and other substances, and by long-distance transmission. In addition, he stated that diseases can arise within an individual spontaneously. His book has chapters for the arrangement of contagious diseases. His theory remained influential for nearly three centuries, before being superseded by a fully developed germ theory. But the Contagion theory was developed by French scholar Gustave Le Bon (1841–1931) in his influential 1895 book, The Crowd: A Study of the Popular Mind.

Fig. 2(1)
The drawings from the bubonic plague (Black Death) spread in the Europe

The most feared 19th Century epidemic disease, cholera, could be fitted into either the miasma or contagion camp, but John Snow (1813-58), who is credited as the father of epidemiology, who had done a systematic investigations of the 1848 and 1854 London cholera epidemics, showed that cholera was spread through contaminated water, not through the air as miasmatists had it. He did house-to-house surveillance in the neighbourhood of a contaminated public well in Broad (now Broadwick) Street, Soho, and showed that this single well, into which raw sewage seeped, was the source of hundreds of cases.

A wider epidemiological survey looked at the incidence of cholera in the customers of two London water companies. It showed conclusively that the customers of the company selling unfiltered Thames water from downstream, after London’s sewers had drained into it, were about 13 times more likely to come down with cholera than the customers of an upstream company which filtered its water. In many instances, customers of the two companies lived in the same streets, in identical housing and breathed the same air. Snow analysed the waters chemically and microscopically, and

although he found nothing specific to incriminate, he showed that cholera was a disease which was spread by faeces-contaminated water, not foul air.

Fig.2 (2)
Illustration called "Death striking down troops with cholera during the Balkan Wars" (1912).
Published in 'Le Petit Journal Illustre' on December 1912

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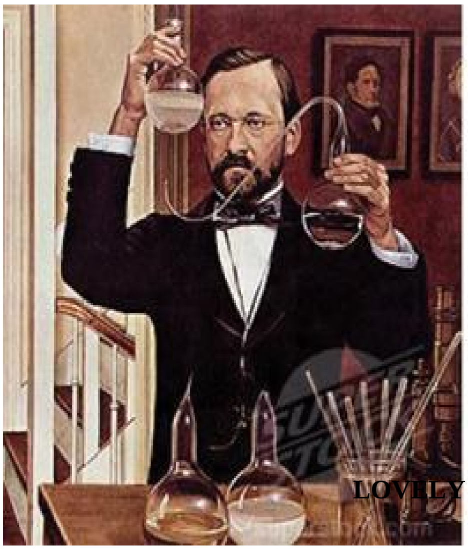
The 19th century witnessed the emergence of various theories with germ theory and the role of microorganisms in the causation of disease but the work of the French chemist and physicist Louis Pasteur (1822-95) was a paradigm shift in the field of epidemiology. As Pasteur came to microorganisms through his chemical work, and in the late 1850s became convinced that yeast and other living organisms could do things that could not be achieved without life. Crucial in his journey was his belief that living organisms could not spontaneously generate from non-living matter. Thus Louis Pasteur with his contribution he is considered the founder of modern immunology because of his studies in the late nineteenth century that popularized the germ theory of disease and introduced the hope that all infectious diseases could be prevented by prophylactic vaccination, as well as also treated by therapeutic vaccination if applied soon enough after infection. However, Pasteur was working at the dawn of the appreciation of the microbial world, at a time when the notion of such a thing as an immune system did not exist.



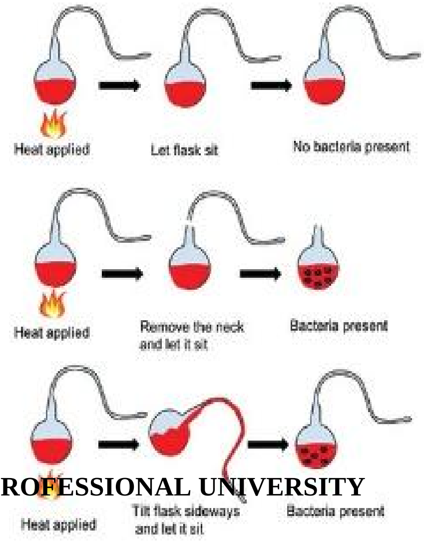


Fig. 2(3)
Louis Pasteur and his contributions

At the same time, a German physician and microbiologist named Heinrich Hermann Robert Koch, popularly known as Robert Koch discovered the tuberculosis bacterium and was awarded the Nobel Prize in Medicine in 1905. As the discoverer of the specific causative agents of deadly infectious diseases including tuberculosis, cholera, and anthrax, he is regarded as one of the main founders of modern bacteriology. The tubercle bacillus is slow-growing, difficult to culture, and causes a chronic disease that is totally unlike acute disorders such as typhus, cholera, smallpox and scarlet fever. Koch followed his research on tuberculosis with the identification, in early 1884, of the comma bacillus, which causes cholera. Neither of Koch's major discoveries achieved instantaneous assent, but by the 1890s, numerous bacteria had been implicated in disease causation: these organisms satisfied what is still called Koch's Postulates. The bacteria were in locations in the body that showed they could be part of the disease; they could be isolated and grown in the laboratory, and they could be injected into experimental animals to produce the disease in question. Showing that specific bacteria could and did cause specific diseases fulfilled the old dream of Paracelsus and Van Helmont, and justified Sydenham's belief that the course of the disease is sufficiently regular that a real classification was possible. It also alerted public health doctors to the fact that individual patterns of spread were the case: cholera through water, typhoid through food, and tuberculosis through air-borne droplets and sputum.

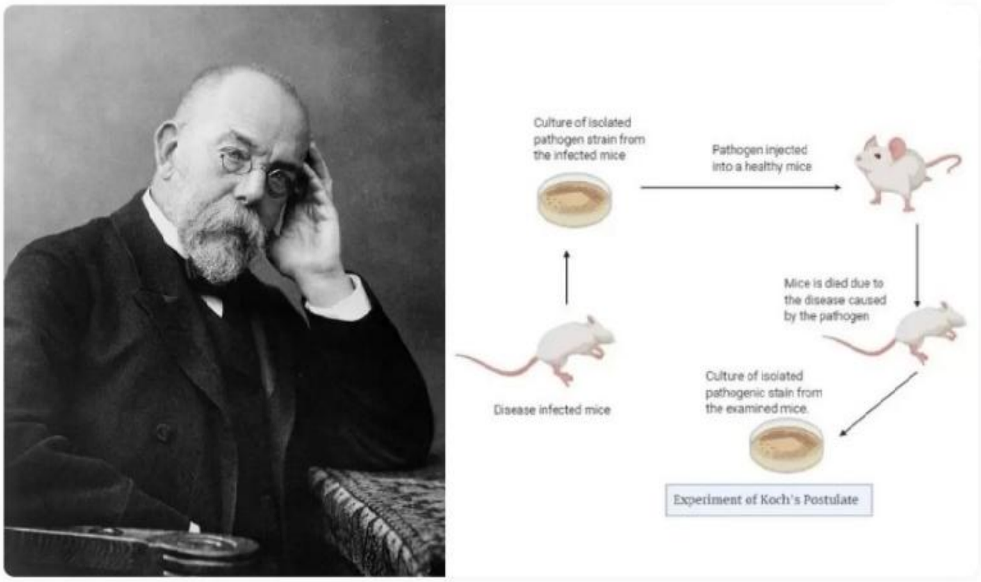
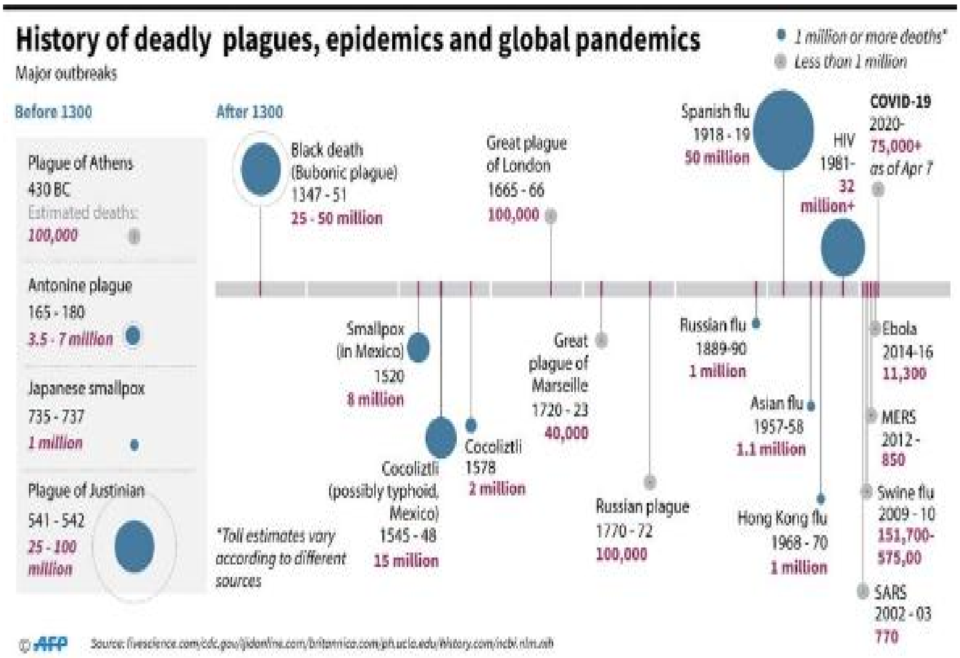


Fig. 2(4)
Robert Koch and Experiment of Koch's Postulates

Thus the introduction and rigorous research in the field of germ theory has opened up the technology and science to offer prevention through control of water and food supplies, isolation when required, and improvement of people's working and living conditions. One of the advancements of the research is by Joseph Lister (1827-1912) who developed the 'antiseptic' surgery, which developed into 'aseptic' surgery, sterilising equipment and trying to keep germs from wounds. The milestones have provided the hope of vaccines (named by Pasteur in honour of Edward Jenner's 'vaccine' for smallpox, so-called because Jenner used the related cowpox virus – 'Vacca' is Latin for cow). In addition to anthrax and rabies, vaccines were developed with varying success for cholera, plague and typhoid. A new understanding of the body's response to bacterial invasion led to therapies or immunisations for tetanus, whooping cough and diphtheria.

The triumph of the science and technology of germ theory by about 1900 turned out to be the beginning, not the end of the battle against diseases caused by living organisms. Rabies is caused by a virus, which is so small that Pasteur's microscope could not see it. New techniques and electron microscopes allowed these minute organisms to be identified, grown, studied and, in many cases, prevented by vaccines. Measles, mumps, yellow fever, influenza and German measles have viral causes and successful vaccines. But viruses like influenza are also capable of rapid change, making the battle between a vaccine and the new variant a constant one. Bacteria, too, have shown themselves to be wily, as natural selection favours those strains best able to withstand antibiotics and other therapies thrown at them.



History of deadly plagues, epidemics and global pandemics

Major outbreaks

Source: livescience.com/cdc.gov/ijidonline.com/britannica.com/ph.ucla.edu/history.com/ncbi.nlm.nih

The twentieth century has witnessed triumphs and failures that must be seen beside other diseases. The influenza virus is highly unstable, with new strains demanding vaccines mostly aimed at the current strain. Some of the strains that affect pigs or domestic fowl pose the greatest threat because they can break the species barrier and threaten human populations. This could cause another global pandemic such as seen in 2020's coronavirus outbreak. In addition, the modern era has seen the issue of emerging infections. The power of 'germs' to inflict suffering and death is nowhere better illustrated than with the identification, in the USA in the early 1980s, of what was first called GRID (gay-related immune deficiency) and then AIDS (Acquired Immunodeficiency Syndrome). The biggest challenges encountered by epidemiologists in our time are with the wide spread of the pandemic such as COVID-19, and its variants like Omicron and Delta variants along with the existing chaos of the diseases and bacterial spreads.

2.3 Epidemiological institutes in India

1. All India Institute of Hygiene & Public Health, Kolkata

It is a premier Public Health institute dedicated to teaching, training and research in various disciplines of Public Health. Since its inception in 1932, the institute has been serving the nation through its academic and research activities in collaboration with several national and international organizations. In 1932, The Department of Epidemiology was established along with the formation of the Institute. The Department is the First Institute/College to have a separate Epidemiology Department in India. This department has played a key role in contributing to the development of the discipline of epidemiology and community health in a broader sense.

The contribution of the Institute in Public Health Research has been highly impressive. A few outstanding contributions are given below-

- Epidemic Dropsy – The adulteration of mustard oil with Argemone mexicana seeds was established to be the cause of Epidemic Dropsy.
- Cholera – El Tor serving as a carrier organism in the human gut to assume a pathogenic role under suitable conditions was first postulated in the Institute.
- Typhus – Investigation among troops stationed in Simla, Barrackpore and Palta demonstrated the role of T. deliensis as the vector.
- Plague – The antigenic structure of Y. pestis cultured in a case in a hydrolysate medium paved the way to the development of a vaccine and anti-sera against plague.
- Black Water Fever – Investigations of Black Water Fever established its links with Malaria.
- Protein Hydrolysate – During the famine in 1943 in Bengal, a hydrolysate of protein using pork and papain was prepared. It was fortified with glucose and vitamins to save many lives.
- Health and Morbidity Surveys – The Institute developed and standardised methodology of integrated health, morbidity, environmental and socio-economic conditions of a community to assess the health status and measure changes over time.

2. The Indian Council of Medical Research (ICMR)

The Medical Council of India (MCI) is a statutory body for establishing uniform and high standards, where The Indian Council of Medical Research (ICMR) remains the apex body in India for the formulation, coordination and promotion of biomedical research. This is one of the oldest and largest medical research bodies in the world. In 1911, the Government of India set up the Indian Research Fund Association (IRFA) with the specific objective of sponsoring and coordinating medical research in the country. After independence, it was re-established as the Indian Council of Medical Research (ICMR) in 1949, with a considerably expanded scope of functions. The ICMR is funded by the Government of India through the Ministry of Health and Family Welfare. The Governing Body of the Council is presided over by the Union Health Minister. The Council's research priorities coincide with National health priorities such as control and management of communicable diseases, fertility control, maternal and child health, control of nutritional disorders, developing alternative strategies for health care delivery, containment within safety limits of environmental and occupational health problems; research on major non-communicable diseases like cancer, cardiovascular diseases, blindness, diabetes and other metabolic and haematological disorders; mental health research and drug research (including traditional remedies). Research is carried out currently through the Council's 32 Permanent Research Institutes/Centres which are mission-oriented national institutes located in different parts of India.

2.4 Ecology of Diseases

Infectious diseases have long been known to cause devastating illnesses in humans, crops, and livestock, but until recently pathogens (a bacterium, virus, or other microorganisms that can cause disease) were assumed to have little impact on wild plant and animal populations, except in rare and sometimes spectacular die-off events. During the past two decades, it has become increasingly apparent that parasitic organisms are not only a common and integral part of ecosystems, but they also influence the abundance of wild populations, can cause extinctions of their hosts, and serve as drivers of evolution (Hudson et al. 2002).

Ecological epidemiology is the study of the ecology of infectious diseases. It includes population and community-level studies of the interactions between hosts and their pathogens and parasites and covers diseases of both humans and wildlife. The field of disease ecology, defined as the ecological study of host-pathogen interactions within the context of their environment and evolution, has grown out of this awareness of the pervasive role of pathogens in ecosystems. Disease ecology is a rapidly developing sub-discipline of ecology concerned with how species interactions and abiotic components of the environment affect patterns and processes of disease. To date, disease ecology has focused largely on infectious diseases. At the foundation of the disease, ecology is an effort to understand pathogen transmission and its spread over space and time and its impacts on host populations. These goals differ from those of related fields such as parasitology, which focuses on parasite taxonomy and life cycles, and epidemiology, which aims to identify risk factors for infectious and non-infectious diseases. While not all parasitic infections cause disease, those that do cause disease can have severe effects – sometimes resulting in mass mortalities of particular hosts over wide areas. Disease outbreaks may be episodic, or sustained over long periods. Thus, the disease is often not a fixed outcome from infections but results from the interaction of parasite, host, and local environmental conditions, where particular changes can trigger strong detrimental effects on the host.

Disease ecology strives to understand the mechanisms and scale of pathogen impacts on host individuals, populations, communities and ultimately ecosystem function. The study of infectious diseases is highly interdisciplinary, drawing on genetics, molecular biology, immunology, epidemiology and ecological modelling.

2.5 Social Etiology

The term "etiology" means the science of causes; from a scientific perspective, all diseases must have been caused. A cause is something that produces an effect; in epidemiology, it is customary to distinguish necessary cause, sufficient cause, proximal cause, and distal cause. A necessary cause is one without which a condition cannot occur. Sufficient cause is defined as a set of minimal conditions and events that inevitably produce health, disease, and injury. A proximal cause is an immediate precipitating factor; a distal cause is more remote. These concepts are embedded within epidemiology, the discipline that studies the distribution and determinants of health-related states or events in specified populations, including diseases, causes of death, behaviours, responses to intervention/non-intervention, and the provision and use of health services.

It is now recognized that virtually all diseases have multifactorial causation; in other words, varying combinations of causes are required to produce the effect. This gives rise to a composite framework of health and illness: tissues and organs operating at a biological level, perception and experience at the psychological level, and attribution of meaning at a social level; integrating these elements is critical to understanding the clinical picture. While it was once argued that some IDs, genetic disorders, and traumatic injuries could be considered unifactorial, this was only ever true to the extent that the necessary cause was a defined microbiological agent, a defective gene, or a singular event such as an explosion. In causation as now understood, numerous factors play roles, and some may hold potential for prevention. In 21st-century medicine, illness is viewed as a continuum that may flow in either direction, including reversibility in many conditions.

According to (Aneshensel, 2005), the social etiology model is concerned with the occurrence of one particular disorder and the identification of social risk factors associated with its occurrence. It is etiological given that its motivation is to locate the causes or origins of the disorder. The primary goals of this type of inquiry about the prevention and treatment of the disorder under investigation. This model is employed in not only sociology but also public health, but it derives from medicine insofar as it is concerned with etiology. Although sociological investigators have begun to examine multiple or alternative mental health outcomes (e.g., Simon 2002), the disorder-specific etiologic model continues to predominate in sociological research published, for example, in the Journal of Health and Social Behaviour. The defining characteristic of this model is its focus on a single disorder, such as major depression. Persons with the disorder are treated as being positive on the outcome under investigation, that is, depressed. Other persons are treated as negative on the outcome, that is, not depressed. In very simplistic terms, people who have the disorder are compared to those who do not, that is, depressed versus not depressed. This classification strategy is internally consistent with the etiologic goals of this type of study. In other words, the intent of the research is to identify the causes of a particular disorder and the measurement method match one another.

Within this disorder-specific model, people with different disorders are implicitly classified as "well" because they do not have one particular disorder singled out for investigation. For example, a study of major depression will by default consider a non-depressed person who has a substance abuse disorder to be "well" (i.e., negative on the outcome) because the person does not have major depression. Indeed, the presence of other disorders may not be assessed, despite evidence that comorbidity for psychiatric disorders is extensive (Kessler et al. 1994). Again, this measurement strategy is consistent to identify the causes of the one disorder singled out for investigation, major depression in our running example. The disorder-specific etiological model is extremely powerful. It is used in most medical and epidemiological research. This model has generated a good deal of what we know about what makes people sick, including most of what we know about the social factors that make people sick. It is a good model when used in the service of the etiologic goals of epidemiological and medical research.

2.6 Social Epidemiology

Epidemiology defines as "the study of the distribution and determinants of states of health in populations", whereas social epidemiology is "that branch of epidemiology concerned with the way that social structures, institutions, and relationships influence health. This research includes "both specific features of and pathways by which, societal conditions affect health". The basic theme of social epidemiology, that social conditions affect population health, is not new; several investigations based on the idea were conducted in the 19th century. As a branch of epidemiological study, however, social epidemiology is relatively new. Over the last few decades, the discipline of social epidemiology has developed by refocusing on its traditional perspective with contemporary epidemiological methods to understand disease etiology that includes social experiences as direct causes of diseases.

Defining Social Epidemiology

In “Social Epidemiology,” Berkman and Kawachi defined social epidemiology as “the branch of epidemiology that studies the social distribution and social determinants of states of health.” Social epidemiology focuses particularly on the effects of socio-structural factors on states of health. The major premise of social epidemiology is that each society forms its distribution of health and disease. In other words, social epidemiology assumes that the distribution of health and disease in a society reflects the distribution of advantages and disadvantages in that society. Based on this premise, social epidemiology examines which socio-structural factors affect the distribution of health and disease, as well as how these factors influence individual and population health. Social epidemiology proposes to identify societal characteristics that affect the pattern of disease and health distribution in society and to understand its mechanisms. Although social epidemiology has developed recently, the idea that social conditions affect health already existed at the beginning of the 19 century.

History of social epidemiology

At the beginning of the 19th century, several investigations were conducted based on the idea that social conditions affect health. In France, Villerme examined differences in mortality between the poor and the affluent. He emphasized that improved schooling and working conditions would reduce disparities in mortality between the poor and the affluent. In Germany, Virchow reported the relationship between poor social conditions and the typhus epidemic in Upper Silesia. He speculated that unequal access to society’s products was the fundamental cause of the unequal distribution of diseases in society. He highlighted the central role of social conditions in population health. In the middle of the 19th century, Chadwick reported that unsanitary soil, air, and water were major causes of diseases and promoted sanitation measures to improve the health of the poor. Studies in the beginning and middle of the 19th century were conducted with the assumption that societal conditions affect physical health. At the end of the 19th century, germ theory came into fashion; germs were considered the major cause of diseases. Epidemiological studies during this period concentrated on identifying new germs that cause diseases. Consequently, the idea that social conditions affect health was overshadowed. In the early 20th century, the idea flourished that it was exposure to a single individual risk factor, including germs, which led to disease; however, with the rise of infectious diseases, the idea that disease is caused by exposure to multiple individual risk factors, the so-called “web of causation,” entered the main-stream of epidemiological theories. Modern epidemiology has developed based on this multi-factorial model. The original concept of social epidemiology was concealed within the prosperity of modern epidemiology.

By the 1980s, however, several epidemiologists developed social epidemiology, underscoring the importance of socio-structural factors on health as well as from a population perspective. In a backlash against the strong individualism of modern epidemiology, social epidemiologists argued for the need to return to the traditional epidemiological theme: how do social conditions produce patterns of health and disease? The central question of social epidemiology—what are the effects of social factors such as social structure, culture, and environment on both individual and population health—has existed since the beginning of epidemiological history. However, the new focus on this theme using current epidemiological methods is a relatively recent phenomenon.

Over the past 30 years, the term social epidemiology has been increasingly used to refer to a sub-field within epidemiology that focuses on understanding how social organization shapes the distribution of health and disease. The social organization encompasses a range of structures and systems, including social and economic relationships, rules and policies, and norms. It includes a broad set of factors such as social structure and levels of inequality, the economy and distribution of resources and organization of work, social hierarchies and relations between racial and ethnic groups, as well as cultural factors and social norms. In contrast with other areas within epidemiology that are defined by the health outcome, social epidemiology is defined by its focus on the broad set of social conditions that affect many health-related outcomes.

Although one could argue that all epidemiology necessitates consideration of the social world, in a context where epidemiologic research has been heavily influenced by a biomedical and individualistic approach, the naming of "social epidemiology" allowed explicit emphasis on the social production of disease as a powerful explanatory paradigm and as critical to identify the policies needed to improve population health. The complexity of the social and biological worlds and how they interact to affect health has made this line of inquiry particularly challenging but has also made it fertile ground for critical thinking and innovation in epidemiology and population health research more generally.

The significance of social Epidemiology

The study of social conditions and how theseinfluence and determine the health situation of populations has always been a subject of interest and importance for public health in general. In recent years, a stronger tie between epidemiology and the social sciences has been forged, as it is promoted by the need to recognize and document the wide spectrum of health determinants, from a micro level where individual biological factors operate, to a macro level that expresses social conditions in which populations live. This endeavor has given birth to so-called "social epidemiology."

The principal concern of social epidemiology is the study of how society and different forms of a social organization influence the health and well-being of individuals and populations. In particular, it studies the frequency, distribution, and social determinants of the states of health in a population. Thus, social epidemiology goes beyond the analysis of individual risk factors to include the study of the social context in which the health-disease phenomenon occurs.

In order to explain the path between exposure to social characteristics of the environment and its effects on public health, social epidemiology enriches the traditional epidemiological approach with concepts and techniques from social disciplines such as economics, sociology and demography, as well as biology. This fusion of techniques from different fields creates a methodological challenge. Examples of development in this field include the growing use of methods of multi-level analysis in ecological design, control of the ecological fallacy and the use of new applications of already-known tools and techniques.

A constant and current concern in the global sanitary landscape is the presence of inequalities - particularly social inequalities - in health. Social epidemiology makes it possible to incorporate the social experience of populations in the traditional etiological approach to public health and, as a result, permits a better understanding of how, where and why inequalities affect health. In this regard, social epidemiology can contribute significantly to the health management process and the reduction of inequities in health.

Summary

Epidemiology is a discipline that has a crucial role in describing health status, identifying risk factors, and analyzing relationships between health and different hazardous agents, i.e. when there is a disease occurs in a population, epidemiologists help us to understand where the disease is coming from, and who it is most likely to impact. They gather information and used it to control the spread of the disease and prevent future outbreaks. As Epidemiologists rely on other scientific disciplines like biology to better understand disease processes, and statistics to make efficient use of the data and draw appropriate conclusions, But with the introduction of the new branch of epidemiology called Social Epidemiology, it paved the way for social scientists and health professionals to understand with the help of social sciences to explore the proximate and distal causes and engineering for exposure assessment. Along with understanding the epidemiology and social epidemiology in detail the chapter also gives glimpses to understanding the historical sketch of the history of diseases, the field of disease ecology and Social Etiology as a model to know the origin of disease outbreaks.

Keywords

- Epidemiology - Epidemiology is the method used to find the causes of health outcomes and diseases in populations.
- Epidemic- The rapid spread of disease to a large number of patients among a given population within an area in a short period of time.
- Pandemic- an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people".
- Pathogen- In biology, a pathogen in the oldest and broadest sense is any organism or agent that can produce disease. A pathogen may also be referred to as an infectious agent, or simply a germ. The term pathogen came into use in the 1880s.
- Black Death- the Black Death was a bubonic plague pandemic occurring in Western Eurasia and North Africa from 1346 to 1353. It is the most fatal pandemic recorded in human history, causing the deaths of 75–200 million people, peaking in Europe from 1347 to 1351.
- Mortality- refers to the state of being mortal (destined to die).
- Morbidity- Morbidity is defined as a "morbid state or quality, i.e. refers to having a disease or a symptom of disease, or to the amount of disease within a population.
- Ecology- Ecology is the study of organisms and how they interact with the environment around them. An ecologist studies the relationship between living things and their habitats.
- Ecology of disease - The field of disease ecology, defined as the ecological study of host-pathogen interactions within the context of their environment and evolution, has grown out of this awareness of the pervasive role of pathogens in ecosystems.
- Etiology- (Pronounced as aetiology) which a branch of knowledge concerned with causes specifically the origins of diseases.
- Social epidemiology - a branch of epidemiology that focuses particularly on the effects of social-structural factors on states of health. Social epidemiology assumes that the distribution of advantages and disadvantages in a society reflects the distribution of health and disease.

Self Assessment

1. Epidemiologists are interested in learning about……………..

A. the causes of diseases and how to cure or control them
B. the frequency and geographic distribution of diseases
C. the causal relationships between diseases
D. all of the above

2. Which of the following statement is correct concerning epidemic diseases

A. They are usually not very contagious.

B. At the end of an epidemic, a disease spreads at an increasing rate and then abruptlydisappears.

C. They usually appear and disappear seasonally.

D. Persistent undernourishment among children rarely results in serious healthProblems.

3. …………focus on investigating a hypothesis about the cause of disease by studying how exposures relate to disease.

A. Epidemiology

B. Social epidemiology

C. Analytic epidemiology

D. Descriptive epidemiology

4. In an epidemiological context, what is the population at risk?

A. The proportion of a population that engage in risky behaviours.

B. The group of people that may experience the outcome we want to study.

C. A group of people participating in a study that may be harmful to them.

D. The population group with the highest relative risk of disease.

5. Who is known as father of Epidemiology?

A. Louis Pasteur

B. John Snow

C. Robert Koch

D. Girolamo Fracastoro

6. The expansion of ICMR is ………………….

A. Indian Council of Malaria Research

B. Indian Council of Medical Research

C. Indian Council of Molecular Research

D. Indian Council of Maternity Research

7. According to ………………believed that the evil spirit as a messenger of God giving warnings in the form of diseases.

A. Humoral theory

B. Germ theory

C. miasmatic theory

D. Demonic theory

8. …………….. Contributed that the equilibrium among these humours characterizes health, and disequilibrium characterizes the disease.

A. Hippocrates

B. Aryabhata

C. Socrates

D. Aristotle

9. The invention of ………………was really beginning to be scientific medicine.
A. Germs
B. Miasma
C. Bacteria
D. Cholera

10. ………… is considered the founder of modern immunology
A. Hahnemann
B. Girolamo Fracastoro
C. Louis Pasteur
D. John Snow

11. If any disease could be spread by touch, whether of infected cloth or food or people, and recommended quarantine as the best defense is Known as ……………
A. Infection
B. Germs
C. Contagion
D. Bacteria

12. ………………..developed the 'antiseptic' surgery, which developed into 'aseptic' surgery, sterilising equipment and trying to keep germs from wounds.
A. Edward Jenner
B. Joseph Lister
C. Van Helmont
D. Robert Koch

13. ………………concerned with how species interactions and abiotic components of the environment affect patterns and processes of disease.
A. Disease ecology
B. Immunology
C. Social Epidemiology
D. Public Health

14. Contagion theory was developed by …………………
A. Ernst Haeckel
B. Rosalind Franklin
C. Charles Darwin
D. Gustave Le Bon

15. ………..branch of epidemiology concerned with the way that social structures, institutions, and relationships influence health.
A. Social epidemiology
B. Social Etiology

C. Public Health

D. Community health

Answers for Self Assessment

1.	D	2.	C	3.	C	4.	A	5.	B
6.	B	7.	D	8.	A	9.	B	10.	C
11.	C	12.	B	13.	A	14.	D	15.	A

Review Questions

1 Define the etymology of Epidemiology?
2 What is Social epidemiology?
3 Define Social ecology?
4 Outline the historical sketch of epidemiology
5 What is Disease ecology?

Further Readings

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Unit 03: Health as Discourse

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Objectives

After completing this Unit, you shall be able to:

- To know the definition of discourse.
- To understand what is discourse in Social Sciences.
- To understand what is Health as discourse.
- To understand health as a discourse in Foucault's term.

Introduction

Over the past several decades there has been considerable interest among discourse analysts in various aspects of health communication, including physician- patient interaction, the discourse of health promotion texts, the construction of health and risk in the media,and the discursive negotiation of health and risk in everyday life (Candlin and Candlin 2003, Gwyn 2002, Jones 2013). Discourse analytical approaches to health and risk communication have been heavily influenced by work in disciplines such as medical anthropology, with its concern with understanding how people's explanatory models of illness and danger can vary across cultures, are embedded in social structures, and cultural studies, with its preoccupation with the ideological and disciplinary nature of biomedical discourse (Foucault 1976). What distinguishes a discourse analytical perspective from other approaches to health and risk is its focus on 'language in use, that is, on the way people use discourse as a tool to take concrete social actions. This focus is especially suited to the domains of health and risk, whose most pressing problems hinge on this relationship between discourse and action: Much of what clinicians do, for example, depends on successfully transforming interactions with patients into various kinds of texts (such as medical records and diagnoses), and then using these texts (along with their patients) to take further actions (such as treatments). Similarly, the central task of health promoters is to make sense of the actions that people take with various health issues and to determine what kinds of discursive interventions are most likely to result in changing or maintaining those actions (Jones 2013). Discourse analysis, with its rich collection of analytical tools, provides the resources to help scholars and healthcare practitioners understand not just how people make meanings around health and risk, but also 'how people "do" health through daily embodied and discursive practice' (Paugh and Izquierdo, 2009, p. 188). Health educators and medical practitioners have traditionally viewed the relationship between discourse and action in a rather straightforward way, assuming that discourse leads (or should lead) rather directly and unproblematically to some kind of the desired action, and that the 'better' the discourse (in the form of information) the better the health outcomes.

3.1 What is Discourse?

Discourse is a generalization of the notion of a conversation to any form of communication. Discourse is a major topic in social theory, with work spanning fields such as sociology, anthropology, continental philosophy, and discourse analysis. Discourse in context may consist of only one or two words as in "stop" or "no smoking". Alternatively, a piece of discourse can be hundreds of thousands of words in length, as some novels are. Following pioneering work by Michel Foucault, these fields view discourse as a system of thought, knowledge, or communication that constructs our experience of the world. Since control of discourse amounts to control of how the world is perceived, social theory often studies discourse as a window into power. Within theoretical linguistics, discourse is understood more narrowly as linguistic information exchange and was one of the major motivations for the framework of dynamic semantics, in which expressions' denotations are equated with their ability to update a discourse context. It is a typical piece of discourse is somewhere between these two extremes," (Hinkel and Fotos 2001). "Discourse is how language is used socially to convey broad historical meanings. It is language identified by the social conditions of its use, by who is using it and under what conditions. Language can never be 'neutral' because it bridges our personal and social worlds," (Henry and Tator 2002).

3.2 Discourse in Social Science

Discourse refers to how knowledge, subjects, behaviour, and events are depicted and defined in statements, assumptions, concepts, themes, and shared ideas. The simplest way to think of the concept of discourse is that it provides a framework through which we see the world. Jane Ogden advocates that "Within social science, discourse is mainly used to describe verbal reports of individuals. A particular discourse is analyzed by those who are interested in language and talk and what people are doing with their speech. This approach [studies] the language used to describe aspects of the world and has tended to be taken by those using a sociological perspective," (Ogden 2002). Sociologists and philosophers tend to use the term discourse to describe the conversations and the meaning behind them by a group of people who hold certain ideas in common. Such are the definitions by philosopher Michel Foucault, who holds it to be the acceptable statements made by a certain type of discourse community. This explanation will primarily consider the definition of sociology. Perhaps because of the interdisciplinary nature of discourse theory, most of its main practitioners came from outside sociology itself. Key works include Barthes' Mythologies (1957), Baudrillard's Symbolic Exchange and Death (1993) and Said's Orientalism: Western Conceptions of the Orient (1978). However, the discursive approach to analysing the social is primarily associated with Michel Foucault's work, which he first outlined in The Archaeology of Knowledge (1972). His premise was that systems of thought and knowledge (epistemes or discursive formations in his terminology) were governed by rules that operated beneath the consciousness of individual subjects that determines the boundaries of thought in a given sphere and period. In his view, a discourse gave credibility to certain ideas and denied credibility to others, thus establishing what could be known and thought about a subject.

Thus, the discourse is a joint activity requiring active participation from two or more people, and as such is dependent on the lives and knowledge of two or more people as well as the situation of the communication itself. Herbert Clark applied the concept of common ground to his discourse studies as a way of accounting for the various agreements that take place in successful communication.

3.3 The Public Health Discourse

Public health promotes the welfare of the entire population and also ensures its security and protects it from the spread of infectious disease and environmental hazards, and helps to ensure access to safe and quality care to benefit the population. The fundamental quality of Public Health is its preventative nature and prevention is far more effective and far less expensive than cure. The public health discourse entails an extended dialogue on the health of the population and communities. However, in recent times, the dominant discourse in the field has been shaped by vested interests that have been powerful and have controlled the resources and institutions. The Institute of Medicine (1988) in their report 'The Future of Public Health has defined public health as 'what society does collectively to assure the conditions for people to be healthy. The definition emphasises the role of society and people in shaping the health of the population. Thus, it is important that the public should be brought back into the public health discourse with a focus on their socio-cultural and political context. It will help common people and social groups to articulate their interests, and their legal rights, to meet their obligations and to mediate their differences and ensure that each individual or community irrespective of their ethnicity, gender, class status, existing or emerging, receives the universal health care services as per their actual needs through a process of good governance at an affordable cost.

The history of public health can be traced back to the evolution of human society. Since its origin, human civilizations have been challenged by illness and the outbreak of infectious diseases and other health emergencies that have spread and caused death at unique levels. Different societies and civilizations responded to it differently based on their experiences, knowledge and learning. The Indus Valley Civilization's drainage and sanitation system is one such example of an ancient public health system in India. The ancient practices of healthy living and wellness such as Ayurveda and Yoga are practiced since 1000 BC in India. Quarantine, the practice of separating people with illness from the healthy population is an ancient practice which can be found in Biblical and Quranic references. Isolation of lepers from the healthy population is one such example (World Health Report 2007). These ancient practices may be considered the real beginning of "socialized medicine" or "social medicine" emphasizing "the organized community efforts" and "the development of social machinery" where the people were at the centre of affairs in taking care of individual and community health. This approach emphasizes the role of the society including the people, the state, the community and the governance structure (Ahmed FU-2011). One may assume that in ancient societies, the public health approach was guided by the notions of the common good, human existence, survival, and social capital. In short, they tried, to put the people at the centre of public health concerns. These notions were guided by the strong belief that for ensuring the common good and by extension public health, people's participation, social capital, trust, and indigenous local knowledge are indispensable. This commons approach guided by collective ownership and participation was the only way to ensure good health. It was also believed that the common good approach will bring people together to think collectively for their survival and well-being including public health. This commoner approach also generated trust in the public health system which was owned, managed, developed, and practiced by the people, and for the people. Although this evolutionary public health approach and practices were not known as public health, the intent and goal were similar to the intent of modern public health.

The evolution of modern public health in India as a discipline can be traced back to 1835 with the establishment of the Calcutta Medical College which was an era of colonization and industrialization. It also marked the advent of the germ theory of disease and several scientific and technological advances. These developments changed the perception and understanding of human beings as a producer or consumers. Human value was redefined in terms of their economic value which was a transgression from the notion of the common good. These developments in the West significantly influenced the understanding and approach towards public health in India, which led to the development of present-day models of public health which are technology-oriented, patented, and controlled by powerful players and stakeholders such as large multinational companies and pharmaceutical companies. Public health became important for production and labour rather than for common good. The centre stage was taken by technology and the market and the people were pushed to the periphery. Little space was left for the people's participation in designing public health programmes and interventions.

Today, the public health debate and direction in India are mostly guided and shaped by the developments in the West, where multi-national companies, pharmaceutical companies and university research departments are key stakeholders and their presence can be felt by the funding in public health research, and designing public health policy and programmes. The shaping of public health policies appears to be an endogenous process but unfortunately, the policymakers in India and other non-western parts of the world too speak the language of the West and make policies which echo the interests of these giant multinationals.

Before the advent of modern public health, the initial knowledge of public health was developed by the indigenous people who were guided by a perspective based on the principle of survival instinct and the common public good (public health). These indigenous and locally developed practices of public health are based on experiences, often time tested over centuries and if these practices are integrated with modern scientific knowledge, it will help in developing technologies which would be more appropriate, suitable, and easily acceptable to the people. We need to understand that without involving the people in the dominant public health discourse, the whole effort of promoting good health and reducing the burden of disease would be a futile exercise. People should be brought back to the centre stage of public health planning, and promotion of good health which is very much possible. Thus, to improve the health of the population, people and communities need to be empowered to utilize their skills, affirm their rights and take up the responsibility to improve their health and public health.

In principle, people have a presence in public health policy making and planning through various committees and institutional representation such as the Village Health and Sanitation Committee (VHSC) to look after community health at the village level, Primary Health Centre (PHC) Monitoring and Planning Committee to monitor the functioning of sub-centre under PHC and developing the PHC health plan, Block Monitoring and Planning Committee, District Health Monitoring and Planning Committee, and State Health Monitoring and Planning Committee, and *Rogi Kalyan Samiti* to manage the health institutions at sub-district, district and state level and many more committees. The NRHM Programme proposes several monitoring and planning committees at different levels to ensure people's participation in public health programming and the delivery of its services. However, in reality, in many places, these institutions are not functional, or they are weak and their roles are limited to approving the finances. They are not real decision-makers, and neither have they had the expertise or the capacity to perform these roles. Although these structures are there to improve people's participation in the planning and delivery of health services, the shreds of evidence show that successfully establishing a VHSC and other committees is a long and formal process. It takes time to gain acceptance and generate community participation and ownership and there are complex local socio-political issues that may need to be addressed.

The Comptroller and Auditor General's Report (2010) mentions that district and block-level community monitoring committees had not been constituted in many of the selected districts and blocks in five states of Assam, Jharkhand, Karnataka, Madhya Pradesh and Maharashtra. The report further mentions that the non-formation of community planning and monitoring committees at various levels adversely affects the monitoring of the programmes by various stakeholders. In other words, it disempowers people to become part of public health planning, delivery of services and ultimately the discourse in shaping their health and well-being. In such a situation, it is important to build the capacities of these people's institutions and make them more functional, effective, and accountable. There are cases where people have brought change through people's participation in public health. The case given below is one such example of public or community participation in the promotion of public health.

3.4 Discourse Analysis

Discourse analysis (DA) is a broad field of study that draws some of its theories and methods of analysis from disciplines such as linguistics, sociology, philosophy and psychology. More importantly, discourse analysis has provided models and methods of engaging issues that originate from disciplines such as education, cultural studies, and communication and so on. Discourse analysis is the study of social life, understood through an analysis of language in its widest sense (including face-to-face talk, non-verbal interaction, images, symbols and documents). It offers ways of investigating meaning, whether in conversation or in culture. Discourse analytic studies encompass a broad range of theories, topics and analytic approaches for explaining language in use. They ask 'What is the social life like?' and 'What are the implications for individuals and/or wider society?'

The term 'discourse analysis' was first used by the sentence linguist, Zellig Harris in his 1952 article entitled 'Discourse Analysis. According to him, discourse analysis is a method for the analysis of connected speech or writing, for continuing descriptive linguistics beyond the limit of a simple sentence at a time (Harris 1952). Meanwhile, a way to simplify the attempt to define discourse analysis is to say that discourse analysis is 'the analysis of discourse. It evolved from works in different disciplines in the1960s and early 1970s, including linguistics, semiotics, anthropology, psychology and sociology. Some of the scholars and the works that either gave birth to or helped in the development of discourse analysis include J.L. Austin whose How to Do Things with Words (1962) and introduced the popular social theory, speech-act theory. Dell Hymes (1964) provided a sociological perspective with the study of speech. John Searle (1969) developed and improved on the work of Austin. The linguistic philosopher, M.A.K. Halliday greatly influenced the linguistic properties of discourses (e.g. Halliday 1961), and in the 1970s he provided a sufficient framework for the consideration of the functional approach to language (e.g. Halliday 1973). H.P. Grice (1975) and Halliday (1978) were also influential in the study of language as social action reflected in the formulation of conversational maxims and the emergence of social semiotics.

Since the 1970s, the term 'discourse' has referred to an extraordinarily diverse field of research concerned with the analysis of language, signs and text. Some have described the 'linguistic turn' as a major development in Western thought (Rorty, 1967), a 'growth industry' among Anglo-American academics (Hook, 2001a, 2001b), and the product of 'marketing' aimed at undergraduate pedagogy (McHoul, 1997). What has become known as 'discourse analysis' reflects a distinct interest in the social, political and psychological characteristics of language used. Given the variety of approaches that now exist, discourse analysis means different things to different tribes within the social sciences. For us, discourse refers to institutionalized patterns of knowledge that govern the formation of subjectivity. This is quite different to other approaches that apply Foucault's ideas as a method of applied linguistic analysis.

3.5 Michel Foucault (1926–1984)

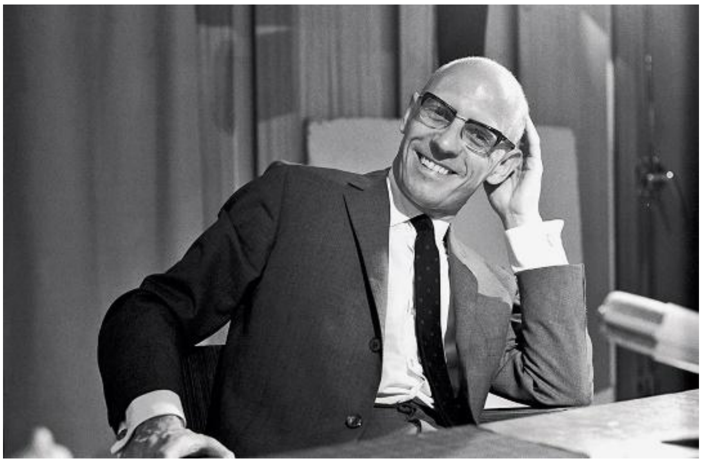

Fig: 3 (1)
Michel Foucault (1926-1984)

Michel Foucault (1926-1984) was one of the most famous thinkers of the late 20th century, achieving celebrity-like status before his untimely death in 1984. He is remembered for his method of using historical research to illuminate changes in discourse over time, and the evolving relationships between discourse, knowledge, institutions, and power. Foucault's work inspired sociologists in subfields including the sociology of knowledge; gender, sexuality and queer theory; critical theory; deviance and crime; and the sociology of education. His academic career culminated in a 1970 appointment as "professor of history of systems of thought" at France's most prestigious university – the College de France. His most well-known works include *Discipline and Punish*, *The History of Sexuality*, and *The Archaeology of Knowledge*. Foucault's key intellectual contribution was his smart ability to illustrate that institutions-like science, medicine, and the penal system--through the use of discourse, create subject categories for people to inhabit, *and* turn people into objects of scrutiny and knowledge. Thus, he argued, those who control institutions and their discourses wield power in society, because they shape the trajectories and outcomes of people's lives.

Foucault also demonstrated in his work that the creation of subject and object categories is premised on hierarchies of power among people, and in turn, hierarchies of knowledge, whereby the knowledge of the powerful is considered legitimate and right, and that of the less powerful is considered invalid and wrong. Importantly, though, he emphasized that power is not held by individuals, but that it courses through society, lives in institutions, and is accessible to those who control institutions and the creation of knowledge. Foucault argued that knowledge and power are intimately bound up. So much so, that that he coined the term "power/knowledge" to point out that one is not separate from the other. Every exercise of power depends on a scaffold of knowledge that supports it. And claims to knowledge advance the interests and power of certain groups while marginalizing others. In practice, this often legitimizes the mistreatment of these others in the name of correcting and helping them.

What has made Foucault so appealing to such a broad range of scholars is that he did not just look at abstract theories of philosophy or of historical changes. Rather, he analysed what was actually said. In his most important works, this included an analysis of texts, images and buildings in order to map how forms of knowledge change. For example, he argued that sexuality was not simply repressed in the 19th century. Rather, it was widely discussed in an expanding new scientific literature where patients were encouraged to talk about sexual experiences in clinical settings. With the recent explosion in surveillance cameras as well the role of "big data" we have now well and truly entered the surveillance society. Foucault's insights on this topic continue to be explored by scholars across the social sciences and humanities.

An important feature of his theory is that where there is power there is also always resistance. So there are always "sites of resistance": spaces that hold out the promise for a reconfiguring of power relations in a way that might redress oppressive institutions and practices. For example, homosexuality has historically been reinterpreted as a "sin", a "medical pathology", and now a legitimate "sexuality", showing how change is possible. But it is only through a deepened understanding of the origin and structure of our present social order that we will be able to grasp and seize future possibilities for social change.

Foucault was particularly concerned with the exercise of power within social systems. He explored the ways in which social control is constructed and maintained. He saw history as a series of changing thought systems that determine social activity and that are constructed to serve the ends of those in power. He developed this theme through his definitive historical studies of human sexuality, crime and punishment, and of medicine. He developed the concept of 'the medical gaze', describing how doctors modify the patient's story, fitting it into a biomedical paradigm, and filtering out non-biomedical material. A 'gaze' is an act of selecting what we consider to be the relevant elements of the total data stream available to our senses. Doctors tend to select the biomedical bits of the patient's problems and ignore the rest because it suits us best that way. And the Foucault's charge is that doctors are doctor-oriented, not patient-oriented, and thus medicine creates an abusive power structure. Medical school has taught us more about biomedicine than about patients. The medical tribe tends to dominate rather than share. We control, stick people into appointment slots, strand them in waiting rooms, QOF them, and talk above their heads.

3.6 Foucauldian Discourse Analysis

Foucauldian discourse analysis is a form of discourse analysis, which emphases on power relationships in society as articulated through language and practices, and is based on the theories of Michel Foucault. Besides focusing on the meaning of a given discourse, the distinguishing characteristic of this approach is its stress on power relationships. These are expressed through language and behaviour, and the relationship between language and power. This form of analysis developed out of Foucault's genealogical work, where power was linked to the formation of discourse within specific historical periods. Some versions of this method stress the genealogical application of discourse analysis to illustrate how discourse is produced to govern social groups. The method analyses how the social world, expressed through language, is affected by various sources of power. As such, this approach is close to social constructivism, as the researcher tries to understand how our society is being shaped (or constructed) by language, which in turn reflects existing power relationships. The analysis attempts to understand how individuals view the world, and studies categorizations, personal and institutional relationships, ideology, and politics. The approach was inspired by the work of both Michel Foucault and Jacques Derrida, and by critical theory. Foucauldian discourse analysis, like much of critical theory, is often used in politically oriented studies. It is preferred by scholars who criticize more traditional forms of discourse analysis as failing to account for the political implications of discourse. Political power is gained by those in power being more knowledgeable and therefore more legitimate in exercising their control over others in both blatant and invisible ways.

The duo Gavin Kendall and Gary Wickham outlines the five steps in using "Foucauldian discourse analysis". The first step is a simple recognition that discourse is a body of statements that are organized regularly and systematically. The subsequent four steps are based on the identification of rules: i.e. as follows

1. Simple recognition that discourse is a body of statements that are organized regularly and systematically
2. how those statements are created;
3. what can be said (written) and what cannot;
4. how spaces in which new statements can be made are created;
5. making practices material and discursive at the same time

3.7 Foucault's Discourse on Health

Today the theoretical work of Michel Foucault is widely considered part of the theoretical body of social sciences such as sociology, social history, political sciences, and social psychology. Discourse, as defined by Foucault, refers to ways of constituting knowledge, together with the social practices, forms of subjectivity, and power relations which inhere in such pieces of knowledge and relations between them. Discourses are more than ways of thinking and producing meaning. They constitute the "nature" of the body, unconscious and conscious mind and emotional life of the subjects they seek to govern. Foucault's focus is on questions of how some discourses have shaped and created meaning systems that have gained the status and currency of "truth," and dominate how we define and organize both ourselves and our social world while other alternative discourses are marginalized and subjugated, yet potentially "offer" sites where hegemonic practices can be contested, challenged, and "resisted".

In Foucault's view, the social context in which certain knowledge's and practices emerged as permissible and desirable or changed. In his view, knowledge is inextricably connected to power. Power has an important role in Foucault's view, and power is a process that operates in continuous struggles and confrontations that change, strengthen, or reverse the polarity of the force relations between power and resistance. This means that power is described as a relational process that is embodied in context-specific situations and is partially identifiable through its ideological effects on the lives of people. Power is productive of truth, rights, and the conceptualization of individuals, through the processes, or discursive practices of the human sciences and other major discourses such as social sciences, bureaucracy, medicine, law, and education. Discourse analysts in this way need to be aware of the conceptualizations of power and resistance to be able to recognize them within a discourse. Emancipatory of the marginalized group is an important goal of recognizing the power in Foucault's approach.

Here Foucault challenges the idea that power is wielded by people or groups by way of 'episodic' or 'sovereign' acts of domination or coercion, seeing it instead as dispersed and pervasive. 'Power is everywhere and 'comes from everywhere so in this sense is neither an agency nor a structure (Foucault 1998: 63). Instead it is a kind of 'meta power' or 'regime of truth that pervades society, and which is in constant flux and negotiation. Foucault uses the term 'power/knowledge to signify that power is constituted through accepted forms of knowledge, scientific understanding and 'truth': 'Truth is a thing of this world: it is produced only by multiple forms of constraint. And it induces regular effects of power. Each society has its regime of truth, its "general politics" of truth: that is, the types of discourse that it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, how each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true (Foucault, in Rabinow 1991).

When Foucault spoke of discourse, he was not necessarily referring to discourse in the sense of talk and interaction between individuals, but to the discourse of a field or set of truths, the works and writings on a given subject, which determine, as well as reflect, the reality we perceive. Of particular relevance to healthcare professionals and students learning the art of medical consultation, however, are his works on the internal procedures and external exclusions from discourse, which determine who has the authority to write or talk about a given subject, in a particular situation. Specifically, we would argue that mindfulness of these procedures and exclusions, and how they shape discourse, is necessary to the optimizing of medical education and practice in the 21st century. Power is a central theme within the work of Foucault. However, unlike other theorists, who posited that power was held by the institution, Foucault suggested that power is a strategy rather than a possession, negotiated through the discourse. To Foucault, power and knowledge were intrinsically linked. Indeed, he coined the compound term 'power/knowledge, writing: '... power can't be exercised without knowledge, it is impossible for knowledge not to engender power (Foucault M.1980). Traditionally, the doctor has adopted a position of power within the consultation: he or she alone possesses the medical knowledge and authority required to diagnose, and the patient can share in the doctor's knowledge of his or her illness only when invited to do so.

However, in recent years, the increased presence of undergraduate medical students in wards and clinics earlier in undergraduate medical education has facilitated a transition from a traditionally dyadic interaction to an often triadic or polyadic interaction among the patient, doctor, students and observers. In these polyadic interactions, the doctor can invite the student to adopt the passive role of observer, the more active role of student, to receive knowledge on a given topic, or to take up the most active role, of a clinician, who is equipped with the power/knowledge required to diagnose. More often than not, the student will switch between these different roles, within the clinical environment, at the invitation of the attending physician. However, this transition also impacts the experience of the patient, who now adopts the dual role of patient, with knowledge of his or her illness, and subject, to aid the teaching and learning process. This secondary role of the subject is, by definition, passive, and invites the 'clinical gaze, forcing the patient to temporarily relinquish the more active role and any associated power/knowledge.

However, despite the challenges inherent in managing these multiple roles, doctors rarely receive formal training on how to negotiate these consultations successfully, and little research has addressed this issue (Bristowe K, Patrick PL, 2012) in recent years, there have also been changes in access to power/ knowledge in consultations as a result of the increasing empowerment of patients. Traditionally, physicians have been described as utilising a process of silencing and forcing the patient to speak (an internal procedure referred to by Foucault as 'rarefaction of the speaking subject' (Foucault M, 1981) which institutionalises the discourse, and minimizes and controls opportunities for the sharing of knowledge. Doctors have been criticised for curtailing patient narratives too soon, thereby potentially missing important information, (Beckman HB, 1984) or failing to adequately explore health beliefs and explanatory models of illness.

However, more recent models of communication in medical education, encourage the parallel exploration of the patient's illness experience alongside that of the disease, (Kurtz SM, Silverman,1998) in conjunction with the rise in alternative sources of truth and knowledge (such as Internet-based patient information), have begun to draw the authority to diagnose, and access to power/knowledge, out from the physician's exclusive grasp more with how and why something comes to be 'in the true; to avoid the constraints imposed by methodology, and to embrace interdisciplinarity; not to be judgmental, but to remain skeptical and critical of one's position, and not to over generalise one's findings. These foundations of respect, openness and collaboration can undoubtedly, to paraphrase Foucault, Hyde L, 1998) that make windows where there were once walls.

Summary

Health is one of the most crucial aspects of the well-being of man. Technically, being healthy is a state in which one is fit and devoid of any physical or mental illness. As the changes in lifestyle and climatic changes have impacted the outbreak of many diseases and attacks. Various outbreaks like SARC-19 Corona Pandemic, Nipha Virus attack, Ebola virus attacks etc. point to the theory of the prevalence of the bio war between the countries. In these contexts, health became vital in academia whereas multiple perspectives of health and interdisciplinary possibilities are in the limelight by the Academicians. In this context, this chapter discusses the discourse of health. With an introduction to what is a discourse and how that is understood in social science. Along with the same, the chapter also explains the need and significance of public health discourse and discourse analysis. A brief Introduction of Michel Foucault and Foucauldian discourse analysis, which is a form of discourse analysis, which emphasises power relationships in society as articulated through

language and practices, and is based on the theories of Michel Foucault. Thus with Foucauldian discourse analysis, one can understand Health as a discourse through this chapter.

Keywords

The People's Health Movement (PHM)- It is a global network of grassroots health activists, civil society organizations and academic institutions [particularly from low and middle-income countries having a presence in around 70 countries] to promote universal access to quality health care, education and social services according to people's needs and not their ability to pay.

Discourse analysis (DA)-It is a broad field of study that draws some of its theories and methods of analysis from disciplines such as linguistics, sociology, philosophy and psychology. More importantly, discourse analysis has provided models and methods of engaging issues that emanate from disciplines such as education, cultural studies, and communication and so on.

The germ theory of disease- The germ theory of disease is the currently accepted scientific theory for many diseases. It states that microorganisms known as pathogens or "germs" can lead to disease. These small organisms, too small to be seen without magnification, invade humans, other animals, and other living hosts.

Indigenous people - Indigenous Peoples are distinct social and cultural groups that share collective ancestral ties to the lands and natural resources where they live, occupy or from which they have been displaced.

SelfAssessment

1 A discourse analytical perspective distinguishes from other approaches to health and risk is its focus on 'language in use, that is, on the way people use ……………as a tool to take concrete social actions.

A. Discourse
B. Methodology
C. Theory
D. Statistics

2 Discourse is a …………….of the notion of a conversation to any form of communication.

A. Theatrical
B. Analytical
C. Generalization
D. Rhetorical

3 …………..view discourse as a system of thought, knowledge, or communication that constructs our experience of the world.

A. Anthony Giddens
B. Ulrich Beck
C. Jürgen Habermas
D. Michel Foucault

4 …………….often studies discourse as a window into power.

A. Social theory
B. Globalization
C. Statistics
D. Information and Technology

5 ……………… Is referred as how knowledge, subjects, behaviour, and events are depicted and defined in statements, assumptions, concepts, themes, and shared ideas.

A. Theory
B. Discourse
C. Research
D. Analysis

6 The public health discourse entails an extended dialogue on the ………….of the population and communities.

A. Diseases
B. Health
C. Pandemic
D. Technology

7 The ancient practices of healthy living and wellness such as Ayurveda and Yoga are practiced since 1000 BC in India.

A. The above statement is true
B. The above statement is false
C. The above statement is partially correct
D. The above statement is partially incorrect.

8 The Institute of Medicine (1988) defined Public Health as ………..

A. Healthy society means wealthy society
B. Health is wealth
C. The society does collectively to assure the conditions for people to be healthy.
D. Good society is only where there is good health is.

9 The Indus Valley Civilization's drainage and sanitation system is one such example of an ……………..in India.

A. Ancient Archery
B. Ancient immune system
C. Ancient immigration
D. Ancient public health system

10 Mentioning of "Quarantine" as a practice of separating people with illness from the healthy population is an ancient practice which can be found in Biblical and Quranic references.

A. The above statement is true
B. The above statement is false
C. The above statement is partially correct
D. The above statement is partially incorrect.

11 In……… the public health approach was guided by the notions of the common good, human existence, survival, and social capital.

A. Peasant societies
B. Post-modern society

C. Ancient societies
D. Virtual society

12 The evolution of modern public health in India as a discipline started with the establishment of …………
A. Apollo hospital, Chennai
B. All India Medical College
C. Vellore Medical College
D. Calcutta Medical College

13 Discourse analysis is the study of social life, understood through an analysis of language in its widest sense.
A. The above statement is true
B. The above statement is false
C. The above statement is partially correct
D. The above statement is partially incorrect.

14 The term 'discourse analysis' was first used by ………..in 1952 in an article entitled 'Discourse Analysis.
A. Radcliff Brown
B. Noam Chomsky
C. Claude –Levi-Strauss
D. Zellig Harris

15 Who he coined the term "power/knowledge".
A. Bertrand Russell
B. Karl Popper
C. Michel Foucault
D. Jean-Paul Sartre

Answers for Self Assessment

l.	A	2.	C	3.	D	4.	A	5.	B
6.	B	7.	A	8.	C	9.	D	10.	A
11.	C	12.	D	13.	A	14.	D	15.	C

Review Questions

1 Write a brief note on Public health in Indian Society.
2 What is discourse and how that is significant in Social Science?
3 What is the significance of public health discourse in the contemporary Indian society?
4 What is called "Foucauldian discourse analysis"?
5 Critically analyse health from Foucauldian perspective of thought?

Further Readings

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Unit 04: Health as Embodiment

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Objectives

After completing this Unit, you shall be able to:

- To know the Concepts of disease, illness and health.
- To know what is embodiment.
- To understand Health as the process of embodiment.

Introduction

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

The Definitions and conceptualization of health may vary systemically among various social groups and different accounts of health are likely drawn according to social circumstances. Following are some simple points to understand health:

- Heath is a metaphor for well-being.
- To be healthy means to be of sound mind and body; to be integrated; to be whole.

Over time and across societies, prominent theorists have emphasized that health consists of balance, of being centred. More generally, health refers to a holistic notion of individual well-being. One's perspective on health is oriented by cultural values (Gilman, 1995). For example, contemporary Western medicine evaluates the health of a body organ or individual through a series of technological laboratory tests used to determine if indicators of structure, such as readings of radiographs, and function, such as kidney filtration rates, fall within a 'normal' range for this individual in these circumstances.

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being, and does not consist only of the absence of disease or infirmity". This definition underscores the major theme of this chapter as Health is not just a matter of personal choice, nor it is only a biological issue but it is a patterns of well-being and illness are rooted in the organization of society. This definition also confirmed health as a social issue and this is established by evidence which demonstrates that the standards of health have varied over time and also from one society, culture and country to another. For example, what is considered good health in a low-income country such as Sri Lanka is very different to what is considered good health in the high-income country like United Kingdom and ensuring a safe environment. The biomedical approach which dominated medical thought till the end of the nineteenth century and was based on the 'germ theory of disease' views health as an 'absence of diseases. This approach almost ignores the role of environmental, psychological and other socio-cultural factors in defining health. The ecological approach which views health as a dynamic equilibrium between man and his environment. For them, the disease is the maladjustment of the human organism to the environment. The psychological approach states that health is not only related to the body but also to the mind and especially to the attitude of the individual. The socio-cultural approach considers health as a product of the social and community structure. A function definition of health implies the ability of a person to participate in normal social roles. A sociological understanding of health considers structural and social factors, rather than a simple biological explanation of health and disease. It describes the complex relationship between structural factors and personal choice concerning health inequalities.

4.1 Concept of Health, Disease and Illness

There has not been an absolute consensus on the definitions of health, disease, and illness, even though these concepts are central not only in medicine but also in the health social sciences (e.g., medical sociology, health psychology and medical demography). These are parts of the conceptual tools in various medical-related fields. A definition of each concept is imperative because they constitute parts of the analytical tools in medical sociology. The lack of consensus often prevents uniformity of interpretations and generates more critical. One wonders why there has not been a consensus, despite the long history of medicine. The concepts are multidimensional, complex, and often elusive. For instance, Larson (1999) observed that disagreements about the meaning of health are common because health is imbued with political, medical, social, economic, and spiritual components. It is subject to various conceptualisations and interpretations. While all the concepts have their foundations in medicine, a biomedical perspective of health or disease may not be comprehensive enough. However, a fusion of the various perspectives often presents a complex definition like the WHO's definition of health. This is why the debate on the definition of health is still ongoing. That the debate continues is not a problem as a refinement of the definition could lead to a better conceptualisation.

The concept of health presents a form of ambiguity because it is multidimensional, complex, and sometimes elusive. Notwithstanding, various scholars, apart from the definition given by the WHO, have defined the concept. Although it is not the first definition of health, the WHO's definition will still be the starting point because it is relatively old and has been central to the debate on the meaning of health. WHO (1948) defined health as "a state of complete physical, mental, and social well-being, not merely the absence of disease and infirmity". The definition is holistic, and it presents three major interrelated components of health.

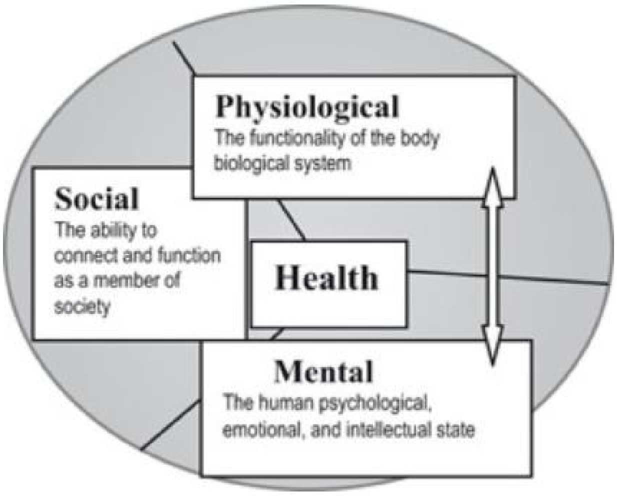

Fig.4 (1)

a) **The physical**: this is the physiological or biological component of the definition. It simply implies the maintenance of homoeostasis. This is often used to infer the soundness of the body. Most often, disease represents a malfunction of a part of the body system or an intrusion of harmful organisms such as a virus or parasite. This may cause a breakdown of the individual affected. This physiological aspect is the most important biomedical criterion in the determination of health. For someone to be healthy, his/her biological components must be in order. A major diagnosis procedure involves a determination of what could be wrong with any component of the body or detection of any intrusion of any anti-body by tracing the pathways of the disease from underlying causes to pathology in the human body system and examination of any emerging symptoms. Determining this may involve a series of laboratory tests or clinical examinations. One may be certified as healthy if there is no detection of any biological hitch.

b) **The social:** this represents the behavioural aspect of human health. Being a member of society is being in the network of social interaction and being able to fulfil social roles and expectations. If an individual is not active in the social network, it represents a form of social pathology —an abnormality, which is an infraction of the norms and values of society. The social also incorporates the spiritual dimension. The spiritual aspect could be personal to the individual by connecting to the world of reality and divinity. Larson (1999) observed that since the WHO's definition of health, medicine has treated individuals as social beings whose health is affected by social behaviour and interaction.

c) **The mental**: this indicates the psychological, emotional, and mental status of the individual. Emotional apathy, fixation, and maladjusted personality constitute a part of the manifestation of illness. Huber et al. (2011) observed that the mental aspect of health signifies the possession of a "sense of coherence," which includes the subjective faculties enhancing the comprehensibility, manageability, and meaningfulness of any circumstances.

The WHO's definition has been heavily criticised since it was conceived in 1946 after the Second World War (see Callahan 1973; Bice 1976; Pannenborg 1979; Wood 1986; Simmons 1989; Saracci 1997; Jadad and O'Grady 2008; Huber et al. 2011; Godlee 2011; Awofeso 2012). For instance, Awofeso (2012) observed that the definition is inflexible and unrealistic. He claimed that the inclusion of the word "complete" in the definition makes it unlikely for anyone to be healthy for a reasonable period of time. Godlee (2011) also noted that the definition is absolute and therefore unachievable for most people in the world. The definition presents an absolutely ideal situation by combining the three aspects of human life. It is often difficult, if not impossible, to gain complete contentment in all aspects. It is observed that since health is a goal, not only of the health care system but also individuals and the society at large, it is ideal for a body like WHO to present a realistic definition that can be operationalised and achievable (Godlee 2011).

In addition, Saracci (1997) also submitted that the WHO's definition of health is problematic and should be reconsidered. Saracci observed that the definition equates health with happiness—that disruption of happiness could be regarded as a health problem. He further argued that the WHO's definition reflects that health is boundless. More so, Huber et al. (2011, p. 2) opined that the WHO's definition is problematic because it impliedly declares people with chronic diseases and disabilities definitively ill. The definition further minimises “the role of the human capacity to cope autonomously with life’s ever-changing physical, emotional, and social challenges and to function with fulfilment and a feeling of wellbeing with a chronic disease or disability” (Huber et al. 2011, p. 2). Despite several decades of criticism, the WHO has not reviewed the definition. The idea of a definition is to present a holistic view that is meaningful not only for individuals but also as a (definitive) tool in a scientific investigation. The idea is not to advance an operational perfection that is unchangeable. Perhaps, there is yet a review because there has not been a more holistic and measurable alternative definition of health.

Several other scholars have proposed other definitions of health, which can be used in light of changing global health circumstances. After some criticisms of WHO’s definition of health by Saracci (1997, p. 1410), he proposed a definition of health as “a condition of wellbeing, free of disease or infirmity, and a basic and universal human right.” Impliedly, this definition also defined those who are living positively with chronic disease as unhealthy. It presents health as a basic right, which is also problematic. In most parts of the world, health is a commodity with an insurance premium, a price tag, or it requires a pool from the public tax. This also seems like a theoretical proposition that is not operational. It does not really account for the multidimensionality of health. Therefore, it may not be considered a holistic and viable alternative to the WHO definition.

Health has been conceived in a biomedical model as the absence of disease while the holistic definition from the WHO signifies that health is not a mere absence of disease. Whichever form the definition takes, the question now is “what constitutes a disease?” One major issue is that disease is often conceived from a biomedical point of view. It can also have behavioural manifestations, especially with regard to human functionality. The definition of health is complex, and so also is the definition of a disease. If the lack of health can be defined as not a mere absence of a disease or infirmity, this signifies that there are a number of germs- and non-germ-related (medical) conditions that can signify the presence of a disease. This, however, also makes the definition of a disease complex because of variations in its conceptions.

In a disease-ridden society, when the level of disease or illness is determinable, health becomes measurable. However, when a society is healthy, disease or illness becomes less determinable and health becomes less measurable. Additionally, the three basic elements in the field of public health: people, disease or illness and health in the context of their environment are worth examining. The classical definition of illness: is “an unhealthy condition or unhealthy state of body or mind” (Gove PB, 1968) which contrasts with illness “as a bad moral quality, a condition of wickedness, disagreeableness, troublesomeness, hurtfulness and badness”; while “disease is a corruption of the body and by extension a corruption of the spirit and/or mind” (Alland FA, 1970). The disease may also be defined as “a failure of the adaptive mechanisms of an organism to counteract adequately the stimuli and stresses to which it is subject, resulting in a disturbance in function or structure of some part of the body (Hoerr NL, Asol,1956). This definition is similar to Meerlo’s definition: (Meerloo JAM, 1964) “a failure reaction to a noxious stimulus,” and disease is defined as “an unsuccessful reaction interfering with normal life.” Meanwhile, Clark (Clark DW, MacMahon B, 1967) states that “there are no diseases, there are only sick people.” Another ecological definition is that “disease is an impairment of the normal state of the living animal” (Gove PB, 1968). From the ecological standpoint, disease and illness are closely related resulting in Wylie (Wylie CM, 1970) defining health as “the perfect adjustment of an organism to its environment.” Health in this context is an expression of adaptability, and disease is the failure thereof. This can be compared to what Webster’s Dictionary defines as “health as a condition of an organism or one of its parts in which it performs its vital functions normally or properly.” (Gove PB, 1968). However, a more satisfactory definition of disease is needed.

The real problem of health measurement is the problem of measurement of disease or illness (morbidity). Health is measurable as long as disease or illness is measurable but when disease or illness becomes immeasurable and imperceptible, then health also becomes immeasurable. Among health definitions, the most widely used is from the World Health Organization namely, “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO; 2009). This definition has been regarded as an attainable goal whilst others criticize it as being too ideal and unrealistic. Also, a range of conditions keeps people at some point short of positive health (Dunn HL, 1956). Nonetheless, the above variation of the concepts of health are commonly accepted as statements of an ideal, or as Besson (Besson G, 1967) described it, “optimum health. “The WHO defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO; 2009) and it is objective of “The attainment by all people of the highest possible level of health” (WHO; 2009) has already provided a broad-based foundation for the developmental approach toward positive health as a mandatory function of its member states and other stakeholders. Initially, the WHO had to assist its member countries to fight against diseases stemming from low levels of development, poverty, lack of education and many other prevailing environmental and ecological problems. It was realized that it is not yet possible for everyone to fully enjoy complete physical, mental and social well-being, and not merely the absence of disease or infirmity.

In 1977, the World Health Assembly of the WHO resolved to set the main social target/goal for the governments and the WHO "toward the attainment by all people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (WHO; 1977). Additionally, at the International Conference on Primary Health Care (PHC) held in Alma Atar, USSR in 1978, there was consensus that a PHC approach is the key to attaining the social goal of "Health for All" by the year 2000. However, it was evident by the year 2000, that the achievements of the targets were not at all uniformly met, and yet, it was equally noted that more global health resources were indeed mobilized and made available for supporting worldwide efforts in health development. Furthermore, the general health conditions of people around the world were visibly improved, especially in developing countries, even though not in a uniform or equal manner. PHC forms an integral part, both, of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community (WHO; 1978) Therefore, the World Health Assembly later agreed to keep the goal of "Health for All" without specifying the target date, and since 2000, the idea of a Universal Health Coverage system was conceived as an important step toward Health for All. Thus we can conclude that WHO's definition of health is critically examined concerning its components, criticisms, and alternative definitions of health.

Illness and disease have been major traditional concepts in sociology and medical sciences. The important role of these concepts in human-related medical endeavours was re-emphasised by Nordenfeldt (1993). These concepts are interwoven and often require some analytical clarifications. Most often, people use the words interchangeably. As conceptual and practical tools, they are not the same. The essence of this section is to make some conceptual clarifications of these concepts and not to join the body of unending debate evident in the works of various scholars (including Boorse 1975, 1977; Hesslow 1993; Nordenfeldt 1993; Stempsey 2000; Tengland 2007). More importantly, sociologists have laid more claims on the notion of illness because it is more of a behavioural concept than a medical one. Undoubtedly, illness has a number of undeniable social, moral, and legal contexts. In a simple illustration, the disease is a form of pathology or medical problem, defect, or impairment, while illness is a manifestation of such an impairment, defect/pathology, or disability. Illness is a presentation of a medical condition in a way that limits the functional capability of an individual in society. This is why Nordenfeldt (1993) observed that to be ill is to be in pain, be anxious, or be disabled. The notion of illness fits appropriately into the concept of the sick role described by Parsons (1951). It is a situation when an individual consciously feels that he/she is unhealthy, sometimes as a result of discomfort and pain. Therefore, illness is the live experience of a diseased condition. While a diseased patient might not be real (i.e., without the self-awareness of the condition), an ill patient is real.

Thus to move toward good health, investments in public health interventions, particularly health promotion and disease prevention as well as effective health care must be ensured throughout the life cycle of individuals and at the same time, people who are already sick must receive the best treatment and care to limit the degree of morbidity or disability. To stay healthy, people will have to ensure proper behaviours and lifestyles, and, as far as health is concerned, always keep in mind the influence of two broad areas of health determinants, i.e., environment and genetic endowment. When the intervention moves forward into the area of secondary prevention, health becomes more negative with an increased degree of dependence of a person on others. It is indeed important to delay this pathological process through the most efficient and effective development and implementation of a public health policy program combined with an active medical intervention system that complements a successful healthcare system.

4.2 The meaning of Embodiment

The etymological meaning of embodiment is "investment in or manifestation through a physical body; a bringing into or presentation in or through a form".In the health perspective, the term embodiment refers to the role of an agent's own body in his situated life, suggesting the existence of a bodily root for several experiential and cognitive abilities. A flag is the embodiment of a country. When you talk about embodiment, you're talking about giving a form to ideas that are usually not physical: like love, hate, fear, justice, etc. A gavel is the embodiment of justice; a wedding ring can be the embodiment of love (Finnegan, R (2002). This is a complex term that has a long history within philosophy, psychology and sociology, its specific meaning being contingent on the particular discipline.

The term continues to be contested, particularly within psychology and philosophy, where notions of the mind-body split are still debated. Perhaps of most value to multimodality theory is the conception of the embodied self in phenomenology, especially in the work of Husserl and Merleau-Ponty. Here the body is seen as the centre of identity, inseparable from sensory experience and perception. Embodiment usually refers to how the body and its interactive processes, such as perception or cultural acquisition through the senses, aid, enhance or interfere with the development of human functioning. Within the context of multimodality, the emphasis is on the relationship between physical experience, and multimodal resources, media practices and social spaces. This relationship is an interdependent one where meaning-making is grounded in physical experience, through bodily form, gaze, gesture, body posture, facial expression, and movement, which shapes the kind of interaction with the environment. Equally, media spaces and social practices are produced through the human body in its material form, the nature of the practices being, in large part, contingent on the forms, practices, and plasticity of the human body. A person can also embody an identity (as the phenomenological approach proposes), or a particular set of identities, by the way, one move, interacts, communicates and perceives.

Embodiment, both in terms of the expressive resources of the body and in terms of embodied identity, can also be conceived of in represented bodies, like avatars, which offer a form of 'virtual' embodiment. Such environments offer new ways to 'embody' a set of identities outside one's physical being, where the virtual avatar acts as a tool through which identity can be shaped. Multimodality offers an approach to analysing meaning-making that embraces these different modes of interaction that inherently form notions of embodiment: gaze, gesture, posture, and movement. While some areas of multimodal research conduct analysis of text-like objects and media forms, embodiment signifies the importance of the human body and its communicative and expressive functions, whether these be banal and every day, or those through which performance-based art forms such as dance, music and drama are accomplished. Finnegan (2012) has explored the modes of the body in communication as well as in oral poetry and narrative over many years. There is a longstanding field of work concerned with the semiotics of gesture (Kendon, 2004). More recent work has analysed children's play in terms of the embodied modes at work (Bishop & Burn, 2013).

4.3 Health as a process of Embodiment

In public health, perhaps the most developed and useful conception of the embodiment is that articulated by (Krieger. N, 2001). As a foundational construct of Eco social theory, an embodiment is understood as the process through which the outside physical and social world becomes embedded into our biology—that is, how daily interactions with our social and physical environments "get under our skin" to affect our physical, psychological, and emotional well-being by altering how our body functions. The general idea is that we encounter, perceive, interpret, and incorporate an endless array of social and physical environmental experiences and exposures that shape our physiologic functioning on a day-to-day basis, whether such incorporation is biologically and/or chemically direct (e.g., air pollution, roach antigens), or psychosocially mediated (e.g. experience of discrimination, exposure to community violence, perception of threat). Thus, in the same moment, we might simultaneously incorporate the air around us just as we incorporate the conversation about us, and might do so consciously or unconsciously.

Embodiment, then, is both continuous and dynamic, as well as both objective and subjective. Our bodies keep tallying our lived experiences—our physical and social encounters—and the health and well-being of our bodies can accordingly bear witness to the contexts and conditions of such experiences and encounters. Moreover, these contexts and conditions of embodiment are shaped and organized by societal arrangements of power, privilege, and opportunity—both current and historic. The processes and mechanisms of embodiment—the so-called pathways of embodiment, forged through an interplay of our inner biology and the outer social world—are beholden to and an expression of such social, economic, and political arrangements. Inequalities in health across populations, then, present as "embodied expressions of social inequality". "Reading" bodies as texts can accordingly offer clues for discerning, and provide insight into, the matrix of structural factors that underlie and drive patterns of population health and illness.

Thus our physiologic functioning and overall health are perpetually influenced by and cannot be separated from the lived realities and contexts of our daily lives—lives that unfold in particular locales and periods. Telling the story about the embodiment of place has been the focus of an increasing amount of place-health research in recent years. Much of this place-embodiment work at the population level entails the collection and spatial analysis of biometrics in light of what is considered core social determinants of health, e.g., neighbourhood SES. Generally, this work can be categorized based on whether cross-sectional or longitudinal approaches are taken, whether samples are adults or youth, and whether a cumulative measure of “embodiment”, i.e., multi-component assessments of cumulative biological risk or allostatic load, or a singular biometric component is explored (e.g., diurnal cortisol).

The phenomenological concept of embodiment, including the distinction between the lived and corporeal body, has been applied, to some extent, in qualitative research and clinical practice. However, in most cases, qualitative researchers and clinicians do not draw their concepts directly from classical, philosophical texts. They often adopt concepts from the work of contemporary, philosophically trained phenomenologists who have already applied these concepts in their philosophical studies of illness. We can think of these philosophical applications as an intermediary step between purely theoretical phenomenology, on the one hand, and applications in empirical qualitative research and clinical practice, on the other. Because these philosophical applications provide conceptual formulations that are more readily applied in qualitative health research and clinical practice, it is worthwhile to review some of this literature here.

Jenny Slatman and Gili Yaron have, for instance, used the phenomenological concept of embodiment to explore how people experience their bodies when disfigured. They use the example of a nurse named Leah whose face was disfigured as a result of cancer treatments. They stress that Leah's disfigurement is not something that simply happens to her; she is not a passive object. Rather, “in relating to her condition, she develops various ways of ‘doing’ her body anew—ways that operate both on her body as an image (an intentional object of Körper) and on her body as lived-through (a sensing self or Leib)” (Slatman&Yaron, 2014, p. 231). Others, both friends and strangers, perceive Leah's face in new ways, including as “strange, different, fascinating, or repulsive” (Slatman&Yaron, 2014, p. 231). But is this how everyone experiences the facial disfigurements of others? Not necessarily. Slatman and Yaron consider the example of Royal Air Force aircrew members in the United Kingdom who survived severe burns in the Second World War. In contrast with most people who suffer severe burns, “These men did not have to hide their damaged faces since they were signs of bravery; their faces expressed the honour of having served their country” (Slatman&Yaron, 2014, p. 288). The aircrew members and members of their community experienced the facial scars in a way that differs substantially from the experience of someone who was burned in an accident. What should we take away from the contrasting examples of Leah, whose face was disfigured by cancer treatment, and the aircrew members, whose faces were disfigured after surviving severe burns in war? Disfigurement is never merely disfigurement. Any bodily feature, especially one that strays from the norm, will always be imbued with a particular meaning within the context of one's life and social situation. Carel provides another philosophical analysis of embodiment in illness, which helps us flesh out the dynamics between bodily absence and bodily appearance. As she argues that in severe or chronic illness, one typically undergoes an experience of bodily doubt. The healthy, able-bodied person typically operates with a sense of bodily certainty. This is the sense that my body will carry on functioning in the way it has always functioned: my legs will climb the stairs, my fingers will type, my stomach will digest and my lungs will breathe. This certainty is not, however, an explicit belief that my body will keep functioning. If someone were to ask me if I thought my legs would always be able to carry me up the stairs, I would readily admit that one day, when I am much older, my legs will fail me and I will not be able to climb stairs on my own. But this belief is not a genuine feeling of doubt. As soon as I have expressed this fact about my future, I can put it out of my mind and go back to my everyday routine. So, what does Carel mean by bodily doubt and bodily certainty? The kind of certainty that is lost is not so much a belief as a kind of faith. When you have a chronic illness, you realize that you simply had an unquestioned faith in your bodily functioning. After you have witnessed your own body fail you, this faith can no longer remain unquestioned. The possibility of bodily dysfunction now permeates how you find yourself situated in the world, and this fundamentally alters how you experience and relate to your own body (Carel, 2013). Your body—or at least some part of your body—can never fully recede from awareness. Carel argues that bodily doubt has three key components, one of which is a loss of bodily transparency. Where the body was previously absent or transparent, it now “becomes explicitly thematised as a problem. The tacit taken-for-granted attitude we have towards it (we expect our bodies to perform complex actions, to be pain-free, to allow us to concentrate, and so on) is replaced by an explicit attitude of concern, anxiety, and fear" (Carel, 2013, p. 191). Moreover, this shift in a bodily experience never occurs in isolation. It is always accompanied by a corresponding shift in how one experiences one's environment.

S. Kay Toombs provides an illuminating example of how she experienced changes in her environment while living with chronic progressive multiple sclerosis. She says, "The bookcase outside my bedroom was once intended by my body as a repository for books,' then as 'that which is to be grasped for support on the way to the bathroom,' and is now intended as 'an obstacle to getting around with my wheelchair'" (Toombs, 1995, p. 16). In this example, we see how the very same object initially shifts between two kinds of affordance—something to put books on, then something to grasp for support. But, once Toombs navigates her home in a wheelchair, the bookcase becomes an object of frustration—an obstacle to be avoided. Of course, the physical bookcase itself did not change. What changed was the relation between Toombs' motor capacities and the objects available to her, which reshaped the sense and meaning of her environment. In examples like this one, we gain a better understanding of the personal or individual experience of illness and disability. But some phenomenologists have also studied how the ill or disabled body is experienced in the clinical encounter. Here Toombs goes so far as to argue that the patient and clinician occupy different worlds: "Within the context of the universe of science, illness is rendered thematic in terms of 'objective', quantifiable data. The disease is thus reified as a distinct entity residing in, but in some way separated from, the one who is ill. The patient, however, encounters illness in its immediacy in the context of the world of everyday life, as opposed to the universe of science" (Toombs, 1987, p. 228). Toombs argues that the clinician may fail to address the issues of most concern to the patient because they do not appreciate the lived reality of illness. Leder makes a similar point when he says that the patient presents his lived body for treatment, but the doctor, by contrast, attends to the patient's corporeal or object body (Leder, 1984, p. 32). He says, "…the doctor examines a physical body. Much of her/his medical training has de-emphasized lived embodiment from the first 'patient' encounter – that with a cadaver. The predominant task at hand is to search for a mechanical precipitant of disease, be it a toxin, trauma, or bug" (Leder, 1984, p. 33). However, Leder also acknowledges that this dualistic view is often too superficial. It is too simple to say that the patient experiences her own body only as lived—as sensing and experiencing—whereas the doctor experiences the patient's body only as a physical thing. In some cases, "The patient as well may have come to regard his/her body in an objectified mode. This process is often begun by the illness itself" (Leder, 1984, p. 33).

These philosophical analyses illuminate embodied experiences that are characteristic of illness and healthcare interactions. In this respect, they are more concrete or particular than what we find in purely theoretical accounts of embodiment, which articulate features of experience that hold for any experiencing subject. But they are also less concrete or particular than what we find in empirical qualitative research. While the philosophical applications described above do appeal to personal experiences of illness, they do not illuminate the experience of an individual or a particular patient population. Rather, they use concrete examples to reflect upon and describe the characteristic (or even essential) features of severe or chronic illness in general. They, therefore, represent only the first stage of phenomenological application.

Summary

The chapter gives insight into and overview of the concept of embodiment and how that is connected with the concept of health. The reader can understand the tangible relationship between health, disease and illness and through that the complete picture of the embodiment of health itself. Even though Embodiment is both continuous and dynamic, as well as both objective and subjective. (Krieger N., 2001) discusses the processes and mechanisms of embodiment—the so-called *pathways of embodiment,* forged through an interplay of our inner biology and the outer social world—are beholden to and an expression of such social, economic, and political arrangements. Inequalities in health across populations, then, present as "embodied expressions of social inequality". Thus the construct of the embodiment is vital for epidemiology. This is as true for studies concerned with elucidating micro-level factors influencing the risk of disease as it is for macro-level studies concerned with explaining temporal Embodiment and spatial contrasts of population rates of morbidity and mortality, including social inequalities in health. The domain of study of our field—determinants and deterrents of population rates of disease, disability, death, and health necessarily requires us to study people in context. Ultimately, it is by embodying this context that we manifest the observed population patterns of health, disease, and well-being, hence the rationale for making the study of embodiment a central concern.

Keywords

Health: It is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. I.e. the complete wellbeing of an individual both physically, mentally and socially.

Embodiment:a concept referring to how we literally incorporate, biologically, the material and social world in which we live, from in utero to death; a corollary is that no aspect of our biology can be understood in the absence of knowledge of history and individual and societal ways of living.

Pathways of embodiment: structured simultaneously by (a) societal arrangements of power, property, and contingent patterns of production, consumption, and reproduction, and (b) constraints and possibilities of our biology, as shaped by our species' evolutionary history, our ecological context, and individual histories—that is, trajectories of biological and social development.

Life course perspective: It refers to how health status at any given age, for a given birth cohort, reflects not only contemporary conditions but embodiment of prior living circumstances, in utero onwards.

Health status: It refers to your medical conditions (both physical and mental health), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

Health status indicators: it refers to the measurements of the state of health of a specific individual, group or population.

SelfAssessment

1. Who quoted "Health is the basic human right of all human beings and it contributes to a person's basic capability to function and the denial of health is not only a denial of a 'good life chance', but also the denial of fairness and justice?

A. Amartya Sen
B. A. P. J. Abdul Kalam
C. John Bordley Rawls
D. Narendra Modi

2. Which article of the Constitution of India describes health as an integral aspect of human life?

A. Article 18
B. Article 21
C. Article 38
D. Article 16

3. …………defines health as "a state of complete physical, mental and social well-being, and does not consist only of the absence of disease or infirmity".

A. IMF
B. ILO
C. WHO
D. ECOSOC

4. …………views health as an 'absence of diseases.

A. Evolutionary theory

B. Marxian theory
C. Germ theory
D. Sick role theory

5. Embodiment is understood as a core concept for understanding relationships between ……….

A. Health and Employment
B. State of our bodies and the body politic
C. Health and wellness
D. Good life

6. ……..which views health as a dynamic equilibrium between man and his environment, thus the disease is the maladjustment of the human organism to the environment.

A. Psychological approach
B. Philosophical approach
C. Sociological approach
D. The ecological approach

7. In WHO definition on Health what are the three components and they are……………

A. Physiological, Social and mental
B. Psychological, Social and mental
C. Cultural, Social and environmental
D. Demographic, Social, Geographical

8. An unhealthy condition or unhealthy state of body or mind can be understood as ………..

A. Mortality
B. Fertility
C. Illness
D. Health

9. According to health perspective, the term …………refers to the role of an agent's own body in his situated life, suggesting the existence of a bodily root for several experiential and cognitive abilities.

A. Health
B. Mortality
C. Employment
D. Embodiment

10. Phenomenological concept of …………to explore how people experience their bodies when disfigured.

A. Evolution
B. Embodiment
C. Health
D. Coalition

11. Life course perspective refers to ……………

A. How health is at elderly
B. Statistical understanding of Health
C. Child mortality
D. how health status at any given age

12. ………..refers to your medical conditions (both physical and mental health), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.
A. Health Hazards
B. Health status
C. Illness
D. Sound mental health

13. Health services that cover a range of prevention, wellness, and treatment for common illnesses is called …………..
A. Hospital care
B. States care
C. Primary care
D. None of the above

14. ………providers include doctors, nurses, nurse practitioners, and physician assistants.
A. Secondary Care
B. Territory care
C. Primary care
D. Tertiary care

15. ………is called the measurements of the state of health of a specific individual, group or population.
A. Health statistics
B. Health Methodology
C. Health status indicator
D. Health theories

Answers for Self Assessment

l.	A	2.	B	3.	C	4.	C	5.	B
6.	D	7.	A	8.	C	9.	D	10.	B
11.	D	12.	C	13.	C	14.	C	15.	C

Review Questions

1 What is the controversy with regards to WHO’s definition on Health. ?

2 Define Health and expand your understanding by evaluating the significance of health in India.

3 What is called Embodiment?

4 How embodiment can be understood from Health perspective?

5 Outline the meaning and significance of embodiment of health in the Indian society.

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Unit 05: Hospitals

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Objectives

After completing this Unit, you shall be able to:

- To know the Concepts of hospital as a health care system.
- To know about the types of the hospitals and their functioning.
- To understand new arenas in the Hospital concept.

Introduction

A hospital is a healthcare facility that provides specialized medical and nursing care as well as medical supplies to patients. The most well-known form of the hospital is the general hospital, which usually carries an emergency department to handle urgent health issues such as fire and accident victims, as well as medical emergencies.The hospital is an organisation that mobilizes the skills and efforts of widely divergent group of professionals, semi-professional and non-professional personnel to provide highly personalized services to individual patients. Like other large organisations, hospital is established and designed to pursue certain objectives through collaborative activity.

The main objective of the hospitals is of course, to provide adequate care and treatment to its patients (within the limits that may be imposed by the scarce resources and by extra-organisational forces). Its principal products is medical, surgical and nursing service to the patient, and its central concern is the life and health of the patient. A hospital may, of course, ' have additional objectives, including its own maintenance and survival, organisational stability and growth, financial solvency, in medical and nursing education and research and various employee-related objectives. But all these are subsidiary to the key objectives of service to the patient, which constitutes the basic principle that underlies all activities in a hospital.

Various literatures while describing the origin of hospitals stated that religious forces and institutions was the main force behind the development of hospitals rather than the development in the medical services. It is at times difficult and complex task to dissociate development of hospitals from religion in some cases like early Roman or Greek civilization, temples of Gods were utilized as hospitals. But in 400 BC Hippocrates made it possible to separate medicine from religion on rational grounds.

Modern hospitals are very complex socio-economic, scientific and highly labour oriented organisations. Still they owe their origin to the sufferings and ailments of people and to the compassion and zeal amongst sonic philanthropies to relieve these sufferers from annoy of suffering and discomfort.

Today hospital means an institution in which sick or injured persons are treated, A hospital is different from a dispensary because hospital being primarily an a institution where in-patients are received and treated while the main purpose of a dispensary is distribution of medicine and administration outdoor relief.

5.1 Conceptual understanding of Hospitals

The etymology of the hospital is from the word "hospital" comes from the Latin “hospes”, signifying a stranger or foreigner, hence a guest. Another noun derived from this, “hospitium” came to signify hospitality that is the relation between guests and sheltered, hospitality, friendliness, and hospitable reception.

There are many definitions of hospital available in literature and dictionaries, but not a single definition is perfect in defining a modern hospital and its multifarious services. Even with WHO, there is no proper definition available. The WHO expert group has defined the role of hospital as: Hospital is an integral part of a social and medical organisation, the functions of which arc to provide the population complete health care both curative and preventive with out-patient services reaches out to the family in its own environment and also to carry out training of health workers/functionaries and the bio-social research. Other than this WHO definition, the definition given in the "Directly of Hospitals in India, 1988" is to some extent simple and short. According to this definition. "A hospital is an institution which is operated for the medical surgical and/or obstetrical care of in-patients and which is treated as a hospital by the Central/state Government/Local bodies or licensed by the appropriate authority". That is explained as Hospital are an integral part of a social and medical organisation, the functions of which are to provide the population complete health care both curative and preventive with out-patient services reaches out to the family in its own environment and also to carry out training of health workers/functionaries and the bio-social research.

Other than this WHO definition, the definition given in the "Directory of Hospitals in India, 1988" is to some extent simple and short. According to this definition. "A hospital is an institution which is operated for the medical surgical and/or obstetrical care of in-patients and which is treated as a hospital by the Central/State Government/Local bodies or licensed by the appropriate authority.

5.2 Classification (types) of Hospitals

There is no universally accepted method of classification of hospitals are available but in the year 1988, There was an effort taken to publish in India the Directory of hospitals in India. The Directory of Hospitals in India 1988 listed the various types of hospitals and their types of managements. Based on this the hospitals can be classified in many ways as they can be classified according to their objective or according to the type of patients treatments or according to the control of ownership. But as in academia, we can understand the Hospitals are usually funded by the public sector, by health organizations (for-profit or nonprofit), health insurance companies, or charities, including direct charitable donations. Hospitals may fall into one of three categories based on their funding.

- Publicly owned hospitals
- Nonprofit hospitals
- For-profit hospitals

Hospitals can be further classified based on the treatment provided by them (indicative) or in terms of facilities offered by the as:

General Hospital

General hospitals may be academic health facilities or community-based entities. They are general in the sense that they admit all types of medical and surgical cases, and they concentrate on patients with acute illnesses needing relatively short-term care. Community general hospitals vary in their bed numbers. Each general hospital, however, has an organized medical staff, a professional staff of other health providers (such as nurses, technicians, dietitians, and physiotherapists), and basic diagnostic equipment. In addition to the essential services relating to patient care, and depending on size and location, a community general hospital may also have a pharmacy, a laboratory, sophisticated diagnostic services (such as radiology and angiography), physical therapy departments, an obstetrical unit (a nursery and a delivery room), operating rooms, recovery rooms, an outpatient department, and an emergency department. Smaller hospitals may diagnose and stabilize patients prior to transfer to facilities with specialty services.

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

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

Specialized health and medical care facilities

Hospitals that specialize in one type of illness or one type of patient can generally be found in the developed world. In large university centres where postgraduate teaching is carried out on a large scale, such specialized health services often are a department of the general hospital or a satellite operation of the hospital. Changing conditions or modes of treatment have lessened the need or reduced the number of some types of specialized institutions; this may be seen in the cases of tuberculosis, leprosy, and mental hospitals. On the other hand, specialized surgical centres and cancer centres have increased in number.

a. **Tuberculosis and leprosy hospitals**- Between 1880 and 1940, tuberculosis hospitals provided rest, relaxation, special diets, and fresh air, and even if the tuberculosis was in an early stage, a stay of more than two years was thought necessary to effect a healing of the disease; a permanent cure was not considered entirely feasible. Today the use of antibiotics, along with advances in chest surgery and routine X-ray programs, has meant that the treatment of tuberculosis need not be carried out in a specialized facility. With the intense campaign for leprosy elimination begun in the early 1990s, leprosy is now relatively rare. The purpose of the modern leprosarium is not so much isolation as it is treatment. The chronic form of the disease is treated by surgical correction of deformities, occupational therapy, rehabilitation, and sheltered living in associated villages. Acute leprosy is treated in general hospitals, clinics, and dispensaries.
b. **Mental health facilities-** Psychiatric patients traditionally have been cared for in long-stay mental health facilities, formerly called asylums or mental hospitals. Today the majority of large general hospitals have a psychiatric unit, and many individuals are able to maintain lives as regular members of the community. There are still facilities that specialize in the treatment of mental illness. The hospital stay of many persons with chronic mental illness has been shortened by modern medication and better understanding on the part of the public. Patients are encouraged to participate in facility-based activities and programs. They may be encouraged to return to the community, beginning with trial visits at home, or they may be placed in assisted-living or group homes. Every effort is now made, through the use of appropriate medication and support services, to have the patient integrated into the

community. Even those individuals who require custodial care are no longer isolated from contact with their relatives, friends, and the community at large. In addition, the strong correlation between mental illness and addiction has been noted and has given rise to numerous programs incorporating the simultaneous treatment of both conditions.

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

Sanatorium

Sanatorium (from Latin sānāre 'to heal, make healthy'), also sanitarium or sanatorium are antiquated names for specialized hospitals, for the treatment of specific diseases, related ailments and convalescence. The terms sanatorium and sanitarium are interchangeable, however, sanitarium is primarily a North American word. The difference between the words is their origin, though it is not much of a difference. The word sanitorium is derived from the Late Latin word sanitorius, which means health-giving. The Sanatoriums are often located in a healthy climate, usually in the countryside. The idea of healing was an important reason for the historical wave of establishments of sanatoriums, especially at the end of the 19th- and early 20th centuries. One sought for instance the healing of consumptives, especially tuberculosis (before the discovery of antibiotics) or alcoholism, but also of more obscure addictions and longings, of hysteria, masturbation, fatigue and emotional exhaustion. Facility operators were often charitable associations such as the Order of St. John and the newly founded social welfare insurance companies.

As the first suggestion of sanatoria in the modern sense was likely made by George Bodington, who opened a sanatorium in Sutton Coldfield in 1836 and later published his essay "On the Treatment and Cure of Pulmonary Consumption" in 1840. His novel approach was dismissed as "very crude ideas and unsupported assertions" by reviewers in the Lancet, and his sanatorium was converted to an asylum soon after. The rationale for sanatoria in the pre-antibiotic era was that a regimen of rest and good nutrition offered the best chance that the patient's immune system would "wall off" pockets of pulmonary TB infection. In 1863, Hermann Brehmer opened the BrehmerscheHeilanstalt für Lungenkranke in Görbersdorf (Sokołowsko), Silesia (now Poland), for the treatment of tuberculosis. Patients were exposed to plentiful amounts of high altitude, fresh air, and good nutrition. Tuberculosis sanatoria became common throughout Europe from the late-19th century onward.

In India, the first open air sanatorium for treatment and isolation of TB patients was founded in 1906 in Tiluania, near Ajmer, followed by one in Almora two years later. In 1909, the first non-missionary sanatorium was built near Shimla. Upon the earlier work done by Dr Louis Hart from 1908, the United Mission Tuberculosis Sanatorium (UMTS) was built in 1912 at Madanapalle, south India. Dr Frimodt Moller the first Medical Superintendent played a large role in India’s fight against TB through the training of TB workers, conducting TB surveys (1939) and introduction of BCG vaccination (1948). In addition, the first TB dispensary was opened in Bombay in 1917, followed by another in Madras. Soon anti-TB societies were formed in Lucknow and Ajmer. But currently with the advancement of health and medicine, the concept of sanatoria is not prevalent to this era.

Dispensaries and cooperative Hospitals

In India, a dispensary refers to a small setup with basic medical facilities where a doctor can provide a primary level of care. It does not have a hospitalization facility and is generally owned by a single doctor. The concept of cooperative Hospitals was first introduced India's first Co-operative Society Hospital "Shri J.G. Co-operative Hospital & Research Institute" Ghataprabha, located in Gokak taluk of Belgaum District, Karnataka, India. The hospital was established in the year 1951 with a motto of providing best quality medical treatment and care, freely to the needy poor and downtrodden.The hospital was established in the year 1951 with a motto of providing best quality medical treatment and care, freely to the needy poor and downtrodden. The hospital was grown very widely in last 64 years and become one of the best hospitals along with medical and nursing education institutions. Now the hospital is serving the people successfully.

In Kerala medical cooperatives were set up under the government patronage. However, at present the hospitals are grappling with various problems. They are facing tough competition from the public sector health services, and the emergence of private hospitals. The hospitals face numerous problems in different areas of their operations. These areas are casualty and emergency services, outpatient services, diagnostic services, nursery, pharmacy, transport, etc. The political reasons like lack of autonomy, government interference, etc. have their own significance. The vast potentiality of the health care industry in the state of Kerala is enormous. The cooperative hospitals must visualize ways to forge partnerships with government, private sector, NGO's, etc. The hospitals must constitute governing bodies which must include representatives of all sectors. In the operational areas the hospitals must develop partnerships with the private sector. The hospitals must develop comprehensive health care programmes. As Kerala is cooperatively more developed state as compared to other states, the successful cooperatives must pour in financial resources and pool expertise from all quarters to revitalize the hospitals. In the wake of increasing accessibility of the poor to the cooperatives the cooperative hospitals must strengthen their programmes focusing on rural poor. The cooperatives in Kerala in general have played an important role in poverty-alleviation in the recent times.

5.3 Hospital as a Social Organization

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

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

5.4 Functions of Hospital

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

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

Following are some of the broad categories of Hospital functions:

a. **Medical care**- which involves the treatment and management of patients through the staff of physicians.
b. **Patient Support**- which relates directly to patient care and includes nursing, dietary diagnostic, therapy, pharmacy and laboratory services.
c. **Administrative**- which concerns the execution of policies and directions of the hospital governing discharge of support services in the area of finance, personnel, materials and property, housekeeping, laundry, security, transport, engineering and board and other maintenance.

Some critical points regarding functions of hospitals

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

More over the rising costs and inconsistent quality of health care have raised significant questions among professionals, policy makers, and the public about the way health services are being delivered. For the past 50 years, medical sociologists have made significant contributions in improving our understanding of the nature and impact of the organizations (hospitals) that constitute our health care system. In this section, three central issues in the sociology of health services have been discussed:

a. Health services unequally distributed, contributing to health inequalities across status groups;
b. social institutions reproduce health care inequalities by constraining and enabling the actions of health service organizations, health care providers, and consumers;
c. The structure and dynamics of health care organizations shape the quality, effectiveness, and outcomes of health services for different groups and communities;
d. The policy implications for future health care reform efforts.

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

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

5.5 Hospital as a Community Organization

Community organization or Community Based Organization refers to organization aimed at making desired improvements to a community's social health, well-being, and overall functioning. Community organization occurs in geographically, psychosocially, culturally, spiritually, and digitally bounded communities.The United Nations in 1955 considered community organization as complementary to community development. The United Nations assumed that community development is operative in marginalized communities and community organization is operative in areas in where levels of living are relatively high and social services relatively well developed, but in where a greater degree of integration and community initiative is recognized as desirable.

The Community Organization Model is a participatory decision-making process that empowers communities to improve health. It emphasizes active participation from the community in identifying key health issues and strategies to address them. Communities focus on their strengths and collectively mobilize to develop programs to achieve health goals.Successful health promotion and disease prevention programs rely on involvement from the community. When individual community members come together to identify problems and strategies to address them, it increases the ability of the program to affect change. Other benefits of community organization include empowerment of community members, increased ownership among community members for their health, and improved social support for achieving healthy changes.

India’s healthcare delivery system is categorised into two major components - public and private. The government, i.e. public healthcare system, comprises limited secondary and tertiary care institutions in key cities and focuses on providing basic healthcare facilities in the form of primary healthcare centres (PHCs) in rural areas. The private sector provides majority of secondary, tertiary, and quaternary care institutions with major concentration in metros, tier-I and tier-II cities.

India's competitive advantage lies in its large pool of well-trained medical professionals. India is also cost competitive compared to its peers in Asia and western countries. The cost of surgery in India is about one-tenth of that in the US or Western Europe. The low cost of medical services has resulted in a rise in the country’s medical tourism, attracting patients from across the world. Moreover, India has emerged as a hub for R&D activities for international players due to its relatively low cost of clinical research.

5.6 Medical Social Service in Hospitals

Medical social work primarily focuses on supporting patients and their families in hospitals, community clinics and other health care settings by coordinating patients’ care with the larger medical team. According to occupational profile created by the National Association of Social Workers, social workers in this field play an essential role in many of the non-medical aspects of patient care, including helping patients and their families navigate the medical system, assessing and monitoring patients’ and family members’ mental and emotional health, providing short term counseling and therapy, and communicating patient needs and concerns to the larger medical team. Medical social workers work closely with patients and family members who are experiencing mental, emotional, family and/or financial stress due to their or their loved one’s medical condition. Because of the types of challenges they encounter and the fast pace of medical settings, medical social workers may find this field to be stressful and demanding. However, many medical social workers refer to the relationships they build with patients, families and the medical team, combined with the knowledge that they are helping individuals, as reasons they entered and have stayed in the field. Due to the demands of the profession, becoming a medical social worker typically requires that individuals earn a Master's in Social Work (MSW) degree from a CSWE-accredited institution. Medical social workers typically combine a strong understanding of clinical social work practices and modalities (such as psychosocial assessments, crisis interventions and psychotherapy) with knowledge of medical environments and protocols.

Medical tourism has seen increased traction where people are travelling across international borders to seek healthcare services. Activities that involve a foreign tourist travelling and staying at least one night at the destination for rejuvenating, restoring or maintaining health via medical intervention can be defined as medical tourism. Since the last decade of the 20th century, India has emerged as a global leader in the medical tourism sector. According to estimates from the Ministry of Tourism, India witnessed 186,644 Foreign Tourist Arrivals (FTAs) for medical purposes in 2020, accounting for 7% of the total FTAs. The primary reasons why people travel for medical purposes include the low cost of treatment abroad, cultural aspect of the healthcare provider, common language and specific procedures not available in the domestic country.

Over the past 30 years, India's healthcare sector has made great strides as seen by the significant advancements it has achieved. Healthcare has been one of the biggest contributors to revenue and is growing at a fast pace. Public and private providers both contribute to the healthcare sector. National health policies have played a vital role over the past few years to create a more inclusive healthcare system, while aiming to achieve a Universal Health Coverage (UHC) in a structured manner.

India has highly qualified medical professionals and state-of-the-art equipment. The medical services and facilities are backed by the World Health Organization (WHO) and the US Food and Drug Administration (US FDA). Moreover, India offers less expensive treatment options compared to the US and UK without compromising the quality of healthcare services. The treatment costs in India are around a quarter of those in America.

Summary

The Indian healthcare market is expected to reach 24 lakh crore by 2022 from 9 lakh crore in 2016 growing at a CAGR of 17.7% driven by rising incomes, greater awareness, prevalence of lifestyle diseases and increasing penetration of medical insurance. Over 55,000 hospitals and lakhs of clinics and other healthcare delivery centres constitutes the largest segment of the Healthcare Industry in India together contributing to over 68% of the industry's total revenue. The Hospital sector alone was valued at 4 lakh crore in FY17 and is expected to grow at a CAGR of 16-17% to reach 8.6 lakh crore in FY22[1]. With India having allowed 100% FDI in the hospital sector since the year 2000, the private sector has enjoyed strong capital inflows with 34,000 crores coming into the hospital and diagnostics business through FDI between April 2000 and June 2018. Access to capital continues to remain as one of the biggest roadblocks to the growth of the Indian Healthcare Sector and there is great scope for enhancing the penetration of healthcare delivery services in India.

Keywords

Hospitals, Medical tourism, Health care.

Self Assessment

1. The term hospital is defined from …………….

A. Latin word
B. German word
C. Greek word
D. Indian origin

2. The success of community health programmes relies upon the transfer of information from health professionals to the ………..using one-to-one or one-to-many communication.

A. Doctors

B. Government
C. General public
D. Politicians

3. ………… "is a process through which communities are helped to identify common problems or goals, mobilize resources, and in other ways develop and implement strategies for reaching the goals they have collectively set."

A. Community Health
B. Community Kitchen
C. Community Hall
D. Community Organizing

4. ……….are the lay members of the community who work either for pay or as volunteers in association with the local healthcare system in both urban and rural environments.

A. Community health workers
B. Government officials
C. Doctors
D. Nurses

5. ……..is a healthcare facility that provides specialized medical and nursing care as well as medical supplies to patients.

A. Hospital
B. Community Health Center
C. ICDS Center
D. Primary Health Center

6. ……..defined "hospital is an institution which is operated for the medical surgical and/or obstetrical care of in-patients and which is treated as a hospital by the Central/State Government/Local bodies or licensed by the appropriate authority".

A. WHO
B. UNESCO
C. Directory of Hospitals in India
D. RBI

7. The concept of sanatoria got popular with….., who opened a sanatorium in Sutton Coldfield in 1836

A. George Floyd
B. George Washington
C. George W. Bush
D. George Bodington

8. In India, the first open air sanatorium for treatment and isolation of TB patients was founded in ………… in Tiluania, near Ajmer.

A. 1999
B. 1900
C. 2021
D. 1906

9. …………the first Medical Superintendent played a large role in India's fight against TB through the training of TB workers, conducting TB surveys (1939) and introduction of BCG vaccination (1948).

A. Dr Frimodt Moller
B. Karina Frimodt
C. KarinaKurzawa
D. Akira Kurosawa

10. India's first Co-operative Society Hospital is ………

A. AIIMS
B. J.G. Co-operative Hospital & Research Institute
C. Apollo Hospital, Chennai
D. RCC, Kerala

.

11. India's first Co-operative Society Hospital was established in the year …

A. 1990
B. 1951
C. 1947
D. 2022

12. The cost of surgery in India is about ………of that in the US or Western Europe.

A. one-tenth
B. two third
C. one fourth
D. Not applicable

13. ………..primarily focuses on supporting patients and their families in hospitals, community clinics and other health care settings by coordinating patients' care with the larger medical team.

A. Medical social work
B. psychiatric social work
C. Gynecology
D. Physiotherapy

14. Over 55,000 hospitals and lakhs of clinics and other healthcare delivery centres constitutes the largest segment of the Healthcare Industry in India together contributing to over …..of the industry's total revenue.

A. 68%
B. 98%
C. 21%
D. 35%

15. ……is the basic health care unit for the rural Population.

A. Primary Health Center
B. Public Health Care

C. Community Health Center
D. ICDS Center

Answers for Self Assessment

1.	A	2.	B	3.	A	4.	A	5.	A
6.	C	7.	D	8.	D	9.	A	10.	C
11.	B	12.	A	13.	A	14.	A	15.	A

Review Questions

1. Define Hospitals and list out the types of hospitals in India.
2. Distinguish the differences between sanatoria and Co- operative hospital.
3. Discuss in detail about functions of hospital.
4. Hospital as a community organization. Discuss.
5. Define Medical social service in hospitals.

Further Readings

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Unit 06: Community Health

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Objectives

After completing this Unit, you shall be able to:

- To know the Concepts of disease, illness and health.
- To know what is embodiment.
- To understand Health as the process of embodiment.

Introduction

The century began with a hope and tremendous progress in the health and life expectancy of many people in the world. Infant mortality dropped, many infectious diseases have been brought under control, and better family planning became available. However, the issues related to the individual health behaviours, such as the use of tobacco, poor diet, and physical inactivity, have given rise to an unacceptable number of cases of illness and death from non-infectious diseases such as cancer and heart disease and many new as well. New and emerging infectious diseases, such as severe acute respiratory syndrome (SARS) and those caused by drug-resistant pathogens, are stretching the resources available to control them. Even with all that has happened in recent years in and around the world, the achievement of good health remains a worldwide goal of the twenty-first century. Governments, private organizations, and individuals throughout the world are working to improve health. Although individual actions to improve one's health certainly contribute to the overall health of the community, organized community actions are often necessary when health problems exceed the resources of any one individual. When such actions are not taken, the health of the entire community is at risk.

According to academia, Health is a dynamic concept that every human being desires to achieve. While health refers to the positive end of the spectrum; illness, sickness and disease symbolise the negative side of the spectrum. To protect, promote, and restore the health of individuals and populations, an integrated discipline of public health or community health came into existence. Public health has evolved in India since independence and we have achieved success in terms of improvement of various morbidity and mortality indicators. But over the years, the remarkable development of health followed by indicators are identified and were milestones in various periods before independence, soon after independence and through successive Five-Year Plans, Health became the most important objective of the country. These developments have been under the influence of changing political, and socio-economic conditions, scientific advancements, medical services and technology. In this chapter, the learner will get an overall idea about community health followed by Primary Health Centers. How both these organizations are functioning. Also gives a glimpse into the Community health problems in India, and various concepts of integrated health service. Along with these, the implementation and utilization of health programmes in rural and urban communities are also discussed.

6.1 Meaning of Community Health

Community health refers to the health status of a defined group of people and the actions and conditions, both private and public (governmental), to promote, protect, and preserve their health, Whereas Public health refers to the health status of a defined group of people and the governmental actions and conditions to promote, protect, and preserve their health. Community health is a major field of study within the medical and clinical sciences which focuses on the maintenance, protection and improvement of the health status of population groups and communities as opposed to the health of individual patients. It is a discipline which concerns itself with the study and improvement of the health characteristics of biological communities. While the term community can be broadly defined, community health tends to focus on geographical areas rather than people with shared characteristics. Community health may be studied within three broad categories

a) ***Primary Health care*** refers to interventions that focus on the individual or family such as hand-washing, immunization, circumcision, personal dietary choices, and lifestyle improvement.

b) ***Secondary health care***: it refers to those activities which focus on the environment such as draining puddles of water near the house, clearing bushes, and spraying insecticides to control vectors like mosquitoes.

c) ***Tertiary Health care***: refers to those interventions that take place in a hospital setting, such as intravenous rehydration or surgery.

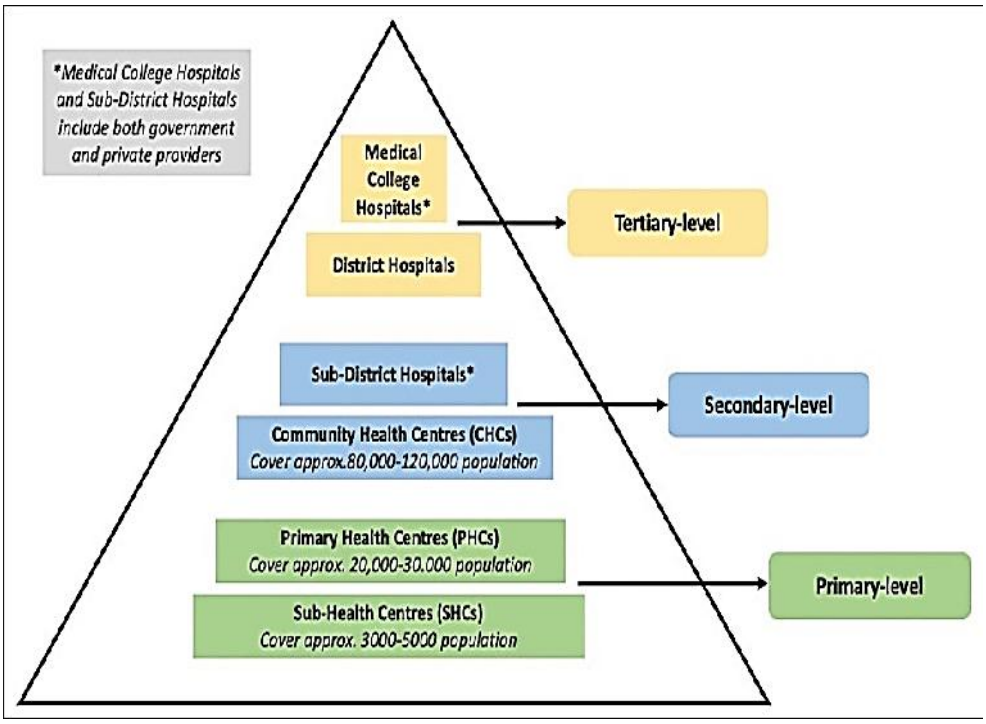

Fig. Fig. 6 (1)

Structure of the Indian public healthcare system based on Indian Public
Health Standard Norms.

The success of community health programmes relies upon the transfer of information from health professionals to the general public using one-to-one or one-to-many communication (mass communication).

Community Health versus Personal Health

It is important to distinguish between the terms personal health and community health activities. Personal health activities are individual actions and decision-making that affect the health of an individual or his or her immediate family members. These activities may be preventive or curative but seldom directly affect the behaviour of others. Choosing to eat wisely, regularly wearing a safety belt, and visiting the physician are all examples of personal health activities. But, Community Health activities are those activities that are aimed at protecting or improving the health of a population or community. Maintenance of accurate birth and death records, protection of the food and water supply, and participation in fund drives for voluntary health organizations etc. are examples of Community Health activities.

Factors That Affect the Health of a Community

There are a great many factors that affect the health of a community. As a result, the health status of each community is different. These factors may be physical, social, and/or cultural. They also include the ability of the community to organize and work together as a whole as well as the individual behaviours of those in the community (see Figure 6.1).

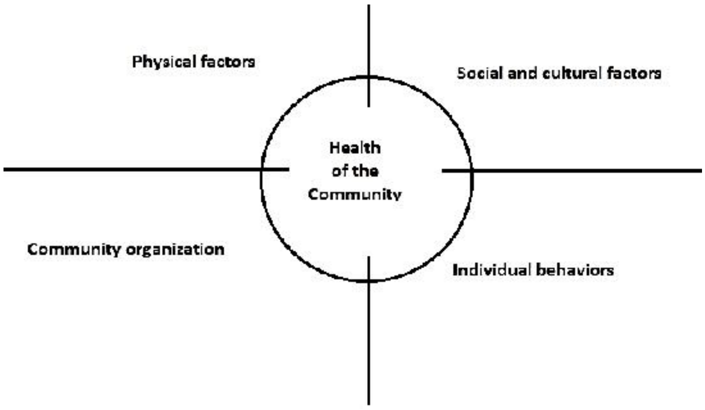

Fig. 6 (2)

Factors That Affect the Health of a Community

a) **Physical factors**: It include the influences of geography, the environment, community size, and industrial development.
   i. **Geography**: A community's health problems can be directly influenced by its altitude, latitude, and climate. In tropical countries where warm, humid temperatures and rain prevail throughout the year, parasitic and infectious diseases are a leading community health problem.
   ii. **Environment:** The quality of our environment is directly related to the quality of our stewardship over it. Many experts believe that if we continue to allow uncontrolled population growth and continue to deplete nonrenewable natural resources, succeeding generations will inhabit communities that are less desirable than ours. Many feel that we must accept responsibility for this stewardship and drastically reduce the rate at which we foul the soil, water, and air.
   iii. **Community Size**: The larger the community, the greater its range of health problems and the greater its number of health resources. For example, larger communities have more health professionals and better health facilities than smaller communities. These resources are often needed because communicable

diseases can spread more quickly and environmental problems are often more severe in densely populated areas. For example, the amount of trash generated in Mumbai cities and the effects of that is directly or indirectly affecting the slums like Dharavi, where with lack of sanitation and clean drinking water for many residents and this pollution and disease are common from the open sewers - there are an average of 4,000 cases of typhoid and diphtheria each day. Thus, It is important to note that a community's size can impact both positively and negatively on that community's health. The ability of a community to effectively plan, organize, and utilize its resources can determine whether its size can be used to good advantage.

iv. **Industrial Development:** like size, can have either positive or negative effects on the health status of a community. Industrial development provides a community with added resources for community health programs, but it may bring with it environmental pollution and occupational illnesses. Communities that experience rapid industrial development must eventually regulate how industries (1) obtain raw materials, (2) discharge by-products, (3) dispose of wastes, (4) treat and protect their employees, and (5) clean up environmental accidents. Unfortunately, many of these laws are usually passed only after these communities have suffered significant reductions in the quality of their life and health.

b) Social and Cultural Factors

Social factors are those that arise from the interaction of individuals or groups within the community. For example, people who live in urban communities, where life is fast-paced, experience higher rates of stress-related illnesses than those who live in rural communities, where life is more leisurely. On the other hand, those in rural areas may not have access to the same quality or selection of health care (i.e., providers, hospitals, or medical specialists) that is available to those who live in urban communities.Cultural factors arise from guidelines (both explicit and implicit) that individuals "inherit" from being a part of a particular society. Culture "teaches us what to fear, what to respect, what to value, and what to regard as relevant in our lives." Some of the factors that contribute to culture are discussed in the following sections

i. **Beliefs, Traditions, and Prejudices** - The beliefs, traditions, and prejudices of community members can affect the health of the community. The beliefs of those in a community about such specific health behaviours as exercise and smoking can influence policymakers on whether or not they will spend money on bike trails and no-smoking ordinances. The traditions of specific ethnic groups can influence the types of food, restaurants, retail outlets, and services available in a community. Prejudices of one specific ethnic or racial group against another can result in acts of violence and crime. Racial and ethnic disparities will continue to put certain groups, such as black Americans or certain religious groups, at greater risk.

ii. **Economy**- Both national and local economies can affect the health of a community through reductions in health and social services. An economic downturn means lower tax revenues (fewer tax dollars) and fewer contributions to charitable groups. Such actions will result in fewer dollars being available for programs such as welfare, food stamps, community health care, and other community services. This occurs because revenue shortfalls cause agencies to experience budget cuts. With less money, these agencies often must alter their eligibility guidelines, thereby restricting aid to only the neediest individuals. Many people who had been eligible for assistance before the economic downturn become ineligible.Employers usually find it increasingly difficult to provide health benefits for their employees as their income drops. The unemployed and underemployed face poverty and deteriorating health. Thus, the cumulative effect of an economic downturn significantly affects the health of the community.

iii. **Politics-**Those who happen to be in political office, either nationally or locally, can improve or jeopardize the health of their community by the decisions they make. In the most general terms, the argument is over greater or lesser governmental participation in health issues. For example, In Independent India, with the introduction of five-year plans, the respective governments who are under the rule can introduce and implement various Health programmes for the needy in their yearly budget allocations. But, at the same time, the local politicians also influence the health of their communities each time they vote on health-related measures brought before them.

iv. **Religion**- Several religions have taken a position on health care. For example, some religious communities limit the type of medical treatment their members may receive. Some do not permit immunizations; others do not permit their members to be treated by physicians. Still, others prohibit certain foods. For example, certain communities of Hindu believers avoid the usage of non-vegetarian food, along with the exclusion of dairy products, garlic and Onion creating an imbalance in a balanced diet other than regulations permit Muslims to eat Non-Vegetarian foods But due to the notion of Halaal Practices make the intake of meat depends upon the availability of Halaal meat from a believable source. Here the Muslims consider Halaal as a sacrament. In Hinduism, menstruation and menstrual blood are considered impure and that taboo creates lots of unhealthy treatments and infections for women during their period's days. Some religious communities actively address moral and ethical issues such as abortion, premarital intercourse, and homosexuality. Still, other religions teach health-promoting codes of living to their members. Religion can affect a community's health positively or negatively.

v. **Social Norms-**The influence of social norms can be positive or negative and can change over time. In India, The Smoking cigarette was a symbol of Elite/ intellectual status during the early 1970's to late 2000 but due to the increasing respiratory cases and alarming situations of cancer made the government to ban the pubic smoking from 2 October 2008 under the Prohibition of Smoking in Public Places Rules, 2008 and COTPA. This created the various regulations to the availability and purchase and usage of cigarette. Similarly the usage of contraceptive methods was not much appreciated in the Indian society as they considers Birth control is taboo and 'God decides when children are conceived' but with the shocking situation of population growth and increasing fertility ratio followed by infant mortality, deficiency in malnutrition, maternal deaths. The ministry of Health and family welfare has introduced the various awareness programmes of usage and importance of Contraceptive methods both husband and wife.

vi. **Socioeconomic Status (SES)-** "In South Asian countries, especially developing countries like India, Bangladesh, Pakistan, Nepal, etc. the gap in health status and mortality between those commanding, and those who lack, economic power and social resources continue to widen. These parallel trends—of growing economic inequalities and growing social inequalities in health—reflect, in part, the relationship between people's socioeconomic position as consumers and employers or employees and their social, biological, and mental well-being." That is, those in the community with the lowest socioeconomic status also have the poorest health and the most difficulty in gaining access to health care. The point of entry into the health care system is for accessibility to private doctors, but those who are economically disadvantaged seldom approach these high-paid doctors. For people like them, In addition to healthcare access, higher incomes enable people to afford better housing, live in safer neighborhoods, and increase the opportunity to engage in health-promoting behaviours.

c) Community Organizing-

The way in which a community can organize its resources directly influences its ability to intervene and solve problems, including health problems. Community organizing "is a process through which communities are helped to identify common problems or goals, mobilize resources, and in other ways develop and implement strategies for reaching the goals they have collectively set." It is not a science but an art of building consensus within a democratic process. If a community can organize its resources effectively into a unified force, it "is likely to produce benefits in the form of increased effectiveness and productivity by reducing duplication of efforts and avoiding the imposition of solutions that are not congruent with the local culture and needs."

d) Individual Behavior

The behaviour of the individual community members contributes to the health of the entire community. It takes the concerted effort of many—if not most—of the individuals in a community to make a program work. For example, if each individual consciously recycles his or her trash each week, community recycling will be successful. Likewise, if each occupant would wear a safety belt, there could be a significant reduction in the number of facial injuries and deaths from car crashes for the entire community. In another example, the more individuals who become immunized against a specific disease, the slower the disease will spread and the fewer people will be exposed. This concept is known as herd immunity.

Community health workers (CHWs)

WHO states "Community health workers (CHWs) are health care providers who live in the community they serve and receive lower levels of formal education and training than professional health care workers such as nurses and doctors. This human resource group has enormous potential to extend health care services to vulnerable populations, such as communities living in remote areas and historically marginalized people, to meet unmet health needs in a culturally appropriate manner, improve access to services, address inequities in health status and improve health system performance and efficiency". They are lay members of the community who work either for pay or as volunteers in association with the local healthcare system in both urban and rural environments. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, help people get the care they need, give informal counselling and guidance on health behaviours, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening.

6.2 The organisation and Function of Community Health

The Community Health Centre (CHC), the third tier of the network of rural health care institutions, was required to act primarily as a referral centre (for the neighbouring PHCs, usually 4 in number) for the patients requiring specialised health care services. The objective of having a referral centre for the primary health care institutions was two-fold; to make modern health care services accessible to the rural people and to ease the overcrowding in the district hospitals. The CHCs were accordingly designed to be equipped with four specialists in the areas of medicine, surgery, paediatrics and gynaecology; 30 beds for indoor patients; operation theatre, labour room, X-ray machine, pathological laboratory, standby generator, etc., along with the complementary medical and paramedical staff.

At the instance of the Planning Commission, the Programme Evaluation Organisation undertook the study to evaluate the functioning of the Community Health Centres (CHCs) and their effectiveness in bringing specialised healthcare services within the reach of rural people. Both secondary and primary data were required to be analysed to test and the major part of the data which is required for the study, was generated through a sample survey of 62 PHCs and 31

CHCs spread over the 16 sample districts of eight states selected for the study. The findings of the Study are as follows:

a. Given the other relevant factors, the services of a CHC are likely to be used less intensively, if: (i) its geographical coverage is very large; (ii) it has inadequate medical staff, particularly the specialists; and (iii) the mean distance of the PHCs from the CHC is longer.
b. Some CHCs have been approved without sanctioning all the posts of specialists. Only 30 per cent of the required posts of the specialists were found to be in position. More than 70 per cent of the sample CHCs are running either with one specialist or without any specialist.
c. There is a mismatch between the medical specialists's vis-a-vis types of equipment/facilities/ staff, leading to sub-optimal utilisation of resources. The overall productivity of public health services can substantially be improved if this mismatch as well as the thin spread of resources is avoided.
d. Only two out of 31 CHCs were found to have been used as referral centres to some extent. As many as 11 CHCs have not attended any referral case, while the remaining 18 have been used sub-optimally with an average of 206 cases per year. The constraints to the utilisation of the services of CHCs relate to inadequacies of infrastructure, medical and paramedical staff, and more importantly, the mismatch of various inputs.
e. Notwithstanding the existing limitations in the services delivery system, a large majority of the households expressed their strong preference for the public health care system as against the private facilities.

The findings tend to suggest that CHCs have not made any significant contributions towards the realisation of the intended objectives even after about two decades of their establishment. The study has been able to identify a set of key factors that have contributed to the poor performance of CHCs. It is hoped that the findings of the study will be useful to the planning/ implementing agencies in introducing the necessary corrective steps for improving the services delivery system. The study was designed and conducted under the direction of Shri Amar Singh, Deputy Adviser (PEO).

6.3 Primary Health Centres & their Organization and Functioning

Primary Health Centres are the cornerstone of rural health services- the first port of call to a qualified doctor of the public sector in rural areas for the sick and those who directly report or are referred from Sub-centres for curative, preventive and promotive health care. The concept of a Primary Health Centre (PHC) had its foundation with the Bhore Committee in 1946 gave the concept of a PHC as a basic health unit to provide as close to the people as possible, an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. The health planners in India have visualized the PHC and its Sub-Centres (SCs) as the proper infrastructure to provide health services to the rural population. The Central Council of Health its first meeting held in January 1953 had recommended the establishment of PHCs in community development blocks to provide comprehensive health care to the rural population. These centres were functioning as peripheral health service institutions with little or no community involvement. Increasingly, these centres came under criticism, as they were not able to provide adequate health coverage, partly, because they were poorly staffed and equipped and lacked basic amenities.

The 6th Five year Plan (1983-88) proposed the reorganization of PHCs based on one PHC for every 30,000 rural populations in the plains and one PHC for every 20,000 populations in hilly, tribal and desert areas for more effective coverage. However, as the population density in the country is not uniform, the number of PHCs would depend upon the caseloads. PHCs should become functional round the clock with the provision of 24 × 7 nursing facilities. Selected PHCs, especially in large blocks where the CHC is over one hour of journey time away, may be upgraded to provide 24-hour emergency hospital care for several conditions by increasing the number of Medical Officers; preferably such PHCs should have the same IPHS norms as for a CHC. 23673 PHCs are functioning in the country as on March 2010 as per Rural Health Statistics Bulletin, 2010. The number of PHCs functioning on a 24x7 basis is 9107and the number of PHCs where three staff Nurses have been posted is 7629 (as of 31-3-2011). It acts as a referral unit for 6 Sub-Centres and refers out cases to Community Health Centres (CHCs-30 bedded hospitals) and higher-order public hospitals at sub-district and district hospitals. It has 4-6 indoor beds for patients.

PHCs are not spared from issues such as the inability to perform up to the expectation due to (i) non-availability of doctors at PHCs; (ii) even if posted, doctors do not stay at the PHC HQ; (iii) inadequate physical infrastructure and facilities; (iv) insufficient quantities of drugs; (v) lack of accountability to the public and lack of community participation; (vi) lack of set standards for monitoring quality care etc. Standards are a means of describing the level of quality that healthcare organizations are expected to meet or aspire to. The key aim of these standards is to underpin the delivery of quality services which are fair and responsive to clients' needs, provided equitably and deliver improvements in the health and well-being of the population. Standards are the main driver for continuous 4 Indian Public Health Standards (IPHS) Guidelines for Primary Health Centres improvements in quality. The performance of healthcare delivery organizations can be assessed against standards. The National Rural Health Mission (NRHM) has provided the opportunity to set Indian Public Health Standards (IPHS) for Health Centres functioning in rural areas. In order to provide an optimal level of quality health care, a set of standards called the Indian Public Health Standards (IPHS) was recommended for Primary Health Centre (PHC) in early 2007. The nomenclature of a PHC varies from State to State that includes a Block level PHC (located at block HQ and covering about 100,000 population and with the varying number of indoor beds) and additional PHCs/New PHCs covering a population of 20,000-30,000 etc. Regarding the block-level PHCs, it is expected that they are ultimately going to be upgraded as Community Health Centres with 30 beds for providing specialized services. Setting standards is a dynamic process.

Currently, the IPHS for Primary Health Centres has been revised keeping in view the resources available with respect to a functional requirement for PHCs having 6 beds with minimum standards such as building manpower, instruments, equipment, drugs and other facilities etc. The revised IPHS has incorporated the changed protocols of the existing health programmes and new programmes and initiatives, especially in respect of Noncommunicable diseases. It is desirable that on the basis of essential services, State/UT should issue the Government notification for minimum mandate standard for services at PHC.

6.4 Community Health Problems in India

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

Under the Constitution, health is a state subject. Central Government can intervene to assist the state governments in the area of control/eradication of major communicable and non- communicable diseases, broad policy formulation, medical and Para- medical education combined with regulatory measures, drug control and prevention of food adulteration, Child Survival and Safe Motherhood (CSSM) and immunization programme. However, there are numerous health problems in India, like water supply and sanitation continue to be a challenge, and only one of the three Indians has access to improved sanitation facilities such as the toilet. India's HIV/AIDS epidemic is a growing threat. Cholera epidemics are not unknown. Maternal mortality in India is the second highest in the world. India is one of the four countries worldwide where polio has not yet been successfully eradicated and one-third of the world's tuberculosis cases are in India. Three out of four children who died from measles in 2008 were in India. According to the World Health Organization, 900,000 Indians die each year from drinking contaminated water and breathing in polluted air.Following are some of the major community health problems in India.

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

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

c. **Diseases**-Diseases such as dengue fever, hepatitis, tuberculosis, malaria and pneumonia continue to plague India due to increased resistance to drugs. In 2011, India developed a drug- resistant form of tuberculosis. India is ranked 3rd highest among countries with the amount of HIV- infected patients. Diarrheal diseases are the primary causes of early childhood mortality. These diseases can be attributed to poor sanitation and inadequate safe drinking water in India. India also has the world's highest incidence of Rabies.However, in 2012 India was polio- free for the first time in its history. This was achieved because of the Pulse Polio Programme started in 1995- 96 by the government of India. Indians are also at particularly high risk for atherosclerosis and coronary artery disease. This may be attributed to a genetic predisposition to metabolic syndrome and adverse changes in coronary artery vasodilatation. NGOs such as the Indian Heart Association and the Med win Foundation have been created to raise awareness of this public health issue.

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

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

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

Other than the above mentioned, the Community Health give a serious attention to Female health issues with special focus. And it is noted that the health situations of women in India is poor when compare to the total health situation of India. To provide a balanced health status and also the eradication of the health issues of women became the government's highest priorities over the time. Here follows some of the issues faces by women folk in India.

a) **Malnutrition:** Most Indian women are malnourished. The average female life expectancy today in India is low compared to many countries. In many families, especially rural ones, the girls and women face nutritional discrimination within the family and are anemic and malnourished. The main cause of female malnutrition in India is the tradition of requiring women to eat last, even during pregnancy and when they are lactating.
b) **Breast Cancer:** One of the most severe and increasing problems among women in India, resulting in higher mortality rates.
c) **Polycystic ovarian disease (PCO**D): PCOD increases the infertility rate in females. This condition causes many small cysts to form in the ovaries, which can negatively affect a woman's ability to conceive.
d) **Maternal Mortality:** maternal mortality in India is the second highest in the world. Only 42% of births in the country are supervised by health professionals. Most women deliver with help from women in the family who often lack the skills and resources to save the mother's life if it is in danger. According to UNDP Human Development Report, 88% of pregnant women (15- 49) were found to be suffering from anaemia.

Recent reports of healthcare reforms in India have reinforced the view that India's current healthcare system is not sustainable for its 1.25 billion population. An estimated 600 million people in India, many in rural locations, have little or no access to healthcare. India faces a critical shortage of trained health professionals such as doctors, nurses, and allied healthcare workers. The government has announced a new health policy that focuses on reducing malnutrition, improving the use of essential medicines, expanding immunization, modernizing public hospitals, and instituting a better tobacco control program. The government is also considering a holistic healthcare system that is universally accessible, and affordable, and dramatically reduces out-of-pocket health expenditures.

The key to delivering good healthcare in rural areas without compromising quality is the biggest challenge. The majority of our modern medical fraternity and tertiary health facilities are concentrated in urban areas, which are often overcrowded with patients and healthcare workers alike. The solution lies in ensuring a uniform health force in all areas.

6.5 Concept of Integrated Health Service

Integrated health systems, according to the World Health Organization in 2017, are "the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money." This is a very important concept in today's day and age, as access to healthcare has become a challenge and the population has never been sicker.The primary focus of integrated health systems is to provide seamless care or coordinated care for patients and their families. The theory is that it will lead to a higher quality of care as well as better health outcomes for patients by making sure a patient transitions appropriately through the healthcare system.There are many forms of integration: it may refer to a package of preventive and curative health Integration is best seen as a continuum rather than as two extremes of integrated/not integrated. The idea of integrated health services is not new; indeed it was the basis for the focus on primary health care in the 1980s, which not only envisaged essential health care under one roof but also integrated health into other sectors like water and sanitation.

Integrated health care is important in the contemporary health system for many reasons. As funding for single-disease or population-group-specific programs, such as HIV/AIDS, TB, and malaria and polio eradication might not be sustainable, integrated health service delivery could be an answer to the "horizontalization" of vertical single-disease programs. This will increase the efficiency of the health system; more so when health services constantly face human resource constraints. Integrated health care service will be convenient to the people as they receive multiple services at one place or a continuum of services through referral. In the current scenario of economic downturn, integration could be an answer to "do more with less".

Thus we can summarise the main characteristics of health care can be summarised as follows:

- Appropriateness (relevance) i.e. whether the service is needed at all in relation to essential human needs.
- Comprehensiveness i.e. whether there is an optimum mix of preventive, curative and promotional services.
- Adequacy i.e. if the service is proportionate to the requirements like doctor patient ratio.
- Availability i.e. ratio between the population and the health facility
- Accessibility i.e. geographic, economic and cultural accessibility
- Affordability i.e. expenses involved in availing the health care services.

National Programmes have the following features in common: Targeting one disease — usually national health programme is shaped to target one disease. For example, National Malaria Programme focused specifically on malaria. Vertical in nature — i.e. each national programme has a separate workforce, fund allocation and research institutes etc., and the programme is usually not integrated with the general health system. However, under the aegis of the National Health Mission (NHM) almost all the national programmes are integrated with the general national health services. The impact of National Health Programmes is constantly monitored through surveillance mechanisms. This is to check the impact on the disease burden. They focus on both preventive and curative aspects. The programme will have both curative and preventive elements integrated into the system.

Scope for integrated service delivery in national health programs in India

The public health system in India is synonymous with National Rural Health Mission (NRHM), which primarily provides reproductive and child health (RCH) services. For more than two decades the National AIDS Control Organization has been providing HIV/AIDS services at the district level below which is primarily through the NRHM. In the fourth phase of the program (2012-17) there is a plan for the gradual integration of the two long-standing separate programs i.e., the National AIDS Control Program and NRHM. With the increased prevalence of obesity and a risk factor for NCDs, it is time to integrate primary health care with NCDs, both at the facility and community levels. There should be integrated patient management, integrated counselling, integrated laboratory investigations and integrated management information system. Similarly, instead of multiple large-scale population-based surveys like National Family Health Survey, District Level Household Survey, HIV Sentinel Surveillance survey, Integrated Behavioural and Biological Surveillance and Diabetes survey, there could be an integrated health survey to capture Reproductive and Child Health, Communicable and NCD information.

6.6 Implementation and utilization of health programmes in rural and urban communities

The bidirectional relationship between economic development and health justifies greater investment in the health sector. The National Rural Health Mission (NRHM) has been described as one of the largest and most ambitious programmes to revive health care in the world and has many achievements to its credit. It seeks to provide universal access to health care, which is affordable, equitable, and of good quality. It has increased health finance, improved infrastructure for health delivery, established institutional standards, trained health care staff and provided technical support. It has facilitated financial management, assisted in the computerisation of health data, suggested centralised procurement of drugs, equipment and supplies, mandated the formation of village health and hospital committees and community monitoring of services. It has revived and revitalised a neglected public health care delivery system.

- **Challenges and solutions**: The NRHM has injected new hope into the healthcare delivery system in India. However, it continues to face diverse challenges, which need to be addressed if its goals are to be achieved shortly.
- **Health as a State subject**: The location of health in the State list rather than the concurrent list poses major problems for service delivery. This is also compounded by the fact that the NRHM funding is from the Centre while the implementation is by the State governments. Healthcare delivery cannot be improved to provide a seamless service without the removal of these barriers.
- **Project mode and problems**: The NRHM is currently functioning as a project of the Government of India and is due to end in 2012. Its significant contribution to improving health care infrastructure and service delivery across the country will be frittered away if it's funding ceases with the 11th Five Year Plan (FYP). The NRHM should be not only included in the 12th FYP but also be changed from its limited-term project mode to a permanent solution to India's health problems.Its status as a project makes the integration of the NRHM with the State health care systems problematic. The divisions run deep resulting in an irrational distribution of human resources and infrastructure. The inertia of the old system and the low morale and discipline of its staff continue to be major challenges. The NRHM has been able to add new infrastructure and personnel; however, its impact on re-inventing and re-invigorating systems seems to be limited, with much more effort being required. There is a need for a more coordinated approach which optimally utilises resources.
- **Improving governance**: A comparison of data between States and within regions and social groups suggests marked variations in the NRHM process indicators, utilisation of funds, improvements in health care delivery, health indices and in community participation. Regions with prior good health indices have shown marked improvements, while those with prior poor indices have recorded much less change. This is true, despite a greater NRHM focus on and inputs to poor-performance States. Improving governance and stewardship within the NRHM programmes mandates general improvement in the overall governance of States and regions.
- **Increased funding**: Health care costs for the average Indian usually results in catastrophic out-of-pocket expenditure and is a well-recognised cause of indebtedness in the country. The total health budget for India is about 1 per cent of the country's GDP. Most developed nations prioritise health care and provide 5-10 per cent of their GDP. The 12th FYP should increase funding for health to the tune of 2-3 per cent as promised by the United Progressive Alliance.The diversion of funds, through private health insurance schemes for the care of rare disorders to be treated in corporate hospitals, takes away funding from the public health care system. The injection of such money into the public system would allow for the provision of universal health care, improve government health systems and provide for common health conditions benefiting larger numbers.

- **Urban health**: The NRHM has focussed on rural health. Many parts of urban India have similar healthcare needs and currently have glaring deficiencies. The National Urban Health Mission should be accorded the same status as the NRHM. Both efforts should be coordinated and combined into a National Health Mission.
- **Expand focus**: The major focus of NRHM is on maternal and child health. While this is vital, there is a need to expand the vision to other common general health problems. There is evidence to suggest that other crucial government programmes (e.g. blindness) have taken a back seat.
- **Cash transfers and outcome:** The NRHM currently employs process indicators to measure its implementation. The measures used are mainly related to finance, infrastructure and personnel. There is a need to shift over to indicators of efficient functioning and examine their impact on health outcomes. The initial high rates of mortality tend to reduce rapidly with early inputs but require fully functional, efficient and effective systems for sustained results. The Janani Suraksha Yojana, a conditional cash transfer scheme to incentivise the use of health services to reduce maternal and neonatal mortality among poor women, has become a success by encouraging institutional deliveries. However, the evaluation of its success should be based on its impact on the health outcome of the mother and baby, rather than on financial process indicators.Similarly, the diverse and difficult circumstances of medical practice across the country mandate a differential reinforcement for health professionals. There is a need for differential payments to healthcare staff who work in remote situations and difficult contexts.
- **Health information and monitoring**: The NRHM has provided infrastructure, personnel and training for Health Management Information Systems. However, these are not optimally utilised. There is a need to improve the information system as part of the process of monitoring the health indices of populations and the functioning of the public health care system. The NRHM already has a programme of community monitoring and social audit. This should be strengthened to monitor the use of funds and empower local communities.
- **Social determinants and public health approach:** The goals of the NRHM clearly state the need to impact the social determinants of health by coordinating efforts to provide clean water, sanitation, nutrition, housing, education and employment. It should, in conjunction with other government programmes, work towards the reduction of poverty, social exclusion and gender discrimination, all of which have a significant impact on health. There is a need to increase the synergy and coordination between government programmes (e.g. the Integrated Child Development Scheme, the Mahatma Gandhi National Rural Employment Guarantee Act, etc.) and the NRHM.

Summary

Health care delivery in India has been envisaged at three levels namely primary, secondary and tertiary. The secondary level of health care essentially includes Community Health Centres (CHCs), constituting the First Referral Units (FRUs) and the Sub-district and District Hospitals. The CHCs were designed to provide referral health care for cases from the Primary Health Centres level and for cases in need of specialist care approaching the centre directly.A community health centre is a not-for-profit, consumer directed healthcare organization that provides access to high quality, affordable, and comprehensive primary and preventive medical, dental, and mental health care.CHCs are being established and maintained by the State government under MNP/BMS programme. As per minimum norms, a CHC is required to be manned by four medical specialists i.e. surgeon, physician, gynaecologist and paediatrician supported by 21 paramedical and other staff. Whereas the Primary Health Centres that are state-owned healthcare facilities at either urban or rural levels. These centres will provide comprehensive health care, covering around 70% of out-patient care, including noncommunicable diseases and maternal and child health services. These centres will also provide free essential drugs and diagnostic services as well as referral access to secondary and tertiary health care. But compared to these integrated health services, based on strong primary care and public health functions, directly contribute to a better distribution of health outcomes and enhanced well-being and quality of life, which in turn bring important economic, social and individual benefits.

Keywords

Community Health, Community health Workers, Primary Health Centres, Integrated Health System.

Self Assessment

1. ………..refers to the health status of a defined group of people and the actions and conditions, both private and public (governmental), to promote, protect, and preserve their health.

A. Public Health
B. Mental Health
C. Community Health
D. Maternal Health

2. ……….refers to the health status of a defined group of people and the governmental actions and conditions to promote, protect, and preserve their health.

A. Maternity Health
B. Social Health
C. Community Health
D. Public health

3. Community health is a major field of study within the …………which focuses on the maintenance, protection and improvement of the health status of population groups and communities as opposed to the health of individual patients.

A. Engineering
B. Medical sciences
C. Sport
D. Aeronautical

4. ……….may be studied within three broad categories they are Primary health, Secondary health, and tertiary health.

A. Community health
B. Maternity Health
C. Social Health
D. Animal Health

5. The success of community health programmes relies upon the transfer of information from health professionals to the ………..using one-to-one or one-to-many communication.

A. Doctors
B. Government
C. General public
D. Politicians

6. ………… "is a process through which communities are helped to identify common problems or goals, mobilize resources, and in other ways develop and implement strategies for reaching the goals they have collectively set."

A. Community Health
B. Community Kitchen
C. Community Hall
D. Community Organizing

7. ……….are the lay members of the community who work either for pay or as volunteers in association with the local healthcare system in both urban and rural environments.

A. Community health workers
B. Government officials
C. Doctors
D. Nurses

8. The expansion of CHW is ………..

A. Customer Health Wizard
B. Community health workers
C. Customer Healing Work
D. Community Holding work

9. …… conducted a study to evaluate the functioning of the Community Health Centres (CHCs) and their effectiveness.

A. World Health organisation
B. ICMR
C. Programme Evaluation Organisation
D. Planning Commission

10. The concept of a Primary Health Centre (PHC) had its foundation with …….in 1946

A. Bhore Committee
B. Kothari Commission
C. Mandal Commission
D. Simon Commission

11. ……is the basic health care unit for the rural Population.

A. Primary Health Center
B. Public Health Care
C. Community Health Center
D. ICDS Center

12. ……Works as an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care.

A. Community Health Center
B. Anganwadi
C. Medical College
D. Primary Health Center

13. ……….provide seamless care or coordinated care for patients and their families.

A. Public health

B. Integrated health systems
C. Child health
D. Maternal Health

14. The NRHM has focused on ……..
A. Rural health
B. Adult health
C. Mental health
D. Child health

15. The expansion of NRHM
A. National Road Health Mission
B. Nation Rural Healing Mission
C. National Rural Health Mission
D. National Risk Health Mission

Answers for SelfAssessment

1.	C	2.	D	3.	B	4.	A	5.	C
6.	D	7.	A	8.	B	9.	C	10.	A
11.	A	12.	D	13.	B	14.	A	15.	C

Review Questions

1. Distinguish the differences between Public health and Community health.
2. What are the factors that affect the community Health?
3. Distinguish the differences between Community Health Centers and Primary Health Centers.
4. Discuss in detail about the Community health problems in India
5. Define Integrated health systems and state its significance?

Further Readings

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Unit 07: Sociology of Risk

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Introduction

The notion of risk is something we are all aware of in our everyday lives. It could mean a different thing for different people. It is also associated with ‘chance ‘or ‘probability ‘or 'danger‘. People take a ‘chance ‘in the hope of achieving something bigger and better. It could also mean ‘probability ‘in the sense of uncertainty, over a certain outcome. The risk could also mean unforeseen ‘danger‘– possible loss of life and property – due to unfavourable circumstances. If uncertainty is the outer dimension of risk, vulnerability is the inner dimension of risk. As a social phenomenon, sociologists are interested in how the notion of risk is embedded in our culture and history and how it continues to shape our civilization. In trying to understand the risk associated with the techno-scientific world, sociologists look at risk within the framework of modernity. In this regard, the contribution of Ulrich Beck and Anthony Giddens is of seminal importance.

7.1 Concept of Risk

In simple terms, **risk** is the possibility of something bad happening. Risk involves uncertainty about the effects/implications of activity concerning something that humans value (such as health, well-being, wealth, property or the environment), often focusing on negative, undesirable consequences. Many different definitions have been proposed. The international standard definition of risk for common understanding in different applications is the “effect of uncertainty on objectives”. Risk is the probability of an outcome having a negative effect on people, systems or assets. Risk is typically depicted as being a function of the combined effects of hazards, the assets or people exposed to the hazard and the vulnerability of those exposed elements. The understanding of risk, the methods of assessment and management, the descriptions of risk and even the definitions of risk differ in different practice areas (business, economics, environment, finance, information technology, health, insurance, safety, security etc.). The international standard for risk management, ISO 31000, provides principles and generic guidelines on managing risks faced by organizations. According to the International Organisation for Standardization (ISO), risk would be defined as a "combination of the probability of an event and its consequences". Consequently, a potentially dangerous event, the hazard, is not transformed into risk only if it applies to a zone where human, economic or environmental stakes are presence and this zone has a certain degree of vulnerability.

The emergence of risk has been much of interest to scholars of the sociology of risk. Sociologists are interested in finding out how risk has become a part of our history and culture. Scholars like Peter Taylor-Gooby and Jens O. Zinn in their work Risk in Social Science (2006) traced the origin of risk in history and how it entered the vocabulary of everyday language. By tracing its origin and evolution in history, the authors gave us a picture of how risk is integral to our history and culture – right from the beginning of mercantile capitalism to contemporary global capitalism. It also tells us the pervasive influence of risk and risk analysis as a tool in different fields of study ranging from the study of epidemiology to the study of crime. This work also put into sharp contrast the risk of everyday living and the risk born out of modern institutions; of science, business and politics.

The origin of the notion of risk has been under much debate. One scholar observes that it is derived from the Arabic ―risq" (i.e. ―something from which you draw profit"). Another scholar points out the Latin ―riscum" (an expression that describes the ―challenge of barrier reef to sailors"). In the mid-sixteenth century, the Germans used the same term. However, scholars like Anthony Giddens suggested that it might have come from the Spanish ―risco" (which means ―a rock"). Risk, therefore, seems to have emerged in the context of exploring sea voyages and medieval mercantilism. It refers to the uncertainty of the outcome of a sea-faring voyage. It is such uncertainty that led to the emergence of the concept of insurance, which gradually entered the world of money lending and finance. Insurance, in the earlier form, was based on experience and personal judgment.

By the eighteenth century, the mathematics of probability was developed and applied to risk issues. With the application of probability and economics in risk, it began to affect investment decisions and market behaviour. It was in the eighteenth century that insurance in trade and finance was also extended to life insurance. Initially, insurance started in the form of shared insurance and friendly societies among the upper working class. This risk-sharing scheme in the late nineteenth and early twentieth century ultimately developed into social insurance. Under political pressure, social insurance became the basis of the European welfare state. With the emergence of census and mortality statistics and the establishment of the Institute of Actuaries in 1848, probability assessment laid the foundation for modern banking, investment and insurance. Subsequently, in the 20th century the coming of globalization, it has led to the growth of the international financial market. Probability assessment is now widely used in the study of epidemiology, environment and crime.

7.2 Rise of Risk society

The concept of risk, long associated with the language of maritime trade and insurance, has become a key term for characterizing contemporary Western societies. Important early contributions to the development of this analysis were the work of Patrick Lagadec (1981), who coined the term *risk civilization,* and that of Mary Douglas and Aaron Wildavsky (1982). However, Ulrich Beck's *Risk Society* (1992), originally published in German in 1986, and was the decisive contribution to a new theory of society. Beck's conceptualization has inspired research that focuses on the implications of science and technology for the social and natural environment and on the increasing use of risk analysis in discussions of public policies related to science and technology, which involve ethical questions.

Unlike all other known forms of risks, the notion of 'risk 'in late modernity as analysed by Ulrich Beck and Anthony Giddens as being different from all previous risks. 'Risk', in late modernity, is born out of modern institutions – like politics, business and science – which are supposed to prevent, control and manage risk (Beck 2006: 336). These modern institutions, according to Beck, are the source of new risk. This shift in perception happens because any possible loss or danger can now be traced back to human decisions. Man is now seen as somehow responsible for even natural events or disasters. Earlier, the occurrences of natural events like earthquakes, floods, famines, etc., are attributed to supernatural forces. But today, with increasing secularisation, God is banished from the picture and is replaced with human rationality. Any impending catastrophe or risk is now explained, justified and legitimized based on human rationality and decision-making (Beck 2006: 333). Since man has replaced God as the cause of a catastrophe, there is increasing fear and anxiety about the future.

In the pre-modern, any catastrophe or natural event was attributed to an act of God and the explanation and justification of an event flow from this. Therefore, the risk would mean the possibility of a potential loss or damage due to a natural event considers being an act of God. This concept of risk absolves man of any responsibility or fault. So, in that sense, this pre-modern notion of risk is different from the modern notion of risk. With the coming of modernity, any disaster is explained and traced back to human decision-making. As a result, insurance and compensation were given based on calculable risk and disaster. However, in late modernity, "risk'is no longer calculable and hence not compensable. There is a breakdown in the logic of compensation. This, according to Beck, is the condition of 'reflexive modernization.

Beck was a well-known German Sociologist who was particularly sized on trying to understand modern society which he summarized was characterized by uncertainty, ignorance and fear which he termed Risk Society. He also introduced the concept of reflexive modernization to understand self-criticality in the new phase of modernity. He studied modernization, globalization, individualization and also new work forms in the wake of flexible production and labour in global capital.

"Risk' is the condition of radicalized modernization. In other words, it means radicalization of rationalization, which is reflexive. Reflexive modernization can be seen in the critique of science, which has its origin in the Green Movement of the 70s in the west. This reflexivity gained momentum among the lay public in opposition to the scientism of science, which tends to make false claims and expectations in society. This reflexive modernization is neither post-modern nor modernist but falls mid-way between the two. As the term indicates the condition of modernity itself becomes a subject of reflection and re-examination. The very aspects of modern technological advances, rational institutions, etc. have also been found to be the cause of self-destruction leading to environmental catastrophes and risks, making one question the project of modernity.

In defining risk, Beck said, "Risk does not mean catastrophe. Risk means the anticipation of catastrophe". Risk remains 'virtual'and becomes part of discourse as long as it is anticipated. The moment risk becomes 'real'; it becomes a catastrophe and ceases to be a risk (e.g. terrorist attack). In that sense, the risk is not real but more of 'becoming real'. In other words, 'risk' is an event that is considered to be threatening. The new risk, as can be seen in the work of Beck and Giddens, is radically different from the risk generally known to us. In this regard, we can say that Mary Douglas and Michel Foucault's notion of risk comes from a more empirical and instrumental understanding of risk. However, for Beck and Giddens, the new risk cannot be captured by the usual nation-state framework. For them, it emanates beyond modern science or human experience, as it stands outside scientific rationality and human experience. It has its origin in advanced industrialization and reflexive modernization, where modernity has extended itself. The new risk is a consequence of 'hyper-rationality'. As risk emanates outside the nation-state framework, and beyond scientific rationality and human experience, it creates a sense of pervasiveness. To control and manage such risk, one needs to prepare for the 'unknown unknowns'. For what can be known is 'unknown' and hence not knowable, therefore, there is an element of incalculability. As a consequence, one has to consider all kinds of fear, fiction, and imagination in tackling "risk'. The option of ignoring risk is not viable as the damage or loss due to ignorance could be incalculable as it could lead to a catastrophe. In fact, 'risk'is a sign of growing connectivity and interdependency in an age of globalization.

Beck in his 1986 publication described risk society as a structural condition of advanced industrialization. Such a society is defined by risk, rather than class, as the principle of inequality in modern society. Risk being a social construct, some people have a better way of defining risk and benefitting from it. The way of defining risk between people and countries reveals the kind of power relations that exist in society and between countries. In other words, defining risk is a power game. Beck argues that even the most restrained and moderate discourse on risk has its hidden implications, with its politics, ethics and morality.

7.3 Enlightenment Function of Risk

Apart from its negative aspect, 'risk' could also serve an enlightenment function in the world risk society. To understand the enlightenment function of world risk society, we need to understand what Beck meant by the "cosmopolitan moment". The cosmopolitan moment begins as a response to the experience of risk. It is made possible by the self-destructiveness of modernity, which is not only physical but also ethical as well. This, according to Beck, led man to outgrow both the nation-state and the international order. It also means the abrupt and full confrontation of the excluded other, where national boundaries are no longer relevant and the 'distant other becomes the 'inclusive other', through risk and not through mobility. As a result, everyday life becomes cosmopolitan and the meaning of life is found in the exchange with others and not in the encounter with those who are alike. This cosmopolitan moment that opens up creates the possibility of a new beginning. With the advancement in industrialization, universalization of modern technological institutions and the coming of neo-liberal policies, 'risk' has transcended border, time and space. ‘Risk’is no longer a problem of the Global North alone. It is a problem of the Global South too due to increasing integration and interdependency on a global scale. The problem of new risk cannot be solved by the usual national politics and international cooperation. For example, the outbreak of BSE (Bovine Spongiform Encephalopathy), commonly known as mad cow disease, in the UK in 1986 and the subsequent ban on the import of beef and its product in the EU and other countries. What started as a public health event affects the business and economy of many countries. Another example is the outbreak of avian influenza in 1997, where the first known transmission of H5N1 to humans took place in Hong Kong. There is a fear that, with increased connectivity in a globalized world, local outbreaks could easily become pandemic risks using the same network of connectivity and efficiency. Another global risk that needs to be considered is that of globalized capital, which tends to destabilize the market and in the process activate opposing global civil society. While global risks exposed the order of power of the neo-liberal (capital-state coalition) regime, global civil society tries to connect civil society with the state to create a "cosmopolitan form of statehood". This cosmopolitan form of statehood is marked by ethnic and cultural diversity. Beck believes this is a "post-national order". Although the goal of capital is to instrumentalized the state to optimize and legitimized its interest worldwide in the process, it also weakens capital by creating its opposing protagonist – the global civil society, which questions the legitimacy and order of the global capital. One of the agendas of the global capital is to create its own space, autonomous and free from outside interference. This has its legitimacy. However, the agenda of civil society is concerned with human rights, global justice and democratization. With the coming of global crisis and risk, according to Beck, nation-based realpolitik is replaced by "Cosmopolitan realpolitik". Beck suggests that individual freedom and national autonomy could best be preserved through transnational alliances and networking. However, the dark side of this "Cosmopolitan vision" is invasion and war waged in the name of justice and human rights. Beck believed this to be the unwanted 'side-effects’of the cosmopolitan vision because the rhetoric of cosmopolitanism – peace, human rights and justice – becomes the basis for national hegemony and imperial ambition. He gave the example of the Second Iraq War, where the idea of cosmopolitanism can be abused and instrumentalized by the state and global capital for its ends. Further, world risk society also opens new lines of conflict. If the first modernity was marked by socio-economic conflicts between labour and capital, the second modernity (i.e. world risk society) is marked by cultural ones between different risk cultures or 'risk religion’. For instance, the dominant risk belief and risk tendencies of Europe and the US are different because they have a different 'risk culture’and 'risk religion’. For Europeans, the risk of climate change is more than the risk of terrorism. But for Americans, terrorism is a bigger threat than climate change. Just as there is 'class conflict’in the first modernity, there is a 'clash of risk cultures’ in the second modernity. And this clash is not a matter of life and death for individuals or nations but for everyone. The physical and moral survival of mankind depends on the decision made based on 'not-knowing’. It is a well-known fact that the experimental logic of trial and error failed in the face of a new form of risk. Due to cultural differences in risk perception in the west, two contradictory risk philosophies have emerged. The philosophy of laissez-faire is that it is safe, as long as it has not been proven to be dangerous. And the philosophy of precaution, that nothing is safe, as long as it has not been proven harmless. These two philosophies continue to guide risk prevention and management today.

A comparative study of different perspectives on risk reveals two distinctive approaches – one within the 'nation-state’ framework and the other beyond (i.e. within the 'modernity’ framework). The distinctive approaches to the risk undertaken by sociologists are also shaped by their intellectual background which defines the trajectory of their risk discourses. In the previous section of the block, we have seen how Beck and Giddens work within the same framework of modernity, but their risk discourses diverged due to different objects of sociological inquiry and intellectual backgrounds. In the next section, we examined the different perspectives on risk and how they relate to each other.

Looking at the work of scholars like Ulrich Beck and Anthony Giddens on risk and modernity, Scott Lash and Brian Wynne point out the parallels between their ideas. They observed that the divergent backgrounds of Beck and Giddens shape the trajectory of their discourse on risk and modernity. Beck’s Risk Society (1992), originally published as Risikogelsellschaft in 1986, made him popular in the Anglophone world. Subsequently, he also later published World Risk Society in 1999. Giddens’s parallel work on risk and risk society was published as Consequences of Modernity (1990) and Modernity and Self Identity (1991). For Beck, the study of risk and identity led to the theory of reflexive modernization – an extension of modernity rather than a break with modernity (as advocated by the postmodernist). However, for Giddens, the notion of reflexive modernity is a social construct born out of the reflexive shaping of one's biographical narrative (Lash and Wynne, in Beck 1992: 7). Much of Beck's idea on reflexive modernization is born out of his long period of study on institutions (Lash and Wynne, in Beck 1992: 8), whereas Giddens' idea on reflexive modernity developed from his study on agency in social theory and his rejection of structural functionalism.

Reflexive Modernity

Ulrich Beck's theory represents a continuation of the German tradition of an ethical questioning of modernity, including science and technology, that runs from Max Weber (1864–1929) through Jürgen Habermas (b. 1929). In contrast to postmodern theories that present late twentieth-century social transformations as going beyond modernism, Beck argues that modernity is going through an unintended and unseen phase that is forcing it to confront the premises and limits of its model. Modernization has become, in his words, "reflexive." The concept of reflexive modernization, which was introduced by Beck and developed in subsequent work with Anthony Giddens and Scott Lash (Beck, Giddens, and Lash 1994), propounds a "radicalization" of modernity in which the dynamics of individualization, globalization, gender revolution, underemployment, and global risks undermine the foundations of classical industrial modernity and make old concepts obsolete. The internal dynamism of modernity brings it up against the previously unknown possibility of global self-destruction as a result of the risks generated by certain technologies.

Risk as an expanded Concept

Many theoretical works in other disciplines had formerly analysed the risk concept, although more narrowly: economics, behavioural theory (in particular decision-making and game theory), anthropology, and technology assessment.

In economics, where the concept has always been fundamental, prevailing interpretations make a clear distinction between risk and uncertainty. Whereas risk can be assessed and calculated in terms of its numerical probabilities, uncertainty cannot be treated in that manner. Introduced at the beginning of the twentieth century by Frank Knight (1885–1972) and John Maynard Keynes (1883–1946), this distinction made possible the recognition of the ontologically contingent nature of economic behaviour and its aggregate outcomes. An economic agent cannot avoid wide margins of uncertainty or eliminate it using the application of more information or scientific knowledge.

The anthropological work of Douglas and Wildavsky (1982) diverges from this classical approach in emphasizing the subjective aspect of risk and how risk is assessed and perceived by individuals. Their work helped significantly to shift attention away from a probabilistic approach to the cultural framework of risk perception. Variations in the understandings and perceptions of risk in different societies demonstrate the cultural relativism involved in judgments of risk.

Beck's main contribution was to build risk systematically into a theory of modern society and its dilemmas. Risk is seen as a defining feature of society itself, forming the dark side of industrial successes, technical and scientific progress, and economic growth. It has stimulated changes in social relations, family structure, political and cultural organization, and even the self.

Unlike the threats of early industrialization, the risks of "late modernity" (nuclear, chemical, genetic, ecological, etc.) are generated by techno-economic decisions and considerations of utility. The novel aspect of contemporary risk society is that people's decisions as a civilization lead to problems and dangers that radically contradict the established language of control and conventional techniques of calculation. Current risks are not socially, spatially, or temporally demarcated; there are no clear-cut solutions, and it is difficult to trace responsibility or assess compensation for those who are affected. In addition, human perception fails to notice many of the risks: they become visible only through scientific interpretation (as in the case of stratospheric ozone depletion), which in turn increases dependence on experts.

Beck focuses above all on environmental and health risks, especially genetic technology. He later extended the concept of risk to global financial crises and transnational terrorist networks (Beck 2002). Bringing together such disparate phenomena enables him to identify relevant trends in modern societies but has the drawback of implying a less fragmented world than that which Beck perceives.

NiklasLuhmann (1993 [1991]) has enriched "risk society" analysis with his theory of autopoietic systems. Here the risk is a specific form of dealing with the future that has to be decided in the context of probability and improbability. The uncertain and unforeseeable nature of the future arises not only from complexity and people's cognitive limitations but also from the decision-making process itself. There is a long hiatus between when a decision is made and when its consequences are felt, with random factors affecting them. To talk of risks is to see future losses as the consequence of a decision that has been made. For Luhmann, this is where "risk" differs from "danger," with the danger being attributable to external causes and corresponding to those "affected" by decisions. Although the distinction is slight because "one person's risk is another person's danger," it points to the key issue of acceptance of risk decisions.

Developments and Implications of Risk Society

Beck's message on the relationship between science, technology, politics, and ethics in late modernity is that our language does not inform future generations of the dangers people create when they use certain technologies. As it develops technologically, society encounters the difference between two worlds: the language of quantifiable risk, in which people think and act, and that of nonquantifiable insecurity, which people also are creating. As risks become more complex and the need for precise calculations increases, there is growing doubt about the ability of science to control and foresee those risks. This situation has shaken the belief that technological and social progress go together and has forced science to acknowledge both its collateral effects and its inherent epistemological limitations. The concept of a "world risk society" (Beck 1999) draws attention precisely to the limited controllability of globalized and artificially produced risks.

In these circumstances, human responsibility for technological advancement is an ethical issue that is both relevant and complex. For Beck, the processes and techniques of risk management block out responsibility. Modern society operates as a "laboratory" in which no one, in particular, must answer for the negative effects of technological experimentation. The institutions of modern society recognize the existence of risk but permit an "organized irresponsibility" (Beck 1995 [1988]). Pollution, along with its increasingly global impact in the form of climate change, graphically illustrates this paradox. The greater the environmental degradation is, the more laws and environmental regulations there are, but at the same time, no institution seems to be specifically responsible.

Technologically induced risks lead to calls for the demonopolization of scientific expertise, its subjection to social scrutiny, and the extension of democratic accountability to science, technology, economics, and government. For this to be achieved politics must "(re)-invent" itself and focus on issues previously regarded as apolitical. What once was the exclusive province of science has become the subject of intense political debate, as in the case of biotechnology. In this context individual citizens, movements, and interest groups participate and influence political decisions in the field that Beck describes as "sub-politics," which is located beyond the formal representative institutions of the political system

Because the concept of risk is probabilistic, it tends to deny inherent uncertainties and place greater emphasis on scientific control over randomness, contingencies, and chance. In the vast literature on risk, some authors argue, however, that the language of uncertainty would be more appropriate for a better understanding of the current world, full of indeterminacies and contingencies, whether inherent in the world or epistemic. Underlying this argument would be a lack of knowledge of the statistical probability of many of the possible outcomes, public distrust of the estimates produced by experts, potential margins of error, and the random unpredictability of nature and human behaviour (Martins 1998). This approach has affinities with the work of authors who underline the ontological nature of uncertainty that is inherent in the natural and social worlds and focus on "ignorance," "catastrophes," and "accidents" (see, for example, Perrow 1984). It differs from the work of those who stress above all the social perception of risks (such as Douglas and Wildavsky 1982).

Beck often is said to alternate between the realist and the constructivist approaches and to absorb uncertainty into the general category of risk. However, he cannot be said to limit risk to the perceptual aspect or to avoid a strong emphasis on uncertainty. There are several studies of practical situations in which risk is not limited to perceptions, such as the sub politics of medicine. At the same time, in light of the emphasis Beck places on deregulation, uncertainty, and contingency, his "risk society" cannot properly be understood according to the probability model. In introducing the notions of "unintended consequences and unawareness" into his theory of reflexive modernity instead of emphasizing the "knowledge," as Giddens and Lash do, Beck recognizes that there are areas of unknowability, contingency, and ignorance. For this reason, his theoretical approach lends itself to multiple interpretations that lie between the concepts of risk and uncertainty.

These issues are relevant because a decision based on risk or uncertainty is not neutral in its political consequences. Risk is associated with prevention, whereas uncertainty is associated with precaution (Godard et al. 2002). The risk may lead to a process of risk-mitigating negotiation and agreement, whereas uncertainty may lead to risk-avoiding prudence. The possibility of rejecting certain techno-economic decisions and actions has provoked a lively ongoing debate about the advisability of the "precautionary principle" at a time of rapid technological change.

7.4 Risk Society and Health Care

Peter Dahler-Larsen (2011) argues for the diagnostic abilities of reflexive modernity in ascertaining the problems in contemporary modern society. Out of perceived 'risk' arises historical governance of healthcare for an increasing citizen population in the latter part of the industrial revolution. Doctors are taught how to diagnose and treat within a biological model of what is normal, and a statistical model of what is uncertain. Management of healthcare transitioned more firmly from the individual to the State during industrialization in the form of hospitals established via the Church and in some instances via Royal dispensation. For the governance of large peoples, the corresponding increasing rule of correlations based on mathematical assessments in medicine has offered assurances concerning welfare in terms of: - diagnosis (basing diagnosis and professional education on a hierarchy of symptom frequency that of necessity eliminates the infrequent and unusual); - treatment (what works for most people becoming protocol); - medicine (an exact science of manufacturing, quantifying and prescribing) and; - care (rationalized via time management). In the biomedical paradigm, the medium of illness acts to impersonalize an individual's human body for diagnosis and treatment. This intervention is subject to risk assessment and management, sometimes but not always shared with the individual. The system is, of course, heavily dependent on the goodwill and vocational professionalism of large numbers of people and the understanding that patients have that this is the case. The management of the system underestimates this trade in 'care' at its peril. A plethora of threads of networked external and internal consequences across medicine and healthcare form an interwoven risk 'text' and necessitate risk 'assessment' and 'management' of those consequences. The commercial activity of drug manufacture has for some time driven the increasing rule of scientific risk-based research in medicine based on mathematically designed trials that offered both manufacturers and prospective purchasers a 'gold' standard in respect of safety. This meant trading on an assurance that in large populations very few individuals might have adverse reactions or a low-risk correlation. In an era in Western countries where more and more medicines are consumed, there is an ageing population, and an increased rise in obesity, diabetes and autoimmune illness. It has become necessary to individualize and contextualize new ways of working with illness. Managing the risks associated with the chemical interactions of drugs that may take place in the body of a person who is taking a range of different medicines together, and one for which drug research was unprepared, has become a new focus of the consequences of medical intervention. A rise in more individualized treatment, or patient-centred medicine, includes recognizing patient expertise in their conditions, part of the newly developing field of personalized medicine. A forerunner of this trend, rebutting traditional scientific and positivist risk methodologies, is the recognition of toxic waste activism. For Lupton (1993) the consequence of lifestyle choices (discussed below under food marketing) is one of two sorts of public health risk discourses, with hazardous societal by-products being the other. Localized disease clusters related to environmental hazards have evidenced non-traditional (lower class, female) lay expertise and established critiques that rebut and highlight the differences between public and scientific perceptions of risk. Indeed, localized contamination by toxic waste that correlates with cancers and other illnesses in clusters, despite scientific risk evidence, has demonstrated that the model presents a particular perception dangerously far from lived lives and removed from notions of even domestic environmental justice. This is a powerful argument for epidemiology with a social justice focus through the elevation of public health concerns, but it also requires consideration of uncertainty and therefore of risk. The boundary of the interrelation between public and private spheres is precisely the fertile space in which the Arts and Humanities operate and from where they offer expertise, demonstrating innovative ways of negotiating and engaging in communication. Another aspect of market-driven medical intervention requiring new forms of risk management is the overuse of antibiotics leading to the rise of antibiotic-resistant germs. A rising incidence of autoimmune illnesses with a wide range of contributory factors, including environmental triggers, stress and diet, has led to the developing field of environmental medicine. Further, concerns and issues around food and diet demonstrate similarly problematic market-driven consequences influencing consumer behaviour and health - for example in the changing use of sugar in everyday foods, the demand-driven provision of unseasonal and unripen foods, as well as shelf-life and refrigeration-led genetic modifications. Linked to this, as an issue of risk and related governance, are management proposals linking obesity, diet and poverty in the UK. The digestive system - and its risk properties - is placed at the centre of individual and public health. Environmentally, in lay activist terms, the knowledge processes of the 'slow' movement demonstrate an additional and eco-centric view of international and local environmental risk perceptions concerning food, and diet. Nowhere does this debate between the individual and the State become more critical than when it concerns life and death, and indeed to whom the life of an individual belongs. This is clear, for example, in the euthanasia debate. It is also clear, from a different perspective, in consideration of risk during medical treatment, with potential consequences of litigation. The burden of responsibility is enacted as a transaction, and while the risk for the professional necessitates a sharing process before treatment, in reality, it is only the professional and not the individual risk that can be shared, or the theoretical (and emotional) but not the practical. The irony is that the risk is not equal and that in this evaluation, medical treatment and life are both afforded financial value. While what a life worth is individual, globally incomparable, and profoundly inequitable, it is externalized, away from an individual. The technologies of modernity afford a dehumanizing cost basis to life, death and the area in between (damage). The role of risk in transactions crossing ethical divides is extremely complex. It is not straightforward in these real-life aspects, nor is it binary, but entangled and messy. Regulation is a political business. The growth of bureaucracy fits with the project of modernity in the Western world. Bureaucracy is a post-colonial and re-colonizing process that restricts and paralyzes movement. Yet, the reflexive approach is an ancient one, originating in the healthy self-questioning practices of individual dialecticism. As a bureaucratic function, risk-driven management is metaphorically and stressful. Propelled by outcomes and facing the future it is driven by fear, again located in the kidneys in East Asian medicine. Adrenally responsive, it is always alert for things to go wrong. It is a watchful Janus figure of the threshold, with one eye looking to the past and the other to an uncertain future societally programmed with a rapid, but limited, cognitive function. Whatever mathematics and cognitive psychology aim to assert, this is not a neutral figure: regulatory mechanisms aside, it can be creatively reconfigured to be plurally read and misread as a metaphor for social change.

Refiguring risk in medicine and healthcare

The dynamics of risk presented in mainstream social, historical and managerial contexts are overloaded with paternalist, Western governance in Foucauldian and feminist terms. Intrinsically linked to Western Classical heroism and laced with aspects of deadly danger, risk is presented as affordable in the sense that it offers a promise of individual success. This may come to nothing depending on the throw of the dice, or the will of the Gods, a sort of containment of events that sometimes involves a righting of wrongs done to individuals, and might today comprise a natural order of things, as a form of moral discourse. It is interesting that in this particular model personal wit - a kind of street-wise sense relative to the immediate environment coupled with the ability to sense and seize opportunities - is more important than skills of integrity. In this Western representation of the heroic, skills are necessarily gendered male and recognizably human although extreme in scale. The hero's environment is frequently a territory, being difficult, alien or dangerous, feminized as virgin, to be mapped or conquered. Bound up in metaphors of colonialism, this is also the space occupied by societal out-riders: the rogue, adventurer, pirate, financial wizard and potential law-breaker.

Gender-testifying narratives of success are disseminated through narratives that permeate Western culture extending from Ancient Greek and Roman myth into philosophy, psychoanalysis and contemporary films and books (Patterson, 1993). The concept of the individual against the odds extends politically through the heroic to the individual risking all against the state. It is arguable that any notion of a singular heroic is completely misleading as the role creatively lends itself to being viewed as a 'syndrome' of gender-imposed traits of masculinity, even a multiple personality disorder in relation to changing cultural and historical environments and expectations (Nagy, 2013). Yet, this is also one of the faces of leadership. One important general theme and counter theme is that the importance of community is inversely important in relation to the perceived threat to the protagonist. So, ultimately, the promise of risk is that of a re-cognition or re-thinking of the heroic; the creation or forging of individual identity and worth, a measuring against the odds that takes place through the medium of risk. The doctor, too, is archetypal hero as medicine follows the martial metaphors of 'conquering' and 'eradicating' disease.

Ulrick Beck's view of a second modernity is a self-reflexive one that raises issues of trust and credibility in relation to risk and the dominance of the institutions of science and technology (including medicine) as powerful creators and managers of knowledge about risk. Science and technology in this analogy become corporate bankers trading in a currency of risk in today's 'risk society'.

Trust and Risk society

If risk originates in a shared understanding of the governance of a Western world-order as an active governance of uncertain futures, whether self-reflexive or not, then it is equally important to highlight the gendered origins implicit in all of these discourses and their deployment across science, engineering, technology and medicine (STEM). STEM fields are traditionally and historically associated with invention and heroism with high status, engendered white, socially self-reproducing stereotypes. They are fields from which women have been until recently excluded and in which both women and minority ethics are persistently under represented with recognizable hermeneutic self-determining and out-mode characteristics (Smeding, 2012; Beede et al, 2011). These are the fields that drive the technologies of positivist risk mechanism as the means of managing or dialoguing with uncertainty.

In any politics of equity, this raises further issues of trust, as risks are both regulated and generated by the practices of the institutions that create them. To benefit from these practices is to accept an internalizing of these risks and their regulation. In other words, risk is a confection that both reveals and hides the dangers it distances and conceals. It is a symptom of what is wrong with modernity, of societal illness. Within this framework, mistrust is compounded by the constraints of modernity around science and public knowledge, as a form of policing that is particularly evident around the borders and intersections between institutions and the public sphere, between research and practice, measured as benefits and losses, physical reactions and individual experiences. Yet, this is also where creativity and new ways of knowing are created. So risk and trust are highly polarized political activities that relate to social roles, and as such they incorporate and embed the politics of their origins. Carter (1995), in a discussion of HIV/AIDS, points out that neither Beck nor Giddens consider trust and reflexivity in relation to intimacy. Thinking in some detail about dialogues of othering, Carter considers how the construction of identity has a dependency on incomplete conceptualizing of self and other built on ideas of trust rooted in concepts that may fail, such as romantic heteronormative or feminized love as prophylaxis: 'the linear association between risk avoidance and risk awareness is likely to be disrupted by complexities of the relationship between sex and identity' (Carter, 1995: 163).

An ethics of care, such as that grounded in Carol Gilligan's (1982) work, emphasizes the relational nature of research and the emotional aspects of reason. The complex politics of relational positioning shaped by binary, rational logic underpins the pragmatic science of risk assessment outlined above. With woman traditionally othered in the process, LuceIrigaray (1993: 13) outlines her thoughts on what this means: 'Who or what the other is, I never know. But the other who is forever unknowable is the one who differs from me sexually. This feeling of surprise, astonishment, and wonder in the face of the unknowable ought to be returned to its locus: that of sexual difference'. In consequence, therefore 'jamming the theoretical machinery itself…suspending its pretension of a production of a [univocal] truth and a [univocal] meaning' (Irigaray, 1977, trans 1985: 78), wonder in the face of difference returns us to radical uncertainty – an authentic relational risk.

Summary

- People take a 'chance 'in the hope of achieving something bigger and better. It could also mean 'probability 'in the sense of uncertainty, over a certain outcome.

- The risk could also mean unforeseen ‘danger‘– possible loss of life and property – due to unfavourable circumstances.
- Risk involves uncertainty about the effects/implications of activity concerning something that humans value (such as health, well-being, wealth, property or the environment), often focusing on negative, undesirable consequences.
- The emergence of risk has been much of interest to scholars of the sociology of risk. Sociologists are interested in finding out how risk has become a part of our history and culture.
- By the eighteenth century, the mathematics of probability was developed and applied to risk issues.
- This risk-sharing scheme in the late nineteenth and early twentieth century ultimately developed into social insurance.
- The concept of risk, long associated with the language of maritime trade and insurance, has become a key term for characterizing contemporary Western societies.
- In defining risk, Beck said, "Risk does not mean catastrophe. Risk means the anticipation of catastrophe".
- Douglas and Michel Foucault's notion of risk comes from a more empirical and instrumental understanding of risk.
- Apart from its negative aspect, ‘risk‘ could also serve an enlightenment function in the world risk society. To understand the enlightenment function of world risk society, we need to understand what Beck meant by the "cosmopolitan moment".
- A comparative study of different perspectives on risk reveals two distinctive approaches – one within the 'nation-state‘ framework and the other beyond (i.e. within the 'modernity‘ framework).
- Ulrich Beck's theory represents a continuation of the German tradition of an ethical questioning of modernity, including science and technology, that runs from Max Weber (1864–1929) through Jürgen Habermas (b. 1929). In contrast to postmodern theories that present late twentieth-century social transformations as going beyond modernism,
- Many theoretical works in other disciplines had formerly analysed the risk concept, although more narrowly: economics, behavioural theory (in particular decision-making and game theory), anthropology, and technology assessment.
- NiklasLuhmann (1993 [1991]) has enriched "risk society" analysis with his theory of autopoietic systems.
- Beck's message on the relationship between science, technology, politics, and ethics in late modernity is that our language does not inform future generations of the dangers people create when they use certain technologies.
- Technologically induced risks lead to calls for the demonopolization of scientific expertise, its subjection to social scrutiny, and the extension of democratic accountability to science, technology, economics, and government.
- Peter Dahler-Larsen (2011) argues for the diagnostic abilities of reflexive modernity in ascertaining the problems in contemporary modern society.
- The dynamics of risk presented in mainstream social, historical and managerial contexts are overloaded with paternalist, Western governance in Foucauldian and feminist terms
- An ethics of care, such as that grounded in Carol Gilligan's (1982) work, emphasizes the relational nature of research and the emotional aspects of reason.

Keywords

- Standardization
- probability
- hazard
- zone
- vulnerability
- voyage
- uncertainty

Self Assessment

1. If uncertainty is the outer dimension of risk, _____________ is the inner dimension of risk

A. vulnerability
B. Probability
C. predictability
D. impenetrability

2. Risk is the possibility of something _________ happening.

A. Good
B. Bad
C. Weird
D. Amazing

3. The mathematics of probability was developed and applied to risk issues in which century.

A. Sixteenth
B. Fifteenth
C. Eighteenth
D. Nineteenth

4. Under which pressure, social insurance became the basis of the European welfare state.

A. Economic
B. Social
C. Environmental
D. Political

5. Who coined the term 'risk civilization'.

A. Patrick Lagadec
B. Anthony Giddens
C. Ulrich Beck
D. Taylor-Gooby

6. Ulrich Beck's, 'Risk Society' (1992), originally published in German in which year.

A. 1986
B. 1988
C. 1977

D. 1989

7. The risk would mean the possibility of a potential loss or damage due to a natural event considers as ____________

A. Human Fault

B. Act of god

C. Task of evil

D. Tragedy

8. 'Risk'is a sign of growing connectivity and interdependency in an age of ____________.

A. Modernity

B. Technology

C. Industrialisation

D. Globalization

9. In which year first known transmission of H5N1 to humans took place in Hong Kong.

A. 1996

B. 1997

C. 1986

D. 1999

10. On which study of different perspectives on risk reveals two distinctive approaches

A. Calculative

B. Compile

C. Comparative

D. Parellel

11. Who published World Risk Society in 1999?

A. Anthony Giddens

B. Scott Lash

C. Brian Wynne

D. Ulrich Beck

12. Ulrich Beck's theory represents a continuation of the German tradition of an ethical questioning of modernity, including science and technology, that runs from ____________through Jürgen Habermas.

A. Max Weber

B. Karl Marx

C. Scott Lash

D. Brian Wynne

13. Whoenriched "risk society" analysis with his theory of autopoietic systems?

A. Patrick Lagadec

B. Anthony Giddens

C. Ulrich Beck

D. NiklasLuhmann

14. Who argues for the diagnostic abilities of reflexive modernity in ascertaining the problems in contemporary modern society

A. Scott Lash

B. Anthony Giddens

C. Brian Wynne

D. Peter Dahler-Larsen

15. _______ fields are traditionally and historically associated with invention and heroism with high status, engendered white, socially self-reproducing stereotypes.

A. SEBI

B. SETM

C. STEM

D. H5N1

Answers forSelfAssessment

l.	A	2.	B	3.	C	4.	D	5.	A
6.	A	7.	B	8.	D	9.	B	10.	C
11.	D	12.	A	13.	D	14.	D	15.	C

Review Questions

1. What do you understand by Risk Society
2. Explain in detail Rise of risk society
3. Give a detail note on Risk society and health care
4. Throw light on Developments and Implications of Risk Society
5. Write a note on Risk Society and Health Care

Further Readings

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Unit 08: Sociology of Care

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Objectives

After completing this Unit, you shall be able to:

- To know concept of care?
- To understand the risk in the care?
- To understand the relationship between care and health.

Introduction

The idea of care is associated with the provision of what is necessary for the health, welfare, maintenance, and protection of someone or something. But, in the field of health care, this is a key term which is used as serious attention or consideration applied to doing something correctly or to avoid damage or risk. In componential understanding it is always associated with the nursing profession. As per the World Health Organisation (WHO) states Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes. It is based on evidence-based professional knowledge and is critical for achieving universal health coverage.Jean Watson contends that caring regenerates life energies and potentiates our capabilities. The benefits are immeasurable and promote self-actualization on both a personal and professional level. Caring is a mutually beneficial experience for both the patient and the nurse, as well as between all health team members.

8.1 Concept of care

If caring is to be retained as the “essence” of nursing, and if research in this area is to advance, then the various perspectives of caring must be clarified, the strengths and the limitations of these conceptualizations examined, and the applicability of caring as a concept and theory to the practice of nursing identified. Examination of the concept of caring resulted in the identification of the following five epistemological perspectives: caring as a human state, caring as a moral imperative or ideal, caring as an affect, caring as an interpersonal relationship, and caring as a nursing intervention. The following two outcomes of caring were identified: caring as the subjective experience and as the physiologic responses in patients.

In the past decade, nurse theorists have identified caring as a paradigm unique to nursing. Caring has been described as the "core" or the "essence" of nursing. There is no doubt that as a concept, caring has had a profound influence on nursing philosophy, education, and research. Literature expounding on the nature of caring and its implication for practice is rapidly increasing. Recognizing the complexity and significance of the concepts of care and caring, groups of scholars, such as those at the Center for Human Caring at the University of Colorado Health Science Center, have concentrated research efforts on exploring the nature of caring and its relationship to and ramifications for the profession. Moreover, annual conferences and think tanks, such as the one sponsored by the American Academy of Nursing and Sigma Theta Tau in 1989, have focused on this topic.

Despite these efforts, caring as a concept remains elusive. At this time, instead of enlightening the reader, examination of the literature only increases confusion. There is no consensus regarding the definitions of caring, the components of care, or the process of caring. Articles frequently appear repetitive without contributing further information, and different perspectives appear contradictory. Furthermore, in nursing, authors have not debated, commented on, or analysed these different meanings and perspectives associated with the term caring. From the literature, it is difficult to discern the differences between the terms caring, care, and nursing care. Some of the diversity in these perspectives comes from the use of care as a noun or caring as a verb. Care or caring may specify the actions performed, as in to take care of, or the concern exhibited, as in caring about, the former having a more specific sense and the latter a more general one. It is also possible that in a given situation, the word "care" may encompass both meanings, as was the case in some of the conceptualizations reviewed in this chapter. Clearly, it is imperative that if caring is to be retained as the essence of nursing and if research in this area is to advance, then these various perspectives of caring must be clarified and the strengths and the limitations of the conceptualizations must be identified. Therefore, the purpose of this chapter is to discuss the various conceptualizations of caring, to explore the adequacies and inadequacies of these conceptualizations, to evaluate the applicability of caring as a concept to the practice of nursing, and to identify trends and gaps in caring research. It is hoped that examining the literature will raise questions that will facilitate and stimulate debate among nurse scholars pertaining to these conceptualizations of care and caring.

8.2 Caring as a Human Trait

From this perspective, caring is an innate human trait, the "human mode of being," a part of human nature, and essential to human existence. Although all humans have the potential to care, this ability is not uniform. Roach suggests that one's own experience in being cared for and expressing caring influences one's ability to care. The nurse's educational experience professionalizes this caring through the acquisition of knowledge and skills. Despite this assertion that one's ability to care is influenced by life experiences in being cared for and in expressing caring, research that verifies this by examining the early experiences of nurses has yet to test this relationship. Alternatively, Leininger states that diverse expressions, meanings, patterns, and modalities of caring are culturally derived. Attributes of professional caring, such as Roach's dimensions of compassion, competence, confidence, conscience, and commitment, or Leininger's carative constructs, are derived from or have their locus in caring. According to these definitions, the human trait of caring is the motivator of nursing actions.

Benner and Wrubelconcur that caring is the "basic way of being in the world"(p. 398) from which all nursing practice evolves. They agree that one's ability to care is enhanced by learning and that differences in nursing practice reflect different levels of expertise in understanding the meaning of the patients' experiences of health and illness. Similarly, Griffin views caring (and Orem considers self-care) as a human trait underlying nursing practice. However, Orem believes that caring consists of actions by others, which become necessary when self-care requirements cannot be met.

The universal concept of care is extended by Raywho examines the human aspects of caring in the context of bureaucratic hospital organizations. Because all cultures have developed social organizations to some degree, this description of caring is universally apropos. Ray's description of care encompasses a synthesis among political, economic, legal, and technological aspects as well as humanistic dimensions of caring. As such, this theory of "bureaucratic caring" has implications that extend beyond the nursing profession, i.e.Bureaucratic Caring Theory, developed by nursing scholar Dr Marilyn Ray, illuminates the relationship of all stakeholders within a bureaucratic (complex organization) system. Both health care and military systems are inherently bureaucratic in nature.

Caring as a Moral Imperative or Ideal

Authors describe caring as a "fundamental value" or moral ideal in nursing. For example, Gadowand Watson suggest that the substantive base of nursing is preserving the dignity of patients. From this perspective, caring is not manifest as "a set of identifiable behaviors,"(p. 48) images, or traits evident in the caring nurse (e.g., sympathy, tenderness, or support28) nor does it encompass all that nurses do. Rather, caring is the adherence to the commitment of maintaining the individual's dignity or integrity. In contrast to Gadow's realistic and attainable view for praxis, Watson suggests that caring actions revealed in the nurse–patient encounter are merely "approximations of caring" and not a "pure form of caring."(p. 34) According to Watson, caring remains an unattainable ideal.

Nevertheless, in agreement with the theorists who adhere to the human-trait perspective, theorists who describe caring as a moral imperative concur that caring provides the basis for all nursing actions. Thus, the environment in which nurses work must facilitate and support caring. Paradoxically, nurses are caught in a dilemma created by a mandate to care in a society that does not value caring. Nurses are expected to care for others as a duty (i.e., to be altruistic), yet they are unable to exercise their right to control their own practice (i.e., without professional autonomy). Fry notes that if, as a profession, nursing holds caring as a moral ideal and present working conditions increasingly limit the opportunity to care (e.g., unsafe staffing conditions persist), then the survival of the nursing profession remains in question.

Caring as an Affect

The authors who define caring as an affect emphasize that the nature of caring extends from emotional involvement with or an empathetic feeling for the patient experience. For example, McFarlane (p. l89) states that caring "signifies a feeling of concern, of interest, of oversight with a view to protection." Bevis considers caring to be a feeling of dedication, a feeling that motivates nursing actions. It is a response that is primarily focused on increasing intimacy between the nurse and the patient, which in turn enhances mutual self-actualization and consists of the following four developmental stages: attachment, assiduity, intimacy, and confirmation, each with its own tasks to be accomplished. Without successful progression through each stage, caring does not take place; instead, it becomes "warped, non-functional or stagnant" and it becomes distorted, changed, and "no longer caring."(p. 51) from the perspective of caring as an affect (reflecting nursing as a female profession with historical roots in religion), the nurse is moved to act selflessly without immediate gratification or expectation of material reward. The personal vulnerability of the nurse who becomes involved with a patient or patient's family as a result of an empathetic identification with the patient's experience can be potentially damaging to the nurse, but support and recognition from colleagues may alleviate personal frustrations and maintain the nurse's ability to care.

Unfortunately, the affectual nature of caring may be jeopardized or devalued in some situations. For example, constraints on nursing time (e.g., the increased demand for technical skills), technological demands (e.g., the distraction of monitors), and unattractive patient characteristics (e.g., rejecting or unresponsive behaviours) may inhibit the development of a caring feeling toward the patient. Furthermore, institutional incentive for the nurse to care is lacking, and professional socialization to remain objective, such as warnings not to get "too involved" with patients, continues to contribute to the devaluation of the importance of caring as an affect in nursing.

Caring as the Nurse–Patient Interpersonal Relationship

In contrast to those who view the caring relationship between the nurse and the patient as the foundation of human caring or the medium through which it is expressed, authors who believe caring is an interpersonal relationship suggested that the nurse–patient relationship is the essence of caring. Those with this perspective believe the interaction between the nurse and the patient both expresses and defines caring. Caring encompasses both the feeling and the behaviours occurring within the relationship. For example, the relationship (i.e., feeling) and content (i.e., behaviour) of caring include aspects such as "showing concern" and "health teaching."Alternatively, these may be manifested in the supportive relationships that nurses have with their patients.

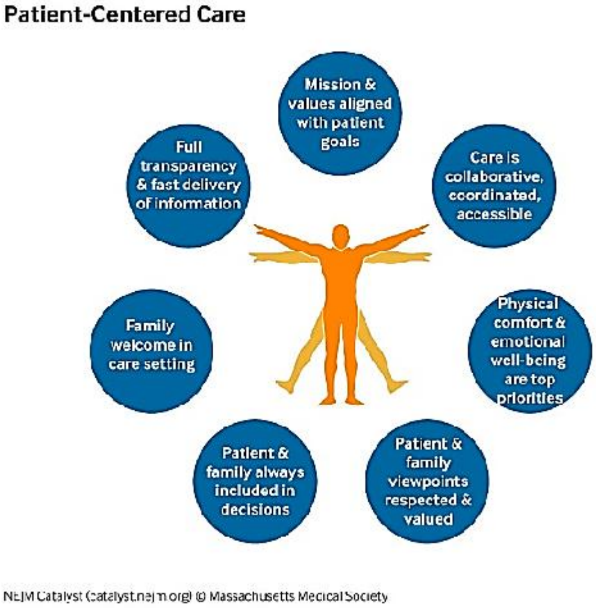

Fig. 8(1): Concept of Patient centred crime

Caring as a Therapeutic Intervention

By defining specific nursing interventions or therapeutics as caring or by describing conditions as necessary for caring actions, these theorists have linked caring more directly than others to the work of nurses. Caring actions may be specific, such as attentive listening, patient teaching, patient advocacy, touch, "being there," and technical competence, or caring may include all nursing actions (i.e., all nursing procedures or interventions) that enable or assist patients. Emphasis is placed on the necessity for adequate knowledge and skill as a basis for these caring actions as well as on the congruence between nursing actions and the patient's perception of need.

Several researchers obtained patients' perceptions of the importance of preselected nursing behaviours and interventions in relation to being cared for, implying that these nursing behaviours and interventions are caring. Two investigations included an open-ended question asking patients to describe situations in which they felt cared for. These data were used to verify the "caringness" of interventions included in the questionnaire rather than to define caring per se.

On the other hand, several authors have focused on the patient as the authority who determines what caring interventions are. It is the patient who defines caring and the components of caring, thus enabling the researcher to delineate the concept of care. This type of research permits patients to identify indicators of nurses' caring behaviours, to recognize qualities of caring, and to report their caring needs, thus providing another way of eliciting appropriate nursing interventions that signify caring. For instance, researchers have noted that patients repeatedly report that they feel cared for when they are treated as individuals, when they receive help in dealing with their illness experiences, when nurses anticipate their needs, when they believe that nurses are available, and when nurses appear relaxed and confident.

Despite this, comparisons of the patients' and the nurses' perceptions of care reveal discrepancies between the two perspectives and identify different, significant caring behaviours, with patients focusing on instrumental behaviours of nursing practice and the nurses focusing on involvement and the affectual or expressive aspects of caring actions. Recognizing the incongruity between these perspectives adds credence to the significance of considering patient satisfaction and goals in the preparation of care plans.But at the same time, these discrepancies may be expected, as patients may not be aware of all of the nurses' intentions underlying nursing actions.

Rather than studying the concept of care and caring, some researchers have examined the concept of care by exploring patient physiologic or psychologic outcomes. This perspective is primarily used by those researchers who focus on quality assurance and use physiologic outcomes as indicators of care (e.g., injuries from patient falls). For example, these outcomes may be the level of care, determined using selected statistical indices, such as morbidity and mortality statistics, length of stay (hospitalization), or the number of patient-incident reports, thus removing the indicators of care to the group level. Alternatively, researchers and auditors may use a physical examination to observe for the absence of indicators of poor care, such as skin conditions (decubitus and abrasions), poor muscle tone, or even the patient's state of hygiene to ensure that an individual patient has been cared for. Attempts are now being made to include patients' subjective responses to care as part of quality assurance programs.

8.3 Rise of Care Society

Feminist organizations have insisted for decades on the importance of recognizing the systemic role of care work. This invisible work is indispensable for reproducing the labour force and more broadly for sustaining life. The COVID-19 pandemic has transformed this feminist message into an accepted truth.

The new coronavirus has forcefully exposed the fragility of human life. All of us face the risk of catching a disease that can kill us. In this context, it is also made very visible that our lives are interdependent. To avoid contagion, we need to take care of ourselves, but we also depend on the whole of society adopting habits of caring. If we get sick, we need the specialized care of people who work in the health sector, but also daily care to meet the daily needs of existence.

Most of the strategies adopted to confront the pandemic, based on physical distancing and social isolation, along with "stay at home" guidelines, have been possible because "at home" there is the regular provision of domestic and care unpaid work that reproduces life on a daily basis. With the closure of schools and of day-care facilities for dependent persons, unpaid domestic and care work in households has increased.

Paid care work has also become more intense and more risky. People who work in the healthcare sector are at the forefront of this increased care, and the high percentage of people with COVID-19 among healthcare workers reflects this increased risk. The risk is higher when the health systems in which they work have been devastated by decades of austerity policies. Paid domestic workers and workers in garbage collection and urban hygiene are also seeing their work increase and their conditions become more difficult.

In the context of greater precariousness and social vulnerability, community care arrangements have proved fundamental in guaranteeing the most basic social rights, such as the right to food. The role of community kitchens or soup kitchens, generally staffed by volunteers, has been fundamental in poor neighbourhoods in many big cities, especially in the global South. Community-based care arrangements have enabled survival in the context of the pandemic, and women's bodies have been at the forefront of sustaining these collective spaces.

The pandemic has revitalized the idea that essential jobs exist. Care-giving jobs are at the top of that list, even though historically they have been hardly recognized, socially devalued, badly paid and poorly protected. This sense of the essentiality of care should foster a process of transformation in the way in which care is socially addressed.

There is ample evidence that the social organization of care is unjust and a vector for the reproduction of inequality. It is unjust because care responsibilities are unequally distributed among the State, the market, the household and the community, as well as between men and women. It is a vector of inequality because possibilities of choosing care arrangements are less, the lower the socio-economic level. Because care demands increase and the possibilities of meeting them decrease when people live in precarious habitats, with little and difficult access to basic social infrastructure (drinking water, sanitation, energy sources). Also, because the social organization of care has become transnational, and in those global care chains labour and immigrants' rights are violated.

The unjust social organization of care continues to be at the root of the reproduction of inequalities in economic participation, access to employment, the possibility of earning one's own income, political participation, opportunities for training and the possibility of enjoying leisure time and self-care.

The re-value of care as an essential activity, as a basis for systemic sustainability, should strengthen the agenda for reorganizing care on the basis of social co-responsibility, including the demand for public care policies that guarantee the necessary conditions for choosing desired care arrangements. As this report has said before, there is an urgent need to adopt an integrated approach to public policy strategies that articulate the building of national care systems with the provision of basic social services (water, sanitation, gas, electricity) as well as with access to efficient public transport that can ease care arrangements.

Care policies can also be thought of as key for post-pandemic recovery. Investing in care services will not only enlarge alternatives for care arrangements, but also create direct and indirect employment, as well as enable other sectors of the economy to function properly. The fast expansion of teleworking as an alternative in many economic sectors also calls for better and more creative alternatives for work-life balance.

The relevance of the local dimension of care policies should also be taken into account. It is worth mentioning the example of the proposal for a local care system in Bogotá, Colombia, that features the design of care provision by neighbourhood, including fixed and mobile care units, and the provision of community spaces to take care of domestic tasks such as laundry.

Democratically expanding horizons of equal care arrangements, allocating public resources to building care infrastructure and recognizing and strengthening community care arrangements are essential elements in any process of building a different way out of the current global crisis.

8.4 Interplay of Care and Health

India's health system faces the ongoing challenge of responding to the needs of the most disadvantaged members of Indian society. Despite progress in improving access to health care, inequalities by socioeconomic status, geography and gender continue to persist. This is compounded by high out-of-pocket expenditures, with the rising financial burden of health care falling overwhelming on private households, which account for more than three-quarter of health spending in India. Health expenditures are responsible for more than half of Indian households falling into poverty; the impact of this has been increasing pushing around 39 million Indians into poverty each year. In this paper, we identify key challenges to equity in service delivery, and equity in financing and financial risk protection in India. These include imbalanced resource allocation, limited physical access to quality health services and inadequate human resources for health; high out-of-pocket health expenditures, health spending inflation, and behavioural factors that affect the demand for appropriate health care. Complementing other paper in this Series, we argue for the application of certain principles in the pursuit of equity in health care in India. These are the adoption of equity metrics in monitoring, evaluation and strategic planning, investment in developing a rigorous knowledge-base of health systems research; development of more equity-focused process of deliberative decision-making in health reform, and redefinition of the specific responsibilities and accountabilities of key actors. The implementation of these principles, together with strengthening of public health and primary care services, provide an approach for ensuring more equitable health care for India's population.

Inequalities in Health care

The inverse care law, whereby those with the greatest need for health care have the greatest difficulty in accessing health services and least likely to have their health needs met, is highly applicable in India. We conceptualize access as the ability to receive a specified set of services, at a specified level of quality, subject to a specified constraint of inconvenience and cost, and use utilization of selected health services as a proxy for access. To illustrate the persisting inequalities and inequities in health care in India, we focus on access to maternal and child health services, as the disease burden relating to communicable, maternal and perinatal conditions are in part addressed by access to these services.

Inequalities in preventative health care

Utilization of preventive services such as antenatal care and immunizations remains suboptimal, with marked variation in the utilization of these services by gender, socioeconomic status, and geography. In 2005–6, the national immunization coverage was 44%. Inequalities in immunization exist by household wealth and education, with absolute and relative inequalities showing signs of reduction over time. Inequalities exist by caste: in 2005–6, immunization coverage among scheduled tribes and scheduled castes was 31.3% and 39.7% respectively compared to 53.8% among other castes with absolute inequalities between these castes increasing over time. Coverage remains higher in urban areas (58%) compared to rural areas (39%), although absolute and relative urban-rural differences have decreased over time. Over time, the absolute gender gap has increased with an absolute 2.6% gender gap in 1992–3 increasing to 3.8% gender gap in 2005–6.

Similar patterns in inequalities are seen for antenatal care coverage. In 2005–6, 77% of Indian women during their pregnancy received some form of antenatal care in the three years preceding the survey, even though only 52% had the recommended three or more visits. Overall, progress in antenatal care coverage has increased over time. Inequalities by wealth, education and urban-rural residence however persist, even though absolute and relative inequalities have decreased over time. For both these preventive services, there are considerable state differences, with both the number of antenatal visits and the type of services provided during these visits varying.

Inequalities in curative health care

Inadequate access to appropriate maternal health services remains an important determinant of maternal mortality. Although the rates of institutional delivery have increased over time, only 40% of women in India report giving birth in a health facility for their last birth in 2005–6. There exists a six-fold difference between the richest and poorest quintile in institutional delivery. Although this relative difference in inequality has declined over time, the absolute percentage point difference in the prevalence of institutional delivery between the poorest and richest has increased from 65% in 1992–3 to 70% in 2005–6. Among scheduled tribes, institutional delivery was 17.1% in 1998–9 with minimal improvement to 17.9% in 2005–6.

Similarly, there are marked variations in general hospitalization rates by gender, wealth, and urban-rural residence.28 Some of this variation may be due to differences in actual and perceived need and health seeking behaviour; indeed, there is evidence of gender inequalities in untreated morbidity with the likely underreporting of illness among women. Although the poor are more likely to seek care in the public sector, the rich capture more of their share of public services because they are more likely to utilize these services, and also seek care in higher level facilities.29 The rich are also more likely to be hospitalized, and have longer in-patient stays in the public sector.30 Previous analysis of public sector health services demonstrated that the preventive care services of immunization and antenatal visits show a more equitable distribution than most curative care.

In summary, even though progress has been made, inequalities continue to persist in access to services. There are differential trends in relative and absolute inequalities suggesting differential uptake and access to services by different groups and understanding these nuanced patterns has policy implications for better targeting services to vulnerable groups.

Summary

There is a cogent moral, social and economic argument for investing in achieving equity in the health care of Indians. Recent rapid economic growth provides for a unique opportunity to increase financial commitments to support the public health system and health systems research. India can also draw on the knowledge capital of its booming technology sector to innovate and strengthen the development of health information systems, which has already begun. Furthermore, there is the opportunity to harness the capability of the domestic pharmaceutical industry by inducing it to take greater responsibility for delivering equity in health care. We have suggested principles to guide this vision. The next step is translating these into real and practical policies and effectively implementing them, and the takes up this challenge. Yet, this focus on the role of the health system needs to be placed within the broader and bigger context of the social determinants of health, and tackling the root causes of social disadvantage. In this way, a health system built on a strong foundation of public health and primary care must be synergized with public policies that promote critical intersectoral approaches. Improved water and sanitation, food security, poverty reduction and changes to other structural factors, complemented by a more equitable health system, will help ensure more equitable health for more than a billion people.

Keywords

Quality of care, Bureaucratic Caring Theory

Self Assessment

1. ……….statesQuality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes.

A. WHO
B. UNESCO
C. MFO
D. HBO

2. ………..based on evidence-based professional knowledge and is critical for achieving universal health coverage

A. Quality of health
B. Quality of care
C. Quality of knowledge
D. Quality in Medical expenses.

3. …….contends that caring regenerates life energies and potentiates our capabilities.

A. Jean Piaget
B. Jean-Jacques Rousseau
C. Jean Watson
D. Jean Baudrillard

4. Caring is a mutually ……..experience for both the patient and the nurse, as well as between all health team members.

A. Negative
B. Sceptical
C. Unavoidable
D. Beneficial

5. Caring is to be retained as the essence of ……..

A. Nursing
B. Plumber
C. Engineer
D. Lecturer

6. Examination of the concept of caring resulted in the identification of the following ……epistemological perspectives.

A. Seven
B. Five

C. Nine
D. Eight

7. …….has been described as the "core" or the "essence" of nursing profession.
A. Selfishness
B. Evilness
C. Caring
D. Possessiveness
8. ………., have concentrated research efforts on exploring the nature of caring and its relationship to and ramifications for the profession.
A. University Of Sussex
B. Howard University
C. Manchester University
D. University Of Colorado Health Science Center

9. The American Academy of Nursing and Sigma Theta Tau….has sponsored researches on exploring the nature of caring and its relationship to and ramifications for the profession.
A. 1989
B. 1899
C. 1090
D. 1990

10. Bureaucratic Caring Theory was developed by……...
A. Mrinalini Sarabhai
B. Marilyn Ray
C. Malika Sarabhai
D. Satyajit Ray

11. ………illuminates the relationship of all stakeholders within a bureaucratic (complex organization) system.
A. Demographic Transition theory
B. Malthusian theory
C. Bureaucratic Caring Theory
D. Functionalist theory.

12. Both health care and military systems are inherently bureaucratic in nature.
A. The statement is partially true
B. The statement is partially false
C. Statement is false
D. Statement is true

13. Caring for Women is a book contributed by …..
A. Bevis
B. Emile Durkheim
C. Karl popper
D. Francis Bacon

14. According to ……………caring to be a feeling of dedication, a feeling that motivates nursing actions.
A. Hebert Spencer
B. Bevis
C. Judith Butler
D. Simone de Beauvoir
15. The inverse care law, whereby those with the greatest need for health care have the greatest difficulty in accessing health services and least likely to have their health needs met, is highly applicable in ……………
A. Denmark
B. Croatia
C. India
D. Spain

Answers forSelfAssessment

l.	A	2.	B	3.	C	4.	D	5.	A
6.	B	7.	C	8.	D	9.	A	10.	B
11.	C	12.	D	13.	A	14.	B	15.	C

Review Questions

1) What do you understand by care Society?
2) Explain in detail Rise of care in the health scenario.
3) Give a detail note on care society and health care
4) Throw light on Developments and Implications of care policies for the patients.
5) Write a note on care and how that is related with nursing profession.

Further Readings

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Unit 09: The Social Construction of Illness

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Objectives

- To understand the concept of Illness
- To know what the social construction of illness
- To understand the rise of medicalization & its implication on health and well being

Introduction

The World Health Organization has defined health as a state of complete physical, mental and social well-being (World Health Organization 1980). However, the meanings and perceptions of health, illness and health-seeking behaviour are not the same across cultures. Hence, to deal with the concept of health and illness it is necessary to include the causes of illness, the treatment-seeking behaviour and the utilisation level of health care services. The concept of illness is very significant as it is defined as the ill health the person identifies themselves with, often based on self-reported mental or physical symptoms. In some cases, this may mean only minor or temporary problems, but in other cases, self-reported illness might include severe health problems or acute suffering. A very large population of people are still living in slums and are vulnerable to ill health due to low socioeconomic status and poor living conditions, which are unhygienic and conducive to infections. Low levels of awareness and lack of access to preventive and curative aspects of care aggravate the situation. Illness extends the range of bodily as well as mental experiences (e.g., delusions and dementia), thus opening up new avenues for the philosophical study of embodiment. Moreover, illness is (at present) an integral part of biological life and thus must be taken into account when considering human life, existence, and questions of its value, meaning, and trajectory. Discussions of the good life, human relationships, and ethics would be incomplete if they did not take into account the full spectrum of human life and experience, spanning sickness and health, childhood, adulthood, and old age. In addition, illness is an opportunity for reflection, because of its distancing effect, which illuminates taken-for-granted values and expectations by destroying the assumptions that underpin them (e.g., assumptions about longevity, capability, and autonomy) (Carel 2013). This chapter gives a glimpse into conceptual understanding of illness and how that becomes a huddle to the social development. For that purpose, the chapter details with how illness can be socially constructed as well as its focus to understand the rise of medicalization & its implication on health and well-being.

9.1 Concept of Illness

Physiologically looking the idea of illness is mentioned when you experiencesill health as appearing dull, weak and turning dark, lack of appetite, sleepiness, inability to walk and upsetting movements, drowsiness, sunken eyes, pale and dry eyes, pain in the body, etc. Changes in the colour of urine and faster pulse rates also imply ill health. The symptoms of ill health for children are not taking food, lack of interest in play, sleepiness, hotness of the body and frequent crying. Physical characteristics such as the pale colour of the body, rashes on the body, protruding belly and narrowing of buttocks also symbolise ill health. Being with these, commonsensical people describe illness, disease, sickness for all these above symptoms. But the concept of illness, disease and sickness have different understanding while relating to it to health. The concept trilogy of ''illness,'' ''disease,'' and ''sickness,'' has been used to capture different aspects of ill health, and is explained to apply the following, generally used, definitions of them. Illness is defined as the ill health the person identifies themselves with, often based on self-reported mental or physical symptoms. In some cases, this may mean only minor or temporary problems, but in other cases, self-reported illness might include severe health problems or acute suffering. It may include health conditions that limit the person's ability to lead a normal life. According to this definition, illness is seen as a rather wide concept.

Disease, on the other hand, is defined as a condition that is diagnosed by a physician or other medical expert. Ideally, this would include a specific diagnosis according to standardised and systematic diagnostic codes. This would in most cases also mean that the specific condition has a known biomedical cause and often known treatments and cures. However, it should be mentioned that there are several limitations to this ideal in practice. One is the fact that several medical diagnoses have to be based on subjective information from the patient concerning pains and feelings. Another limitation is the fact that a number of diagnoses are based on syndromes and complex interrelations between different organ systems and thus are not always very specific. But compared to both Sickness is related to a different phenomenon, namely the social role a person with illness or sickness takes or is given in society, in different areas of life. One type of data concerning a more limited aspect of sickness is that relating to sickness absence from work. Such data are often used to measure social consequences for the person with ill health.

These three concepts are often thought to overlap (refer to figure 09(1)) in that a person who does not feel well, is diagnosed by a physician, and then, if the problems are serious and affect their ability to work, is sick-listed. In reality, however, things are not this simple. In some forms of experienced illness, the person never bothers to have the condition confirmed by a physician, either because the problem is too small or because there is not much help available. Some illnesses and diseases do not lead to sickness and most illnesses and diseases do not lead to sickness absence, either because they do not lead to a reduction in the work capacity needed, or the person may still choose to work, that is t

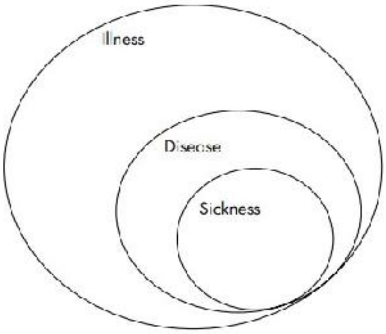

Fig. 09(1).

Apart from these three concepts, which seem to be related in a complex way, we have a fourth one—the concept of health. The concept of health has been defined and understood in many different ways. Often the term is used as the opposite of illness or disease, so that the more you have of illness or disease, the less you have of health and vice versa. In the past decade, however, health has often been understood to belong to a completely different dimension from disease or illness and thus, not defined as their opposite. In this tradition various definitions of health are used, for instance, health is defined as well-being, the capacity to act to reach vital goals or the possibility of experiencing a meaningful life.These theoretical definitions are well in line with the results from different surveys in which laypersons are asked how to define health and most people do not see health only as a state where they are free of serious illness and disease.

Although the concept of illness appears to be an objective construct when compared to the concept of health, a closer look at some philosophical issues which underlie illness definition reveals that it might not necessarily be the case. As indicated by Balog (1978), finding an appropriate and encompassing definition of illness may be as difficult a task as it is to define health. That is while no one would reject the notion that improper functioning and deviation from normality are essential components of illness, it might be not so easy to establish agreement concerning what constitutes proper functioning and what characterizes a deviation from normality. There is reason to believe that an individual may be functioning improperly, though not regarded as ill. Lack of observable or felt symptoms is also not a good delimiter of a non-sick state. Moreover, medical professionals and lay persons differ in their judgements and interpretations of symptoms and signs. Thus, what is considered a "sick condition" by the former group may not be so designated by the latter. Value judgements and social norms have played a strong role, not only in defining health but also in defining illness. Despite the above-mentioned problems in obtaining a universally valid concept of illness, the importance of understanding individuals' ideas of illness and illness-related issues (for both enhancing health, and promoting adaptive coping).

Philosophical reflection on Illness

Philosophical reflection on illness in the Western tradition has tended to be shaped by Stoic, Epicurean, and, later, Christian philosophies, each of which emphasises the importance of achieving an insightful deal with illness, seen as an essential feature of the world. whereas, Epictetus (2004), Seneca (2004), Marcus Aurelius (1995), Boethius (2004), and Descartes (1988) write about illness and its contribution to the modes and themes of philosophising, as well as the relationship between health and virtue, and health's contribution to the good life.

The stoics seem to argue that everything that exists, including apparently bad things like illness, are all essential components of the rational order of the cosmos, so the proper philosophical response is to recognise this and reflectively accept illness. On the same, Epictetus says as a man who has a fever may say: If I philosophize any longer, may I be hanged: wherever I go, I must take care of the poor body, that a fever may not come. But what is philosophizing? Is it not a preparation against events which may happen?" (2004, Discourses, "In what manner we ought to bear sickness").But for later Christian thinkers, such as Boethius, illness is a mark of our corrupt, imperfect state, and hence not an original feature of God's design. Boethius characterises wickedness of the soul as akin to bodily sickness; while the former deserves hatred, the latter should be treated with pity (Consolation of Philosophy, book IV). So, as Ian James Kidd argues, the proper philosophical response is to use illness in a particularly enlightening way: first, as a reminder of the frailty and corruption of our mortal status and, second, as a source of moral and spiritual improvement (Kidd 2012).

Illness Modifies Embodiment, Meaning, and Being in the World

Three aspects of existence are significantly modified by illness: embodiment, meaning, and being in the world. Embodiment is the fundamental characteristic of human existence (Merleau-Ponty 1962; Clark 1997, 2008; Wheeler 2005). Cognition and behaviour cannot be accounted for without considering the perceptual and motor tool that facilitates our dealing with the world (Calvo and Gomila 2008, 7). The body is the condition of possibility for perception and interaction with spatial objects and our means of having a world. As Shaun Gallagher and Dan Zahavi write, "The body is considered a constitutive or transcendental principle, precisely because it is involved in the very possibility of experience" (2008, 135). Every worldly experience is mediated and made possible by the embodiment (Zahavi 2003, 99). Or as Merleau-Ponty puts it, the body is "that which causes [things] to begin to exist as things under our hands and eyes" (1962, 146).

Counter to a purely naturalistic understanding, the body is not merely a thing among things. The embodiment determines spatial relations and temporal experiences, whilst also participating in these relations as a secondary form. The body is "the centre around which and concerning which space unfolds itself (Zahavi 2003, 99). According to Husserl, motility and tactile experience are fundamental not just for perception but for any organised subjective experience (Husserl 1997). In this sense, the body is the foundation of human experience. As Taylor Carman writes, the body "plays a constitutive role in experience precisely by grounding, making possible, and yet remaining peripheral in the horizons of our conceptual awareness" (1999, 208). Or to use Merleau-Ponty's famous formulation, the body is "our general medium for having a world" (1962, 146). I.e. Husserl's terms, the constitution of my body is essential to the constitution of objects appearing to me and indeed to the constitution of space and time (Husserl 1997, & 73)

9.2 The Social Construction of Illness

In the last 50 years, the social construction of illness has become a major research area in the subfield of medical sociology, and it has made significant contributions to our understanding of the social dimensions of illness. The sociology of health and illness studies the interaction between society and health. The sociology of health and illness requires a global approach of analysis because the influence of societal factors varies throughout the world.Where asSocial constructionism is a conceptual framework that emphasizes the cultural and historical aspects of phenomena widely thought to be exclusively natural. The emphasis is on how meanings of phenomena do not necessarily inhere in the phenomena themselves but develop through interaction in a social context. Put another way, social constructionism examines how individuals andgroups contribute to producing perceived social reality and knowledge (Berger and Luckman 1966). A social constructionist approach to illness is rooted in the widely recognized conceptual distinction between disease (the biological condition) and illness (the social meaning of the condition) (Eisenberg 1977). Although there are criticisms and limitations of this distinction (Timmermans and Haas 2008), it is nevertheless an exceedingly useful conceptual tool. In contrast to the medical model, which assumes that diseases are universal and invariant to time or place, social construction it is emphasized on how the meaning and experience of illness are shaped by cultural and social systems.

There are multiple intellectual roots of a social constructionist approach to illness. Some of the basic building blocks are evident in the writings of early sociological thinkers (e.g., Emile Durkheim, Karl Mannheim, and W. I. Thomas), but during the 1960s with the more direct predecessors of, and early contributors to, the social construction of illness. One of the most important intellectual foundations of the social construction of illness is social problems theory and research from the 1960s and 1970s. Distancing themselves from positivist interpretations, scholars in this tradition asserted that what comes to be identified as deviant behaviour or a social problem is not "given," but rather is conferred within a particular social context and in response to successful "claims-making" and "moral entrepreneurialism" by social groups (Becker 1963; Gusfield 1967, 1975; Spector and Kitsuse 1977). These scholars also emphasized the intentional use of these categories for the purpose of social control (i.e., defining and enforcing how particular people ought to behave). The basic tenets of this framework have been readily applied to illness. Specifically, medical sociologists point to the contingent processes by which certain behaviours and experiences come to be defined as medical conditions, and the way those definitions can function as a type of social control (Conrad and Schneider 1992; Zola 1972).

Symbolic interactionism and phenomenology were the two popular and overlapping intellectual trends in sociology in the 1960s that have also significantly contributed to a social constructionist approach to illness. Erving Goffman's (1961, 1963) early work helped to shape the symbolic interactionist tradition. Through his conceptualization of the "moral career," Goffman spoke to the social experiences of patient hood, as distinct from any biological condition that may (or may not) launch such a career. According to Goffman and other symbolic interactionists, individuals actively participate in the construction of their own social worlds, including the construction of selfhood, via ongoing social interaction (Blumer 1969). The key tenets of symbolic interactionism effectively lent themselves to a detailed exploration of illness as experienced within the context of daily social interactions, which in turn alter the performance of self (Charmaz 1991; Glaser and Strauss 1965). In a related fashion, phenomenological tenets (Berger and Luckmann 1966; Schutz 1967) were appropriated by medical sociologists to showcase how individuals make sense of their illness, how they cope with physical and social restrictions, and how they deflect self-erosion in the face of those restrictions (Bury 1982).

Eliot Freidson's (1970) paradigm-shifting book, Profession of Medicine, also laid important groundwork for the social construction of illness approach. In the latter part of the book, in a section titled "The Social Construction of Illness," Freidson (1970) explains how illnesses have con sequences independent from any biological effects as “When a physician diagnoses a human's condition as an illness, he [sic] changes the man's [sic] behaviour by diagnosis; a social state is added to a biophysiological state by assigning the meaning of illness to disease. It is in this sense that the physicians create illness . . . and that illness is . . . analytically and empirically distinct from mere disease, (p. 223). Not only did Freidson (1970) explicitly recognizes the real and tangible social consequences of an illness label, but he also urged sociologists to address "how signs or symptoms get to be labelled or diagnosed as an illness in the first place" (p. 212). By arguing that illness and disease, like deviance, are social constructions (i.e., they are evaluative categories based on social ideas about what is not "acceptable" or "desirable"), Freidson predicted the subsequent sociological study of medical categories and knowledge.

The writings of Michel Foucault (1977) and work in the Foucauldian tradition, although in a different manner, also emphasized the scrutiny of medical knowledge, and, in so doing, contributed significantly to the social construction of illness approach. Foucault regarded knowledge as forof power. Specifically, he argued that expert knowledge about human "normality" and "abnormality," which is not objective or naturally given, is the principal form of power in modern societies: hence, his often quoted expression, "knowledge/ power." Foucault stressed how medical discourse constructs knowledge about the body, including disease. As Bryan Turner (1995) notes, "We can no longer regard diseases as natural events in the world which occur outside the language in which they are described. A disease entity is the product of medical discourses" (p. 11). In turn, medical discourse can influence people's behaviours, impact their subjective experiences of embodiment, shape their identities, and legitimate medical interventions (Foucault 1975, 1977). Accordingly, Foucault-inspired scholars deconstruct medical knowledge (i.e., provide a detailed analysis of medical discourse) to reveal its embedded meanings, normalizing tendencies, and relationship to embodiment and identity (Barker 1998; Lupton 1997; Rose 2006).

This is by no means an exhaustive account of the intellectual strands that lead up to, and continue to inform, a social constructionist approach to illness. Moreover, these strands are not mutually exclusive. Many medical sociologists draw on various aspects of these different traditions. As we proceed, we consider the social construction of the illness approach as something of an amalgam. Although this minimizes important differences between various types of social constructionism, it can be justified in that they all share an eschewal of a strictly positivist conception of illness as the mere embodiment of disease. The approach foregrounds how illness is shaped by social interactions, shared cultural traditions, shifting frameworks of knowledge, and relations of power.

Cultural Meanings of Illness

Illnesses have both biomedical and experiential dimensions. Although often unnoticed or taken for granted, certain illnesses have particular social or cultural meanings attributed to them. These meanings adhere to the illness and may have independent consequences on patients and health care. Cultural analysts point out that illnesses also may have metaphorical connotations. Susan Sontag (1978), for example, argued that negative metaphorical meanings of cancer, such as evil or repressive, are common in our society and significantly impact those afflicted with the disease. Similarly, Barry et al. (2009) examined how obesity metaphors, such as "obesity as sinful" (gluttony), affect individuals' support for different public policies aimed at reducing obesity.

While sociologists have rarely focused on the metaphorical meanings of illness, they have examined the impact of other cultural meanings embedded in illness. In this regard, all illnesses are not the same. For instance, some illnesses are stigmatized, and others are not; some are contested, and others are not; and some are considered disabilities, while others are not. What is important about these distinctions is that they exist for social rather than purely biological reasons. As we will see, sociologists are keenly interested in examining these distinctions because they bring into sharp relief the cultural landscape that ordinarily eludes us; or, as the anthropologist Ralph Linton (1936) once quipped, "The last thing fish would notice is water." But more than mere sociological curiosities, these cultural meanings have an impact on the way the illness is experienced, how the illness is depicted, the social response to the illness, and what policies are created concerning the illness.

Here, one key line of sociological research is that which considers the cultural meaning of stigmatized illnesses. Drawing on the work of Goffman, Gussow and Tracy (1968) were the first to distinguish "stigmatized illness" as a category using the case of leprosy. Subsequent researchers examined the construction and impact of a number of stigmatized illnesses, including mental illness, epilepsy, cancer, HIV/AIDS, and sexually transmitted diseases (STDs). These researchers have identified how some illnesses become stigmatized, the impacts of stigma, the ways individuals and collectivities manage stigma, and how illness stigma can change over time. For example, research has shown, in the case of epilepsy, that it can be more difficult for sufferers to manage the stigma than the seizures (Schneider and Conrad 1983; Scambler 1989). In the case of HIV/AIDS, other research has shown how stigma limits access to treatment and affects relationships and identity (Epstein 1996; Weitz 1990). The lesson from a constructionist standpoint is that there is nothing inherent about a condition that makes it stigmatizing; rather, it is the social response to the condition and some of its manifestations, or the type of individuals who suffer from it, that makes a condition stigmatized (Conrad 1987).

Contested illnesses are a category of disorders that, by definition, have a very particular cultural meaning. These are illnesses where sufferers claim to have a specific disease that many physicians do not recognize or acknowledge as distinctly medical. Contested illnesses, including chronic fatigue syndrome, fibromyalgia syndrome, irritable bowel syndrome, and multiple chemical sensitivity are medically suspect because they are not associated with any known physical abnormality. These illnesses showcase the tension between lay and medical knowledge with respect to the cultural legitimation of symptoms and suffering. In the words of one researcher, these are "illnesses you have to fight to get" (Dumit 2006). Physicians, the public, and sometimes even sufferers themselves question the authenticity of the symptoms and the mental stability of the sufferer. In sum, contested illness sufferers are burdened by the cultural meaning of a medically invisible condition in an era of high-tech biomedicine (Barker 2005; Brown 2007; Kroll-Smith and Floyd 1997). In fact, this becomes one of the most important characteristics of these illnesses, affecting access to a diagnosis and health care, the response of others to one's problem, and the very identity of the sufferer.

Research describing the social construction of disability also provides a powerful example of the cultural meaning of certain conditions. The roots of this approach are found in Goffman's (1963) Stigma, wherein he highlights the social meaning physical impairment comes to acquire via social interactions. Specifically, Goffman claims that the social meaning of impairment does not emanate from the impairment itself, but from the fabric of everyday life. The social model of disability, grounded on social constructionist tenets, conceptually distinguishes impairment (i.e., the attribute) from disability (i.e., the social experience and meaning of impairment). Because the attributes that are deemed disabilities, and the very meaning of being disabled, vary across time and space, disability cannot be reduced to a mere biological problem located in an individual's body (Barnes, Mercer, and Shakespeare 1999). In its most basic form, this distinction suggests that the body has an impairment (e.g., loss of a limb) while society creates the disability (Oliver 1996). Rather than a "personal tragedy" that should be fixed to conform to medically determined standards of "normality" (Zola 1982), disability becomes politicized. New questions then emerge. What obstacles limit the opportunities for individuals with impairments? How can those obstacles be altered or removed?

As we have noted, certain illnesses come to have cultural meanings that are not reducible to biology, and these cultural meanings further burden the afflicted. At a general level, insights from this line of research suggest a shift in emphasis away from an exclusive focus on bio medically fixing individuals and toward changing the social and cultural context that gives particular illnesses their negative meaning. For example, there are policy implications of both stigmatized illness and contested illness. Stigmatized illness can make an illness much more difficult to treat and manage. For example, if an illness such as epilepsy or HIV/AIDS has a powerful stigma, it can make people less likely to seek treatment for fear of being mistreated by health care providers and publicly associated with a tainted condition. Obese women report avoiding routine gynecological exams, despite having higher rates of gynecological cancers than non-obese women, because of the stigma of obesity and the corresponding negative attitudes of health care professionals toward overweight people (Amy, Aalborg, Lyons, and Keranen 2006). Therefore, an effective policy based on early cancer screening must overcome this barrier.

The Continuous changes in economy, therapy, technology and insurance can affect the way individual communities view and respond to the medical care available. These rapid fluctuations cause the issue of health and illness within social life to be very dynamic in definition. Advancing information is vital because as patterns evolve, the study of the sociology of health and illness constantly needs to be updated. Sociologists have rarely focused on the metaphorical connotations of illness; they have examined the impact of other cultural meanings embedded in illness. In this regard, all illnesses are not the same. For instance, some illnesses are stigmatized, and others are not; some are contested, and others are not; and some are considered disabilities, while others are not. What is important about these distinctions is that they exist for social rather than purely biological reasons. As we will see, sociologists are keenly interested in examining these distinctions because they bring into sharp relief the cultural landscape that ordinarily eludes us; or, as the anthropologist Ralph Linton (1936) once quipped, “The last thing fish would notice is water.” But more than mere sociological curiosities, these cultural meanings have an impact on the way the illness is experienced, how the illness is depicted, the social response to the illness, and what policies are created concerning the illness.

The illness experience is socially constructed, for example, the construction and impact of a number of stigmatized illnesses, including mental illness, epilepsy, cancer, HIV/AIDS, and sexually transmitted diseases (STDs). We can observe how some illnesses become stigmatized, the impacts of stigma, the ways individuals and collectivities manage stigma, and how illness stigma can change over time. The assertion is grounded in the strong pragmatist underpinnings of symbolic interactionism and phenomenology, which suggest that reality does not just exist out there in the world waiting to be discovered, but rather is created by individuals who act in and toward their world. Applied to illness, people enact their illness and endow it with meaning. They are not merely passive entities to whom things are done (be it by a disease or by doctors and treatments). This is the general starting point for a number of important lines of sociological research, all highlighting the everyday and subjective experience of illness. In the 1960s, sociologists began to study the patient's perspective of illness (e.g., Glaser and Strauss 1965; Goffman 1961). Strauss and his colleagues (Strauss and Glaser 1975), however, were among the first to recognize that the patient experience is not the same as the illness experience; after all, people with illnesses spend very little time in the patient role. This important step laid a foundation for a more developed approach to the experience of illness. Building on this tradition, Conrad (1987) elaborated the approach: sociology of illness experience must consider people's everyday lives living with and in spite of illness. It needs to be based on systematically collected and analysed data from a sufficient number and variety of people with an illness. Such a perspective necessarily focuses on the meaning of illness, the social organization of the sufferer's world, and strategies used in adaptation. (pp. 4–5) This research is usually based on in-depth interviews, focusing on the subjective illness experience and creating an "insider's" view. Such a perspective is well positioned to examine how individuals construct and manage their illness, and with what consequences. The research of Charmaz (1991) is a well-developed example. Charmaz describes how the worlds of some individuals shrink when they are immersed in the day-to-day aspects of managing a chronic illness. They become increasingly cut off from the routines of conventional life—unable to work, spend time with family, socialize with friends, or move about freely. Thus, the foundation on which a sense of self is based can be lost, there is nothing to look forward to, and nothing to do; time is experienced as unchanging (Charmaz 1991). There are also a number of studies that closely examine the experience of specific illnesses such as HIV/AIDS (Klitzman and Beyer 2003; Weitz 1990), diabetes (Peyrot, McMurry, and Hedges 1987), asthma (Snadden and Brown 1992), and fibromyalgia (Barker 2005). Schneider and Conrad (1983), for example, provide a detailed account of Journal of Health and Social Behaviour 51(S) the experiences of individuals with epilepsy, including the ins and outs of when, and to whom, they reveal or conceal information about their illness. From getting a driver's license and negotiating intimate relationships, to going on a job interview or being on the lookout for "safe places" to have seizures, individuals with epilepsy try to maintain self-control, skirt embarrassment and discrimination, and avoid becoming the object of a public crisis. Whether focusing on chronic illness in general, or on a specific chronic illness, these are the types of rich details that emerge from research into the illness experience. This research also describes how people struggle to make sense of their illness and reclaim a sense of self. People endeavour to endow their illness with meaning within the context of their personal and social relationships, employment status, health insurance coverage, religious and cultural beliefs, and the like. Individuals may abate an erosion of self by engaging in identity reconstruction. Said differently, when illness becomes a "biographical disruption," individuals recast themselves in terms of new and unexpected plot developments (Bury 1982). Chronic illness can prompt a re-evaluation of one's former life and identity, and, in some cases, the creation of a new illness identity (e.g., cancer survivor). Finally, medical sociologists have documented how laypeople sometimes create and join illness-based social movements, generate lay knowledge about their own medical conditions, and forge new communities based on illness identities (Banks and Prior 2001; Brown et al. 2004; Kroll-Smith and Floyd 1997). Millions of American women, for example, identify as breast cancer survivors and activists in the fight against breast cancer. They exchange information about their treatment options, participate in national fundraising events, and mobilize in support of relevant policies and initiatives (Klawiter 2008; Radin 2006).

In sum, individuals actively shape the parameters of their illness and the meaning of selfhood in relationship to those parameters. This line of research brings to the fore aspects of illness that the tools of medicine are unable to reveal. A constructionist approach takes the subjective experience of illness seriously, examining the personal and social meanings of illness, and exploring how illness is managed in the social contexts that sufferers inhabit. This research has given us a detailed and intimate view of the suffering that illness often represents, but it has also shown us that agency and resistance are key to the illness experience. Even in illness individuals are not passive: "the self is more than its body and much more than an illness" (Charmaz 1991:258).

Policy Implications of Illness experience as Socially Constructed, i.e.the key research findings concerning the social construction of the illness experience have a number of critical policy implications. First, some of these findings shed a new light on clinical perspectives and policies toward issues such as "noncompliance" (Conrad 1985; Peyrot et al. 1987) and the impact of the subjective perspective on interactions with medical professionals and care-givers (Waitzkin 1991). The focus on the meanings of medications in the context of a patient's everyday life, rather than on compliance with doctors' orders, allows the clinical policy focus to shift from "compliance" to context-centered strategies to improve the effective implementation of medical regimens. By giving voice to the sufferers' perspective, the experience of illness approach can lead to important clinical reforms. Take the case of pain management. Despite its vast technical arsenal, medicine is simply unable to see or measure pain. For this reason, physicians have often trivialized the pain of patients who lack a visible injury to account for their suffering. More aggressive pain management may be mandated, however, once we take seriously and develop appropriate means of evaluating the vivid accounts of chronic pain sufferers. The current interest in narrative medicine is in large part predicated on the work of sociologists and others who were among the first to listen to illness stories (Frank 1995). As a window into subjective experience, illness narratives are now used as a means of bringing the person back into medicine, both as an end in itself and for potential therapeutic benefits. Again, chronic pain is illustrative: When it comes to affirming the humanity of the sufferer and authenticating the existence of pain, patient narratives are a tool for overcoming the limitations of high-tech medicine (Kleinman 1988). There are also policy and clinical implications associated with the constructionist findings regarding lay knowledge and illness identities. With the expansion of the Internet, laypeople are becoming more actively involved in producing and consuming knowledge about their own health conditions; they are also increasingly likely to create and embrace new illness identities. Some medical Conrad and Barker S73 sociologists suggest that lay ways of knowing may supplement medical knowledge and positively influence health outcomes (Brown 1992; KrollSmith and Floyd 1997). Illness identities might also contribute to improved well-being insofar as they represent a form of self-empowerment (Popay and Williams 1996). However, there are also reasons to be concerned that lay knowledge and illness identities may negatively impact doctor–patient relationships and health outcomes and contribute to the expansion of medicalization (Fox, Ward, and O'Rourke 2005; Hardey 1999). For better or worse, lay and experiential knowledge will increasingly come into conflict with and challenge professional knowledge. This is all the more assured given orthodox medicine's mixed record of therapeutic efficacy in the face of many chronic illnesses. Coming to terms with these lay-medical conflicts and the movements they engender will create major policy challenges.

9.3 Rise of Medicalization & Its Implication on Health and Well Being

Medicalization describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness or disorders. Psychiatry is first to give attention to medicalization, although they did not call it that (e.g. Szasz, 1963). Pitts (1968), Freidson (1970) and Zola(1972) presented the initial examinations of medicalization and medical social control. They took their inspiration from sources as different as parsons (1951) and labeling theory. Parsons was probably the first to conceptualize medicine as an institution of social control, especially the way in which the 'sick role' could conditionally legitimate that deviance termed illness.

A number of case studies of the medicalization of deviance were published in the 1970's: Conrad(19755) on hyperactivity in children, Scull(1975) on mental illness ,Pfohl(1977) on child abuse, and Schneder(1978) on alcoholism as a disease. Other studies analysed changes from non-medical to medical definitions and treatments, although they did not necessarily use a medicalization framework (e.g. Foucault 1965, Gusfield (1967), Wertz & 1989).

The key research findings concerning the social construction of the illness experience have a number of critical policy implications. First, some of these findings shed a new light on clinical perspectives and policies toward issues such as "noncompliance" (Conrad 1985; Peyrot et al. 1987) and the impact of the subjective perspective on interactions with medical professionals and care-givers (Waitzkin 1991). The focus on the meanings of medications in the context of a patient's everyday life, rather than on compliance with doctors' orders, allows the clinical policy focus to shift from "compliance" to context-centred strategies to improve the effective implementation of medical regimens. By giving voice to the sufferers' perspective, the experience of illness approach can lead to important clinical reforms. Take the case of pain management. Despite its vast technical arsenal, medicine is simply unable to see or measure pain. For this reason, physicians have often trivialized the pain of patients who lack a visible injury to account for their suffering. More aggressive pain management may be mandated, however, once we take seriously and develop appropriate means of evaluating the vivid accounts of chronic pain sufferers. The current interest in narrative medicine is in large part predicated on the work of sociologists and others who were among the first to listen to illness stories (Frank 1995). As a window into subjective experience, illness narratives are now used as a means of bringing the person back into medicine, both as an end in itself and for potential therapeutic benefits. Again, chronic pain is illustrative: When it comes to affirming the humanity of the sufferer and authenticating the existence of pain, patient narratives are a tool for overcoming the limitations of high-tech medicine (Kleinman 1988).

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Summary

This chapter gives an overall understanding of Illness and have touched on several different ways medical sociologists have utilized a social constructionist approach for studying illness over the last 50 years. We have highlighted the key findings of three lines of research and pointed to some policy implications of each. First, some ill nesses are particularly embedded with cultural meaning? which is not directly derived from the nature of the condition? that shapes how society responds to those afflicted and influences the experience of that illness. Second, all illnesses are socially constructed at the experiential level based on how individuals come to understand their ill ness, forge their identity, and live with and in spite of their illness. Third, as feminist, science studies, and medicalization analysts have demonstrated, medical knowledge about disease is not necessarily objectively given in nature; rather, it is constructed and developed by claims-makers and interested parties who frequently have a strong evaluative agenda. These findings do not invalidate scientific and medical perspectives, but rather demonstrate that diseases and illnesses are as much social products as medical-scientific ones.

Keywords

SelfAssessment

1. …………has defined health as a state of complete physical, mental and social well-being in 1980.

A. UNICEF
B. UNESCO
C. WTO
D. WHO

2. The concept of …… is defined as the ill health the person identifies themselves with, often based on self-reported mental or physical symptoms.

A. Mortality
B. Fertility
C. Illness
D. Wellbeing

3. ……….is defined as a condition that is diagnosed by a physician or other medical expert.

A. Wellness
B. Disease
C. Immunity
D. Vaccination

4. Disease include a specific diagnosis according to standardised and systematic diagnostic codes.

A. The above statement is true
B. The above statement is false

C. The above statement is not related to chapter
D. The above statement is inappropriate

5. ……….is understood as the social role a person with illness or sickness takes or is given in society, in different areas of life.
A. Illness
B. Disease
C. Wellbeing
D. Sickness

6. …….has often been understood to belong to a completely different dimension from disease or illness and thus, not defined as their opposite.
A. Worthiness
B. Wealth
C. Health
D. Death

7. Earlier Christian philosophies looked at illness as ………….
A. Reason of good deeds
B. Reason of the sins and wickedness
C. Reason for the salvation
D. Reason for loneliness

8. The embodiment, meaning, and being in the world are the three aspects of existence are significantly modified philosophy of ……….
A. Illness
B. Wellness
C. Pandemic
D. Immunisation

9. Who quoted these words "The constitution of my body is essential to the constitution of objects appearing to me and indeed to the constitution of space and time"?
A. Edmund Husserl
B. Kylian Mbappé
C. Johnny Depp
D. Rishi Sunak

10. The social construction of illness has become a major research area in the subfield of medical sociology.
A. Cultural Sociology
B. Medical sociology
C. Political Sociology
D. Military Sociology

11. …………….emphasis on how the meaning and experience of illness are shaped by cultural and social systems.
A. Conservationist

B. Archaeologists
C. Social constructivist
D. Epidemiologists.

12. During 1960's, Symbolic interactionism and phenomenology were the two popular and overlapping intellectual trends in…… that has significantly contributed to a social constructionist approach to illness.
A. Political Science
B. Economics
C. Sanskrit
D. Sociology

13. Cultural Meanings of Illness emphasis on ………..
A. Esteemed
B. Health
C. Wellbeing
D. Stigmatization

14. ………describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness or disorders.
A. Socialisation
B. Medicalization
C. Immunisation
D. Vaccination

15. …….was probably the first to conceptualize medicine as an institution of social control, especially the way in which the 'sick role' could conditionally legitimate that deviance termed illness.
A. Talcott Parsons
B. Niklas Luhmann
C. Herbert Spencer
D. Auguste Comte

Answers for SelfAssessment

1.	D	2.	C	3.	B	4.	A	5.	D
6.	C	7.	B	8.	A	9.	A	10.	B
11.	C	12.	D	13.	D	14.	B	15.	A

Review Questions

1. Differentiate between the concept of illness, disease and Sickness?
2. Debate briefly about the historical growth of the philosophical understanding of illness.
3. Explain the significance of the Social construction of illness.
4. How Medicalisation becomes a tool for health and wellness.
5. Discuss illness, how social construction of illness can be understood.

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Unit 10: Social Determinants of Health

CONTENTS

Objectives
Introduction
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10.2 Politics and Economy of Health
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Objectives

- To understand the concept of Health and how that is understood from Social Determinants of Health perspective
- To understand the philosophical understanding of the politics and economy of Health.

Introduction

Health is a broad concept that includes a broad range of meanings that ranges from narrow technical definitions to all-embracing philosophical definitions. Health is often described as "devoid of illness" and as a state of well-being. These are created and maintained by a set of factors, which are known as determinants of health. According to World Health Organisation (WHO, 1948) "Health" is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". In the context of Medical Anthropology, David Landy (1997) defined health as the condition of an organism that permits it to adapt to its environmental situation with relative minimal pain and discomfort, achieve at least some physical and psychic gratification and possess a reasonable probability of survival.

Health is not just the physical well-being of an individual but also the social, emotional and cultural well-being of the whole country in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their community (Aboriginal Health and Medical Research Council of New South Wales, 2012). Different medical systems conceptualize health in different ways. For example, Ayurveda considers health as a balance between body, mind, spirit and social wellbeing.

Selective Definition	• Health as absence of disease of Health • Health as socio psychological adaptation or adjustment to circumstances • Health as a functional capacity to fulfil essential life functions.
Universal Definition	• Health as growth of Health • Health as independence, the exercise of autonomy and self determination • Health as well-being • Health as the realization of potential Health as

	empowerment Health as wholeness.

Table 10 (1)
(Source: Procter S 2000, Caring for Health, Macmillan Press, London)

If we consider the broad comprehensive definitions of health, we can identity that it covers not only physical health but also include mental, social and even spiritual dimensions of well-being. Hence it is developed and maintained by a number of determinants.

Health disparity, Health outcome and Health inequality

A Health Disparity is a difference that is closely linked with social, economic and or environmental disadvantage in achieving health or health outcomes. Health disparities adversely affect group of people who have systematically experienced greater obstacles to health based on racial group, religion, economic, cultural, gender, age, sexual orientation etc.

A health disparity is the differences in the incidence and prevalence of health conditions and health status between groups based on race, gender, socioeconomic status, disability status etc. Health Outcome is the changes in health that results from measures or specific health care investments or interventions. It is the change in the health of an individual, group or community which is attributable to an intervention or a series of interventions. For example, immunization Programme has brought down Infant mortality considerably in the last fifteen years. For example Niti Aayog (2020) data shows that in 2000, IMR was 68 and in 2016 it is 34. Here immunization is the medical intervention and reduction in IMR is the health outcome.

Health Inequality is observable health differences between subgroups within a given population; it can be measured and monitored. These are unjust and avoidable differences in people's health status between subgroups; health inequalities are against the principle of social justice, because they are mostly avoidable. Different study findings reveal that the degree of health inequalities escalates when the rising average income levels of the population are accompanied by rising income inequalities.

Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first case it may be impossible or ethically or ideologically unacceptable to change the health determinants and so the health inequalities are unavoidable. In the second, the uneven distribution may be unnecessary and avoidable as well as unjust and unfair, so that the resulting health inequalities also lead to inequity in health (WHO, 2018)

.

10.1 Social Determinants of Health

Social determinants of health can be defined as the conditions in the social, physical and economic environment in which people are born, live, work and this include access to health care. They consist of policies, programmes and institutions and other aspects of the social structure including the government and private sectors as well as the community factors. Social determinants affect the health of the population through the social and physical environment (Healthy People, 2000).

They are considered as the life-enhancing resources such as food supply, housing, economic and social relationships, transportation, education and health care whose distribution across the population effectively determines the length and quality of life.

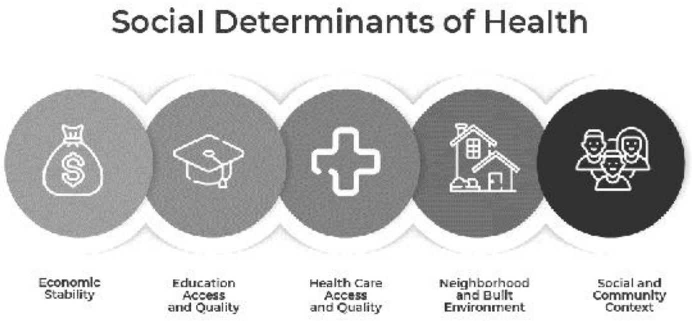
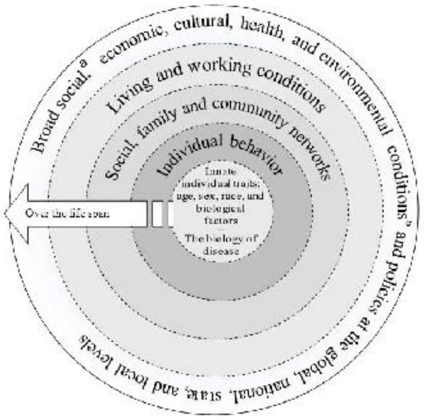


Fig. 10(1)

Let us see some examples on how social determinants of health increase or decrease health inequality:

Education: Mother education emerges as the single most important determinant of child health care utilization in India when the influences of other intervening factors are controlled (Govindasamy and Ramesh, 1997). The empirical results show that a higher level of maternal education results in improved child survival because health services that effectively prevent fatal childhood diseases are used to a greater extent by mothers with higher education than by those with little or no education.

Sex Ratio: According to NITI Aayog Data Number of females per 100 males in Haryana is 831 whereas for Kerala it is 967. The reason for this stark difference is attributed to education of women, employment of women, patriarchal status that is followed in the society etc., over all India's sex ratio is on decline where women are at disadvantage over the last few decades.



IOM model of multiple determinants of health used to develop Action Model for Healthy People 2020. Dahlgren, G (1995) *European Health Policy Conference: Opportunities for the Future. Vol. 11 – Intersectoral Action for Health.* Copenhagen: *WHO Regional Office for Europe*

Fig. 10(2)
Social Determinants of health

Figure 10(2), explains about various determinants of health in a comprehensive manner. This model is developed by Whitehead M and Dahlgren G and first appeared in their article titles "What can be done about inequalities in Health" in the Lancet in 1991.

We shall discuss eight social determinants of health in detail in this section.

a. **Family, Friends and Communities**: Studies show that social isolation and loneliness are associated with increase in the risk of heart disease and stroke. People who are socially connected to their family, friends and community are generally happier and live healthier lives with fewer physical and mental health problems than people who are less well connected.
b. **Money and Resources**: An inadequate income can cause poor health because poor access to resources bring in stress and it affects physical and mental health. Money is essential to have access to good food, water, and immunization etc., poverty damages health.

c. **Housing**: Studies show children living in congested rooms and houses have more than twice likelihood to suffer from respiratory problems rather than children living in spacious- aired houses.

d. **Education and Skills**: Good education and skills can help build strong foundations for support. Accessing good work, lifelong problem-solving ability, develop lifelong healthy habits, afford good quality of life, live and work in healthy environment all this is possible only if good education is ensured to the people.

e. **Good Work/ Employment**: Employability offers stability, security and regular income. It provides good wages and in turn ensures access to quality health care system. Good employment ensures that the person can afford basic living standard, ensure feel of self-esteem and worthiness, which all in turn has impact on the health of the person.

f. **Transport**: A healthy transport system can provide opportunities to improve air quality; also help people travel and access health care services like hospitals.

g. **Physical Surroundings:** Clean surroundings, spaces and buildings are essential for people's physical and mental health. For example, well maintained and easy to access green spaces in a city makes it easy for the people to be physically active.

h. **Access to Food**: Poor diet is one of the biggest risks for ill health. Healthy food needs to be affordable, available and accessible within the available resources at disposal.

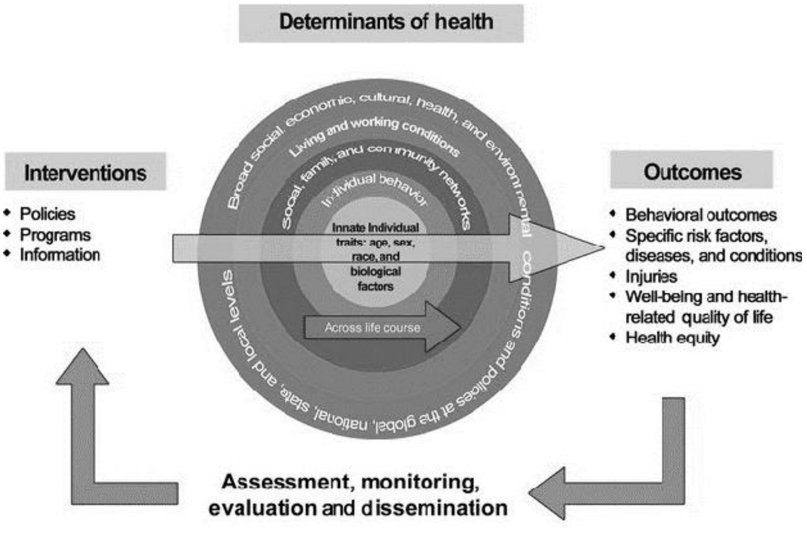


Fig. 10 (3): Action Model to Achieve Healthy People
(Source: Healthy Campus 2020: Determinants of Health and Evidence-Based Actions)

Commission on Social Determinants of Health

Commission on Social Determinants of Health was formed by World Health Organization in 2003. The Commission released its final report in 2008, and this document serves as a guiding principle to policy makers in developing countries like India to shape health policies and programmes that acknowledge the role of social determinants of health. It acknowledged and identified that marked inequities in health care caused by a) Structural Determinants (for example: unequal distribution in power, money, goods and services globally, nationally and locally) and b) Conditions of Daily Life (for example: consequent unfairness in the immediate conditions in people's lives — access to school, education, health care, conditions of work, leisure time etc.).

The Commission made three major recommendations as follows

1. Improve daily living conditions.
2. Tackle the unequal distribution of power, money and resources.

3. Measure and understand the problem of health inequality and assess the impact of interventions continuously

Another Important work in this area by Michael Marmot and his team (2010) suggest that reducing health inequalities requires a series of objectives to be met and they are as follows:

a. Giving every child the best possible start in life.

b. Creating job opportunities and fair working conditions for all

c. Ensuring healthy standard of living for whole of the population

d. Develops pro-healthy physical environment

e. Empowering communities

f. Strengthening disease prevention.

Cultural Determinants of Health

Culture is a system of thoughts and behaviours shaped by a group of people. Our cultural backgrounds have tremendous impact on our lives especially on our health. Culture varies from one local group to another. It endures and evolves as well as is valued for itself. Anthropologists have focused on both artistic as well as behavioral dimensions. Herskovits (1948) tells us that, "Culture is the man-made part of the environment," and Margaret Mead (1953) says culture "is the total shared, learned behaviour of a society or a subgroup." These dimensions are combined in Malinowski's (1931) formulation: "Culture is a well-organized unity divided into two fundamental aspects — a body of artefacts and a system of customs." Cultural determinants of health incorporate the cultural aspects that promote resilience, allow a sense of identity and support good mental and physical health for individuals, families and communities. These norms, values, beliefs, customs and practices are shaped, supported and protected through traditional cultural practice, art, song, dance, traditional healing etc.

United Nations Declaration on the Rights of Indigenous People considers the following cultural determinant elements as very important to shape health culture of the community.

a. Self Determination
b. Freedom from discrimination
c. Individual and Collective Rights
d. Freedom from assimilation and destruction of culture
e. Protection from relocation
f. Protection and promotion of traditional knowledge and indigenous intellectual property rights.

The cultural beliefs of a community shape the health care practices and develop locally believed ideas about illness. Any health intervention for community members must be made sensible in the context of local beliefs and practices. Understanding the beliefs and customs of a community is important to acknowledge and appreciate the differences between groups of people. For example, how Indian women understand and handle pregnancy and newborn care is entirely different from that of women from western developed countries.

Every culture has its own customs which influences the disease pattern. It plays important role in the matters of personal hygiene, family planning, seeking early medical care, immunization etc. in short it has strong influence in the way of lives of people. Not all customs and beliefs are bad. Some are based on evidences (like rest after childbirth) where as some are harmful (like female genital mutilation).

Culture has impact on all the following areas as far as health is concerned with

1. Concept of Etiology and Cure (example, considering smallpox/ worship of goddess Shitala).

2. Environment Protection and Sanitation (Belief that latrines are meant for city people where there are no open fields, protecting water bodies as part of religious beliefs).
3. Sexuality and Family Planning
4. Food Habits (vegetarian or non-vegetarian for religious reasons, considering certain food as hot/cold, fasting on special occasions; avoidance/consumption of certain food items in illnesses)
5. Mother and Child (prolonged breast feeding, oil bath and sun exposure to the new born)
6. Personal hygiene (not taking haircut or cutting nails on certain days; prohibition of haircare on certain days)

Table 10 (2)

Gender and Health

Gender refers to the socially (as well as culturally) defined roles and responsibilities of men and women. The gender roles are learned through socialization in different social institutions. Gender inequality is the discrimination based on the person's sex in terms of opportunities in the allocation of resources/ benefits or access to the services. Gender equality means the absence of discrimination, based on a person's sex, in opportunities, in the allocation of resources or benefits or in access to services. Gender equity means fairness and justice in the distribution of benefits and responsibilities between women and men and often requires women-specific projects and programmes to end existing inequities. In many societies, women systematically fail to achieve or fail to use some basic human rights according to men. Most of the time, women's health status and problems related to affect the mortality, morbidity and disability rates.

Let us discuss three examples.

1. Women's subordinate status in society means that they are often in violent relationships that are both physically and emotionally abusive. This affects their mental health (Sharma and team 2019).
2. Women are twice likely as men to suffer from depression- largely because of poor self-esteem (Orth and Team 2008).
3. Indian women are prone to be anaemic than their male counterparts this is mainly because of their poor eating habits (eating all left over) and less access to nutritious balanced diet (Imrana Qadeer 1998).

There are specific gender barriers that women face while accessing adequate health care services. They are:

1. Limited control over sex and reproduction: In India traditionally, women do not have the right to decide when to get married; how many children to have; spacing between children etc. In these situations, women participation in decision making are almost absent which consequently have tremendous impact on women's body and mind.
2. Time constraints: In the social-cultural contexts of Indian societies, most often, women accord less time to their health and well-being maintenance as household work and child rearing get the main priority both for working or non-working women. Thus diet, personal exercise, meditation or taking care of own health are mostly the least important aspects of women's life. Similarly, seeking health care services (like consulting a doctor) will be postponed as far as possible till the symptoms become intolerable. Hence early detection chances of various diseases are poor among women.
3. Lack of support from health care workers: Health care workers lack of understanding about gender disparities and role gender plays in health ensures that they do not alert

women to their reproductive and sexual rights; these gender insensitive approaches discourage many women from seeking specific treatments.

Gender Inequality in Relation to Health

For Indian women the lower status/social value in the household affect their health outcome. Cultural factors such as lack of female health providers in the community and health facilities hinder their physical access to hospitals and nursing homes. Lower literacy rates and reduced access to information makes the situation worse for women. Social division of labour considers women as informal care provider at home hence it takes toll on her physical and mental health. Issues like violence, alcoholism, smoking and life style related problems are having public health implications and this makes the gender based health inequality very complicated in Indian Context.

WHO Technical Paper on gender and health (1998) cites the main criticism of women empowerment policies as being that they continue to define women themselves as the problem, who need welfare and special treatment if improvements in their circumstances are to be made. The underlying reasons of women are largely unexplored and no explanation is offered for the systematic devaluation of their work or the continuing constraints on their access to resources.

The following table 10(2) gives an idea about certain problems that Indian women face which has huge impact on their physical and mental health.

Childhood	**Adolescence and Adulthood**	**Old age**
• Sex selective abortion • Female Mutilation • Nutrition problems	• Unwanted pregnancies, STDs • Sexual harassment/ abuse • Forced Sex • Smoking and substance abuse	• Increase in morbidity / problems on quality of life • Early years health is not taken care off; so minor ailments and health conditions like diabetes.

Table 10(2)
Problems faced by Indian Women impacting their Physical and Mental Health
(Source: World Health Organisation, 2009)

As per WHO recommendations, women should: (World Health Organisation 2009).

- Be able to access information on and be able to choose from a range of methods to control their fertility (Example: use of services like contraception, abortion etc.).
- Have access to screening of different non communicable diseases including breast and cervical cancer prevention.
- Be able to decide when and with whom to have sexual relationships.
- Be able to protect themselves against STI and HIV.
- Be protected from harmful traditional practices such as female genital mutilation (context of African continent).
- Be able to access psycho-social counseling as a support in case of domestic violence, sexual abuse etc.

Behavioral determinants of Health

Behaviour is associated with health and disease. Health related behaviour of an individual is very important to ensure good health for him/ her. For example a person maintaining personal hygiene is health related behaviour and it affects his/ her health. Behaviour of one individual leaves impact on another person's health (for example impact of passive smoking). Behaviour of groups influence physical and social environment which ultimately has an impact on health. For example, when a community decides to use carpooling system to travel to workplace it has an impact on environment pollution and pollution levels come down which ultimately improves our health.

Health behaviour is any behaviour that has or might have implications for health of an individual. The actions or reactions of an individual to a situation and this can be conscious or unconscious, voluntar Gochman (1988) considers that the personal attributes such as beliefs, expectations, motives, values, perceptions influence a person's health behaviour. Personality characteristics, actions and habits also influences a person's health behaviour. The Lifestyle Diseases are on rise in India, which has strong connection with the behavioral determinants of health. Life style includes "the way that people live reflecting a range of social values, attitudes and activities. This is constituted of cultural and behavioural patterns and lifelong personal habits (for example alcoholism) that are developed through the process of socialization. Life styles are learnt through social interactions and mass media. Many of the current health problems/ health conditions like cancer, obesity etc., are associated with life style that the individual follows. We need to focus on the indirect behaviour route of disease. This is because as per the study by Niaura and Abrahams (2002). Behaviour contributes to 50% of the leading cause of disease, which is followed by 20% causes from environment, 20% causes from biology (genetics) and rest 10% due to poor access to health care services or involuntary (Warwick Medical School, 2016).

Individual behaviours vary depending upon three factors as follows:

1. Emotional Dispositions: They are the psychological processes involved in both the experience and expression.
2. Generalized expectancies: Psychological processes involved in formulating expectation in relation to the future outcomes (locus of control, self-efficacy etc.).
3. Explanatory styles: psychological processes involved in explaining the causes of negative events (optimism, attribution styles etc.).

Economic determinants of Health

Different countries/continents of the world are not equally developed; this is because of the difference in resources, differences in culture, and differences in political and economic systems of the country. The health of a person is primarily dependent up the level of socio-economic development. Examples are per capita income, Gross National Product, employment and housing conditions have tremendous impact on an individual's life. The economic progress of many countries has been a major factor in reducing the mortality, morbidity rates; it also increased life expectancy, family size reduced drastically and there was a decrease in the communicable disease rates.

Health is closely linked with the economic system of a country. Often the main obstacles to the implementation of superior technology in health care in a country are not technical but are economic and political hurdles. Health is closely linked with the economic system of a country. Often the main obstacles to the implementation of superior technology in health care in a country are not technical but are economic and political hurdles.

The economic system and economic stability of a country decides whether to make health care free for all or it should be charged. What per cent of Gross Domestic Product is to be spending on public health is also dependent upon the economic system and economic prospectus of that country. For example in the USA, health care is predominantly based on health insurance coverage. Hence health care is too expensive in that country. India, though devote only 1.5% of GDP into health we have, both government and private health care coexisting and people are free to choose from these available health care systems. Hence health care seems to be more accessible and affordable, though technology wise it is not as superior as in the USA.

Globalisation and its impact on Health

Globalization impacted on the trade relations and movements between countries. The competition and search for new markets, technological developments and agreements and cooperation between countries through international organizations (World Trade Organisation, World Bank) mediations make this process a reality.

Globalization is defined as the processes that are changing the ways in which people interact across boundaries, notably physical (such as the nation-state), temporal (such as instantaneous communications) and cognitive (such as cultural identity). The result is a redefining of human societies across many spheres, economic, political, cultural, and technological and so on (Lee K and his team 2002).

Health achievements are critical international development goal. Globalization is helping to develop new knowledge and skills; promote policy coherence. This also contributes to global public goods for health, global health funds, international standards/ rules are developed for health.

However, some of the specific concerns in a globalized world that has direct/ indirect impact on health are:

1. Food safety
2. Environmental degradation and its impact on health
3. Access to Drugs
4. Health Care Service Availability
5. Emerging issues like Genetically Modified Food's impact on health
6. Increasing Life Style Disease burden.

Globalization has left negative impact on local knowledge, local resources and traditional whereby global knowledge, resources exert hegemony in the power system. The increase in Food chains like MacDonald, KFC and its popularity over Indian food among adolescents/ urban folks is an example to mention. This fast food culture leave impact on health and life style diseases like PCOD and obesity is on increase amongst this age group.

10.2 Politics and Economy of Health

Political economy is a broad theoretical framework which can help health educators better understand the many economic, political, and socio-historical forces which shape contemporary health problems, and our approaches to these problems. Its attention to the dynamics of race, class and gender, as these interact to effect the lives of individuals and broader social groups, makes a political economy approach an important supplement and complement to other macro and micro level theories at the base of health education practice. With defining political economy, highlighting several of its key theoretical assumptions and describing their relevance for our understanding of health issues. Though many people refer to "the political economy of health," the phrase has rarely been defined. For example, Doyal's book by that title offers no definition (1979). Baer defines the political economy of health as "a critical endeavor which attempts to understand health-related issues within the context of the class and imperialist relations inherent in the capitalist world system" (Baer 1982:l). Baer here limits the field to analyses of capitalism and capitalist countries, while the approach has also been applied to research on socialist and communist countries for example, by Guttmacher and Garcia (1975) and Navarro (1976a).

A more comprehensive, although more clumsy definition of the phrase, offered by Janzen, emphasizes a macro analytic perspective, including "larger-scale social entities such as governmental and professional medical groups, academic medical establishments, and political or popular medical movements or economic and ecological forces as they influence individual behaviour. Some political economists extend their analyses even further to the forces that give rise to the "larger-scale social entities" mentioned by Janzen. For example, Berliner (1977, 1982). Navarro (1976a), and Turshen (1984) choose capitalism per se as their principal unit of analysis.

Beyond these basic definitions, a complete political-economy-of-health approach should include a historical perspective, conflict or dialectical models of social change, and a theory of disease causation that is multifactorial and encompasses social etiology. In sum, the definition on the "political economy of health" as a macro analytic, critical, and historical perspective for analyzing disease distribution and health services under a variety of economic systems, with particular emphasis on the effects of stratified social, political, and economic relations within the world economic system analysis addresses] questions of power, resource allocation, and organization". [1978a:121].

Theoretical Paradigms in the Political Economy of Health

Works classified under the rubric of the political economy of health do not all rely on the same theoretical framework. Theories currently subsumed under the heading of political economy of health can be categorized into three broad areas: classical Marxist analysis, the cultural critique of medicine, and the dependency or world systems approach. The three perspectives share certain features, and in some cases prominent political economists may be classified under more than one category as their theoretical perspectives have shifted over the course of their careers (e.g., compare Navm 1976b and 1986). Nonetheless the approaches contain significant differences, as highlighted in the following sketches.

Orthodox Marxist Approaches

The primary feature distinguishing classical Marxist analyses of health from other political economic analyses is the close parallel Marxists draw between health and capitalism. Capitalism operates according to specific rules, such as the accumulation of capital and exploitation of wage labourers, which give it a certain predictable logic. These rules, in turn, determine both the kinds of health problems that will affect the population and the organization of services developed to combat them. Thus orthodox Marxists see health status and the organization of health care as direct results of the capitalist socioeconomic formation.

The prototype for their work is Engels's 1845 classic, The Condition of the Working Class in England, in which Engels attributes the poor health and living conditions of English industrial and agricultural labourers to the expansion of capitalism and the resulting callousness of the English bourgeoisie. Today followers of Engels's historical materialism emphasize metatheory and microanalysis in their treatment of empirical situations. Compared to other sociomedical scientists, they make their political stances explicit (in the tradition of both Marx and Engels) and often discuss medical knowledge as ideology (see Berliner 1982; Kelman 1975; McKinlay 1984; Navarro 1986; Renaud 1975; Stark 1982; Waitzkin 1983). By insisting that health be analyzed within the context of capitalism, they draw attention to the interplay between social class formation and the power of the postindustrial nation-state. This perspective has been used to explain macro phenomena, such as the evolution of the medical-industrial complex (see Ehrenreich and Ehrenreich 1970), as well as micro phenomena, such as the interpersonal aspects of doctor-patient relations (see Waitzkin 1984). Orthodox Marxist political economists have a dual agenda: they seek to explain the socioeconomic and political nature of medicine within a Marxist framework, using concepts such as class struggle and the desirability of socialist revolution; they also wage a constant battle to convince mainstream health professionals to accept their interpretations. To paraphrase Marx, their goal is not simply to understand the world but to change it.

Cultural Critiques

The cultural critique of medicine, identified with Barbara and John Ehrenreich, responds to what they see as an overly mechanistic orthodox Marxist view of medicine as a desirable but poorly distributed commodity (J. Ehrenreich 1978:4). The cultural critics question the value of the medical services themselves, arguing that biomedicine is often detrimental to individual health and standards of social equality. The concept of social control is a frequently used analytic tool of cultural critics, who argue that medicine supports and replicates the status quo by keeping women and minorities subordinate. The cultural critique is similar in one sense to the orthodox Marxist approach, for both analyze individuals within the context of unequal power relations based on gender, race, and socioeconomic status (Navarro 1985535). Yet the cultural critique does not usually explain these inequalities by referring to concepts such as class formation. Navarro, speaking from the orthodox Marxist perspective, criticizes the approach, classing it with other "power elite" and interest group theories, which focus on power struggles among elite groups while excluding the context within which conflict occurs (1985529-532). An understanding of inequality cannot be complete, he says, without considering social class dynamics within the context of changing relations of production. The difference between cultural critics and orthodox Marxists are analogous to the difference between reformers and revolutionaries. While cultural critics comprehend the structural causes of inequality, many are unwilling to suggest that social revolution would be the best cure. Criticisms aside, many important empirical studies have emerged from this paradigm, including Starr's prize-winning book on the rise of the American medical profession (1982) and Ehremich and English's historical analysis of how women are treated by healers and medical professionals (1979).' An example of the cultural critique in medical anthropology is Stebbins's (1986a) assessment of health politics in Mexico, which adopts a critical perspective on the structure and distribution of medical services but does not explore the macro political or economic conditions that might explain how the Mexican situation fits within the logic of capitalism. Another example is Justice's anthropological study of health planning in Nepal, which shows how the competing interests of international planners, national bureaucrats, and village health workers can thwart even the most well-intention4 health plans (1986). All of these studies focus on middle-range interest group politics more than on the macro-level political economy.

During the 1970s there also emerged a perspective that elaborated an account of capitalist exploitation of the periphery from the perspective of the system's core. This theoretical enterprise became known as world systems theory. It typically treats the entire world, at least since the 16th century, as a single capitalist world economy based on an international division of labour among a core that developed originally in northwestern Europe (England, France, Holland), a periphery, and a semi periphery consisting of core regions in decline (e.g., Portugal and Spain) or peripheries attempting to improve their relative position in the world economy (e.g., Italy, southern Germany, and southern France). The division of labour among these regions determined their relationship to each other as well as their type of labour conditions and political system. In the core, strong central governments, extensive bureaucracies, and large mercenary armies enabled the local bourgeoisies to obtain control of international commerce and accumulate capital surpluses from this trade. The periphery, which lacked strong central governments or was controlled by other states, exported raw materials to the core and relied on coercive labour practices. Much of the capital surplus generated by the periphery was expropriated by the core through unequal trade relations. The semi periphery had limited access to international banking and the production of high-cost, high-quality manufactured goods but did not benefit from international trade to the same extent as the core.

Dependency and world systems theories share a common emphasis on global analysis and similar assumptions about the nature of the international system and its impact on national development in different parts of the world, but they tend to emphasize different political dynamics. Dependency theorists tend to focus on the power of transnational classes and class structures in sustaining the global economy, whereas world systems analysts tended to focus on the role of powerful states and the interstate system.

Summary

Many factors combine together to affect the health of individuals and communities. These include determinants of health and his/ her biological/ genetic characteristics. Whether people are healthy or not, is determined by their circumstances and environment. The determinants of health include the social and economic environment, the physical environment, and the person's individual characteristics and behaviours.

The context of people's lives determines their health, and so blaming individuals for having poor health or crediting them for good health is inappropriate (WHO, 2019). Individuals are unlikely to be able to directly control many of the determinants of health and hence it is the responsibility of society, state and health care workers to develop determinants of health to such a level that they influence people's lives in a positive way, promoting health and well-being.

Similarly with the idea of "political economy of health" is concerned with how political and economic domains interact and shape individual and population health outcomes. However, the term is variously defined in the public health, medical, and social science literatures. This could result in confusion about the term and its associated tradition, thereby constituting a barrier to its application in public health research and practice. To address these reflections of the political economy of health tradition, clarify its specifically Marxian theoretical legacy, and discuss its relevance to understanding and addressing public health issues.

Keywords

Social determinants of health, Cultural determinants of Health

Self Assessment

1. If we broad comprehensive definitions of health, we can identity that it covers not only physical health but also include mental, social and even spiritual dimensions of well-being.

A. The above statement is true

B. The above statement is false ʻ

C. The above statement is not related to the question

D. None of the above.

2. ……..is a difference that is closely linked with social, economic and or environmental disadvantage in achieving health or health outcomes.

A. Heath Equity

B. Health Disparity

C. Health economy

D. Public economy

3. Health disparity is the …………in the incidence and prevalence of health conditions and health status between groups based on race, gender, socioeconomic status, disability status etc.
A. Differences
B. Similarity
C. Neutral
D. None of the above

4. ………is the changes in health that results from measures or specific health care investments or interventions. It is the change in the health of an individual, group or community which is attributable to an intervention or a series of interventions.
A. Health inequality
B. Health Outcome
C. Health disparity
D. Wellbeing

5. Social determinants of health can be defined as the conditions in the social, physical and economic environment in which people are born, live, work and this include access to health care.
A. Social determinants of health
B. Behavioural determinants of health
C. Cultural determinants of health
D. Technological determinants of health

6. Who developed IOM Model of social determinants?
A. Isaac Newton and Gottfried Leibniz
B. Charles Darwin and Alfred Russel Wallace
C. Whitehead M and Dahlgren G
D. Jonas Salk and Albert Bruce Sabin

7. IOM Model of social determinants was first appeared as article titles in the …………...
A. Ulysses (1842)
B. The Structure of Scientific Revolutions (1962)
C. Discipline and Punish (1975)
D. What can be done about inequalities in Health (1991)

8. Commission on Social Determinants of Health was formed by ………..
A. WTO
B. UNESCO
C. UNICEF
D. WHO

9. Commission on Social Determinants of Health was formed in ……..
A. 2023
B. 2003
C. 1320
D. 1230

10. ……………incorporate the cultural aspects that promote resilience, allow a sense of identity and support good mental and physical health for individuals, families and communities.

A. Social determinants of health
B. Political determinants of health
C. Cultural determinants of health
D. Technological determinants of health

11. …….means the absence of discrimination, based on a person's sex, in opportunities, in the allocation of resources or benefits or in access to services.

A. Gender Equity
B. Gender Inequality
C. Gender Bias
D. Gender equality

12. The Lifestyle Diseases are on rise in India, which has strong connection with the ………..

A. Social determinants of health
B. Political determinants of health
C. Cultural determinants of health
D. Behavioural determinants of health.

13. ………..is a broad theoretical framework which can help health educators better understand the many economic, political, and socio-historical forces which shape contemporary health problems, and our approaches to these problems.

A. Political Economy
B. Social Economy
C. Market Economy
D. Agricultural Economy

14. The cultural critique of medicine identified with…………. responds to what they see as an overly mechanistic orthodox Marxist view of medicine as a desirable but poorly distributed commodity.

A. Martin Scorsese and Leonardo DiCaprio
B. Barbara and John Ehrenreich
C. Steven Spielberg and David Koepp
D. Wesley Koolhof and Neal Skupski.

15. ……….question the value of the medical services themselves, arguing that biomedicine is often detrimental to individual health and standards of social equality.

A. Political scientists
B. Economists
C. Medical Practioners
D. Cultural critics

Answers for Self Assessment

1. A 2. B 3. A 4. B 5. A

6.	C	7.	C	8.	D	9.	B	10.	C
11.	D	12.	D	13.	A	14.	B	15.	D

Review Questions

1. Differentiate between health outcome, health disparity and health inequality.
2. Define Social determinants of health and discuss eight social determinants that have impact on Health in Indian Context.
3. Comparative analysis between Social determinants of health and behavioural determinants of health.
4. Briefly discuss about the theoretical Paradigms in the Political Economy of Health
5. Discuss the significance of Economic determinants of Health.

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Unit 11: The Political Economy of Medicine

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Objectives

- To know the Political economy approach to health
- To understand what is Bio-politics
- To understand what is Political economy of medical knowledge

Introduction

Incorporating political economy analysis into health financing reform processes can help policymakers develop more effective approaches to navigate political challenges that arise when introducing policy change. WHO has developed an approach to analyzing the political economy of health financing reform to support strategies that support progress towards UHC. This approach shows how integrating the analysis of relevant stakeholders, their respective position and power relative to a reform objective, and the political economy context within which they operate helps to identify challenges and opportunities associated with health financing reform. The WHO made an analysis of the political economy of health financing reform shows that while each country's context differs, there are some key strategies that can be used to strategically manage reform processes:

- Technical work matters: It is essential to be technically ready for political windows of opportunity to open.
- Think strategically about implementation sequencing: Resistance from key stakeholders can be reduced through strategic sequencing of reform elements.
- Compromise is almost always needed: Strategic compromises are often needed to advance reform but not in a way that undermines their core objectives.

Through this chapter studies concept of Political economy approach to health and how that is connected with the interconnection with the new arena in the field of medicine as well as making it a care and health a tool for commercialization.

11.1 Political Economy Approach to Health

The term political economy refers to a branch of social sciences that focuses on relationships between individuals, governments, and public policy. It is also used to describe the policies set by governments that affect their nations' economies. Adam Smith is generally considered the father of economics and the father of the political economy. But the term is generally ascribed to French economist Antoine de Montchrestien, who wrote the book "Traité de l'économiepolitique," which translates to the treaty of the political economy. Besides academia, the policymakers also show a keen interest in the booming of this area of study.

The Indian healthcare sector has made significant progress in the last few decades. The under-5 child mortality rate dropped from 126 in 1990 to 34 in 2019, life expectancy rose from 58 years in 1990 to 69.4 years in 2018, and polio, guinea worm disease, and maternal, and neonatal tetanus were successfully eradicated from the country. Despite the progress, healthcare delivery in India remains largely focused on episodic treatment, with inadequate attention to preventive and primary care. With a predominantly family health and infectious disease focus (although even in these areas, the gaps are stark), the system is not geared to deal with the increasing burden of non-communicable diseases. Lack of access, availability, affordability and quality care have resulted in suboptimal health outcomes for India, well below many of its peer countries, and a significant financial burden of health expenditure at the individual and household level.

The role of the political economy of health in driving health outcomes and the financial burden of health, and make the case for political attention to healthcare, through increased investments, healthcare reforms and improved capacity to deliver health, both public health and curative. We build on both theoretical frameworks and global and sub national experience, to develop hypotheses for greater political priority to health in India.

The shortcomings of low public investment in health, a fragmented provider landscape across public and private providers as well as across levels of care, an equally fragmented health financing landscape and inefficiencies with risk pools, and challenges with quality care and accountability, have all combined to create challenges in access, quality, expenditure and contributed to poor health outcomes, impeding India's move towards Universal Health Coverage (UHC).

These shortcomings do not necessarily exist because the precise constraints and technical solutions are not known. The Indian health eco-system has been analyzed for long, and solutions, although not exhaustive, have also been presented (see NITI Aayog 2018, Planning Commission 2011). The shortcomings exist because despite the knowledge around solutions, policy reform has been minimal, and not well executed. The challenge of reform and its effective implementation (where reform has indeed taken place) has its roots in the lack of political priority to healthcare. Health has rarely made it to being a key policy agenda, possibly because of the contestation in the policy and priority making process across competing priorities in the country. Budget 2021 underlines this, where despite the pandemic through 2020, the budget failed to see any significant priority to health, in allocations (see charts 6 and 7), or system reform. Health spending has not seen any significant increase over several years, either by the Union Government (as a percentage of GDP or as percentage of its total budget), or centre and state governments combined. Continued low investments in health; lack of investments on primary care; absence of reforms that can address fragmentation (in provision and financing), quality and accountability; all combine to suggest that political attention to health has continued to be weak. Health promotion in the country now needs focus on the political barriers to healthcare priority.

The central role of politics to policy change has been established by many scholars (see Reich, 1995; Walt, 1994 and Bambra et al, 2005). Political and economic factors have been shown to influence who accesses healthcare, quality of healthcare delivery, and health outcomes and its prioritization within policy processes. There is significant literature (Gilson et al, 2018, Kingdon 2011, Berger and Luckmann, 1966, Buse et al. 2012, Cobb and Elder, 1972, Edelman, 1988, Shiffman and Smith, 2007, Shiffman, 2009, Campos and Reich, 2018, Sparks et al, 2019) pointing to the multiple factors that drive political commitment to healthcare. Demand from citizens and electoral incentives; concerns about poverty and inequity; macro-economic drivers such as healthcare contribution to human development and growth; and global pressures are some, as evident from the frameworks developed by scholars cited above. Laying out the technical solutions to healthcare challenges is not sufficient to address gaps; the drivers of priority setting and decision making, and the interaction of different actors, political and others, are as critical. Apart from political leaders and national and sub national government, several other institutions such as multilateral organizations, donor governments and philanthropies, citizens and industry bodies influence the process of what decisions are made, by whom and through what process. Health policy thus, can be seen as a complex political process (rather than just technical), driven as much if not more, by 'interests' than by evidence (Reich, 1995).

Political leaders in other countries have been influenced by a combination of drivers, leading to healthcare becoming a political issue and healthcare reforms being a political priority; resulting in increased resources, more efficient and effective use of existing resources, improved design of and outcomes from healthcare systems, increased responsiveness to citizens needs and user satisfaction, and reduced financial risk. Experience from Turkey (Yilmaz, 2017), Thailand (Towse, 2004), Mexico

(Ewig, 2016; González-Rossetti &Bossert, 2000; Rossetti & Mogollon, 2000), Iran and China (Mor, 2019) and other global literature (Tuohy and Glied, 2012) points to the critical role played by political commitment in the health systems reform process. India remains an outlier to such processes (admittedly with cross state variations), where despite continuing poor health outcomes and household level financial burden, impairing social and economic progress at individual and national levels, this area has not witnessed adequate political attention.

Therefore viewing the political commitment as central to health policy, strengthening health systems, improving health outcomes and financial risk protection, through its ability to drive

- resource allocation,
- capacity and accountability in public systems,
- reforms that can in turn strengthen preventive, promotive and curative health and
- Improvedbudget utilization through allocative and technical efficiencies.

Political commitment is fundamental to each of these pillars, which in turn impact and enable other shifts, such as the combination of relevant reforms and increased public resources contributing to financial risk protection for individuals.

Challenges in the Indian Healthcare Sector

The nature and design of the Indian healthcare system makes it particularly difficult for navigation by patients when faced with an illness. A low quality government-owned health-system, absence of significant formal financial protection, and almost no information on provider quality or performance, leads people to enter a fragmented, under-performing, and fee for service private market with no continuity in patient care (NITI Aayog, 2018; Baeza et. al, 2019).

Despite persistent demand to increase budgetary allocations to healthcare in India, as well as potential economic benefits from investments in healthcare (Rao et al., 2005; Jamison et al., 2013; Remes et al., 2020), budgetary allocations to health have remained terribly low, lower than several other South and South-East Asian countries.

Healthcare is provided by myriad organizations, institutions, and arrangements in India without any coordination and often with contradictory incentives. The public sector is vertically fragmented across primary, secondary and tertiary care, and across disease categories, with no integration. The private sector is fragmented with solo practitioners and independent clinics comprising 95% of the private ambulatory market. The mixed and heterogeneous nature of healthcare provision has resulted in an extremely fragmented, disorganized, and disaggregated ecosystem, resulting in gaps in access, quality, and affordability, where patients are left to fend for themselves and seek treatment from multiple service providers without any continuity in service provision (Baeza et. al, 2019).

The Indian healthcare system also witnesses horizontal fragmentation with low levels of coordination between the public and the private sectors. With almost 70% of inpatient care and 80% of ambulatory services being provided by the private sector, the Government has had minimal experience leveraging the private sector effectively, with significant regulator and accountability challenges (Baeza et. al, 2019). Reports suggest varying quality of care, as well as gaps in service delivery in both public and private healthcare provision, leading to avoidable mortality and morbidity (NITI Aayog, 2018).

Like service provision, health financing in India is fragmented in terms of both revenue sources and risk pooling. 64% of healthcare expenditure in India comes from out-of-pocket expenditure, higher than the average in lower middle-income countries (57%), low-income countries (44%), the other BRICS (Brazil – 28%, Russia – 36%, China – 32%, South Africa – 8%), and OECD countries (14%), with the government in India spending 1.1% of the GDP on healthcare (NITI Aayog, 2018; PRS, 2020); divided between the Centre and the States. The government manages several important healthcare pools which are neither efficient nor effective, yet have seen little priority accorded to improving their design and functioning. It is estimated that approximately 4% of the population falls below the poverty line because of healthcare related expenditures (Hooda, 2017), and those already below the poverty line are pushed deeper into poverty. Research across India, Africa and Latin America (Krishna, 2010) found health related expenses to be the prime reason for households descending into poverty (even when income had been secure to begin with) and that millions of households live 'one illness away' from poverty.

Framework for Health Priority in India

Based on existing theoretical frameworks (Kingdon 2011, Berger and Luckmann, 1966, Buse et al. 2012, Cobb and Elder, 1972, Edelman, 1988, Shiffman and Smith, 2007, Shiffman, 2009, Campos and Reich, 2018, Sparks et al, 2019) for analyzing the political economy of health and the specific context of India, we identify five related elements through which political economy of health can better drive attention to health systems in India. These include

a. Recognition and acknowledgement of a problem by political leaders;
b. The presence of feasible and viable policy solutions;
c. Interest groups that promote policy change;
d. Institutions that sustain momentum around policy change;
e. A political opportunity for introducing the policy.

While these would typically be sequential, given that actual policy processes are not an exact science, the starting point and trajectories for political attention could vary significantly by political context.

The landscape of national (or sub national) problems is a contested one and issues compete with each other for public and political attention. In such a context, making healthcare a policy priority in India requires, as a first step, that it be recognised as a problem that impacts key stakeholders, and is therefore acknowledged as a key agenda. Kingdon (2011) and Shiffman (2009) point to the need for going beyond identifying a problem in its objective form, to categorizing and promoting it as a problem that is worthy of attention by key stakeholders through a social construction that drives attention and prioritization. It has to be viewed as an issue which leaders have a stake in. But the mere recognition of an issue as a problem worthy of attention is not enough; action requires a solution, and it is here that Kingdon and others underlines the need for a financially viable, politically and publicly acceptable and technically feasible solution. Despite the acknowledgement of a problem and its solution by some key leaders, there are likely to be a variety of stakeholders with different interests who exert different kinds of power and influence in promoting or obstructing solutions for the problem. The interplay of these invariably has a strong bearing on the issues that get political priority, and therefore mobilizing and engaging with different groups, in the context of construct incentives or disincentives, is key to moving an agenda forward. These processes can take time, during which attention to, and momentum around, the issue needs to be sustained. Global experience has underlined the role of institutions in sustaining such momentum. Finally, the convergence of these factors and forces lead to converting an issue to a policy through a specific political moment or opportunity. It is in this frame that understanding the political economy of healthcare and the process of its political prioritization in India becomes meaningful, not only to lead India towards UHC but to lead the world towards the SDGs. India’s federal structure, with varied political economy contexts across states, underlines this, with some states such as Tamil Nadu according greater political attention to healthcare and developing stronger health systems, while others according much lower priority, resulting in poorer health outcomes. Currently, the challenges of healthcare in India are known. The lack of political attention suggests that the political or economic incentives to addressing healthcare are not clear to leaders. Electoral demands often influence political priority, but India has not seen health as a citizen priority during elections. Post poll surveys of the 2019 and 2014 national elections in India revealed health as a key voting issue for a mere 0.3% and 0.4% of the sample respectively.

Bio-Politics

Bio-politics is an influential theoretical framing as well as an empirical perspective that builds from a base where the “knowledge” of “human species-life” becomes a core from which to understand how strategies of power, government, politics and the economy influence the conduct of social life.Michel Foucault describes it as concept of bio-politics is classically approached as assemblies of multiple, heterogeneous forces of power and its effects, especially when they underline the conditions of life which are subject to modern government and which, in turn, offer spaces of political potential. Bio-politics then considers the relationship between the political with life, and the potential of that relationship in understanding the social.

The bio political approach has been applied and interpreted in widely diverse contexts, and has been found crucial in informing issues such as contemporary local or global governance, health and medical practices, social inclusion and exclusion, war and violence, citizenship and sovereignty, gendered living, surveillance and control, digital technologies of life management, economic or legal practices and much more. Developing a rare non-western perspective, from an Indian location, promises far-reaching social theoretical insights.

Michel Foucault quotes "To say that power took possession of life in the nineteenth century, or to say that power at least takes life under its care in the nineteenth century, is to say that it has, thanks to the play of technologies of discipline on the one hand and technologies of regulation on the other, succeeded in covering the whole surface that lies between the organic and the biological, between body and population. We are, then, in a power that has taken control of both the body and life or that has, if you like, taken control of life in general – with the body as one pole and the population as the other." (1976:252-3).

Bio politics is a complicated concept that has been used and developed in social theory since Michel Foucault, to examine the strategies and mechanisms through which human life processes are managed under regimes of authority over knowledge, power, and the processes of subjectivities. As Thomas Lemke points out, a great deal of the inconsistency with which the concept of bio politics 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 bio power 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 bio power 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 nor 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" (2011:4-5). In what follows within this post, I attempt to pull out the foundational underpinnings upon which Foucault began to develop a theory of bio politics. Paying attention to the historicizing treatment Foucault gives to a notion of power in relation to the rise of bio politics, I ultimately reflect upon present-day phenomena which have been taken by scholars as signalling the movement and transformation of bio politics into new forms and trajectories.

In "The Birth of Bio politics", Foucault begins to theorize liberalism as a practice and as a critique of government, the rise of which he argues is inseparable from the rise of bio political technologies of governance, which have extended political control and power over all major processes of life itself, through a transferal of sovereign power into "bio power"- that is, technologies and techniques which govern human social and biological processes. Pointing to the fact that liberal thought takes society, and not the state, as its starting point; it follows, consequently, the critique of state governing institutions that is internal to liberalism must always, in practice, be negotiating its legitimacy of governance in a relationship between changing internalities and externalities foregrounded in the state, between self-governing "liberal" individuals and the population. This results in liberalism's necessary ability to take many forms and strategies for self-rationalization. For example- the neoliberalism of the U.S., in which the logic of a free market economy has been extended over non-economic domains of human social and biological existence, so that we now conceive of a number of life processes, such as family and reproduction, in economic terms.

The 17th-century historical rupture in the flow of power over life and death that occurred with liberalism should be seen as more of an integration of sovereign power (the "right of the sword") into what Foucault calls "bio power", as opposed to seeing the process as a moment of disjuncture in which bio power came to replace the classical notion of sovereign power. As he writes in "Society Must Be Defended" (1976:241), "I think that one of the greatest transformations political right underwent in the nineteenth century was precisely that, I wouldn't say exactly sovereignty's old right- to take life or let live- was replaced, but it came to be complemented by a new right which does not erase the old right but which does penetrate it, permeate it. This is the right, or rather precisely the opposite right. It is the power to 'make' live and 'let' die. The right of sovereignty was the right to take life or let live. And then this new right is established: the right to make live and to let die."

The effects of the process through which these mutations in the exercise of power occurred can be characterized as having formed two opposite poles of a continuum. The first of these occurred through the development of techniques that operated in and on the individual body as apparatuses of discipline: and "that discipline tries to rule a multiplicity of men to the extent that their multiplicity can and must be dissolved into individual bodies that can be kept under surveillance, trained, used, and…punished" (Foucault 1976:242). This pole is referred to as "anatamo-politics", and it is chiefly concerned with the atomization of a collectivity for the purpose of governance and productivity to a certain end. The second pole is of explicitly bio politics, concerning the whole of a population, with the ultimate effect being characterizable as "massifying, that is directed not at man-as-body but as man-as-species" (1976:243). Said otherwise, bio politics takes population as its problematic, making it both scientific and political, "as a biological problem and as power's problem".

What does all this mean in less-theoretical terms? To begin, it means that the contemporary historical era in which we exist and have come to know in very particular ways, is governed over by means of particular mechanisms that simultaneously operate on our bodies and subjective selves, and on our collective relations taken as a whole- as a global human race. "Biopower" can be understood as a social field of power and struggle, in which the vital aspects of human life are intervened upon for the purpose of rationalizing regimes of authority over knowledge, the generation of truth discourses about life, and the modes through which individuals construct and interpellate subjectivities between a sense of self and the collective.

With respect to populations and governance in the present day, scholars such as Lemke, Rose and Rabinow emphasize the viability of Foucauldianbio politics in understanding the operability of truth discourses, or regimes of truth, when approaching the study of mutating bio political spaces in the contemporary. These spaces, such as genomics and reproductive choice, represent profound biopolitical efforts to exercise the power "to make live" and "let die". As such, questions concerning choice and every day modes of practice surface as the most critical issues when theorizing the border that, according to Foucault, is posed by life, to politics, as it continues to transform within both new and old bio political spaces like race, reproduction, medicine, health, science, technology, and so on.

Political Economy of Medical Knowledge

The knowledge economy is a system of consumption and production that is based on intellectual capital. In particular, it refers to the ability to capitalize on scientific discoveries and applied research. The knowledge economy represents a large share of the activity in most highly developed economies. Developing economies tend to be heavily focused on agriculture and manufacturing, while highly developed countries have a larger share of service-related activities. This includes knowledge-based economic activities such as research, technical support, and consulting. The knowledge economy is the marketplace for the production and sale of scientific and engineering discoveries. This knowledge can be commodified in the form of patents or other intellectual property protections. The producers of such information, such as scientific experts and research labs, are also considered part of the knowledge economy. Thanks to globalization, the world economy has become more knowledge-based, bringing with it the best practices from each country's economy. Also, knowledge-based factors create an interconnected and global economy where human expertise and trade secrets are considered important economic resources.The knowledge economy addresses how education and knowledge—that is, "human capital"— can serve as a productive asset or business product to be sold and exported to yield profits for individuals, businesses, and the economy.

This component of the economy relies greatly on intellectual capabilities instead of natural resources or physical contributions. In the knowledge economy, products, and services that are based on intellectual expertise advance technical and scientific fields, encouraging innovation in the economy as a whole. While higher education and technical training are obvious assets, communication and teamwork are also essential skills for a knowledge-based economy, according to the Organization for Economic Cooperation and Development. Since it is unlikely that any single knowledge worker can generate groundbreaking innovations alone, these interpersonal and workplace competencies are essential to surviving in a knowledge-based workplace.

The current crisis and market pressure from health maintenance organizations has led hospitals and healthcare companies to reduce healthcare costs through efficiencies and beinnovative, with new technologies, processes and services. It has been generally acceptedthat both explicit and tacit knowledge play a basic role in organizational innovation.However, there are few research works that study the relationship between knowledgemanagement and the effectiveness of the innovation process.

Knowledge obviously is, and always has been, central to all development in health. Because knowledge itself is such a wide and general concept, it is encountered in many different manifestations and has many facets. All forms of knowledge tend to be subject to commercial as well as public (that is, government and other non-profit organization) interest. In addition, knowledge relating to health is even more varied because it is often invested in the community in the form of traditional knowledge, which coexists along with various forms of "modern" medical knowledge. Because of its universal applicability, knowledge is often termed the 'archetypal' public good (Stiglitz, 1999). Clearly, therefore, it is important to consider knowledge from the perspective of being a GPGH.

It is evident that all of these are potentially subject to commercial exploitation, and therefore can be classified as "commercial knowledge". Much of the technology can be embodied in specific goods (such as pharmaceuticals or vaccines) which can then be marketed. New markets are also emerging in various other areas including forms of diagnostic activity, including genomics. Given this, all these form of medical knowledge can be potential cross-border "club goods", excludable but non-rivalrous in nature. This also means that the production of knowledge itself can be affected by the clubs that exist with respect to different types of knowledge, as discussed below. Further, the ability to benefit from medical knowledge is not uniform. Even when the best practice is known, such as in preventive actions or treatment of diseases, the effectiveness of such knowledge will depend upon the delivery systems and the nature of the existing health and infrastructure services.

The development and production of medical knowledge requires investment by society – of time, resources, and skills. Because of the non-excludability of such knowledge, there is a danger that levels of investment would be socially sub-optimal, in both static and dynamic senses. In addition, because of the global public good characteristics, there are dangers that public intervention in individual countries would still be inadequate from a global perspective. There are broadly five ways in which societies can choose to promote socially desired medical research.

- the assignment of private rights for the commercial use of research, as in patent regimes and other systems of recognizing private intellectual property rights;
- the direct public funding and organization of medical research;
- ensuring private profitability of investment and production through various means such as public pre-purchase agreements, ensuring monopolies, or providing fiscal incentives;
- reliance upon (or encouraging through fiscal and other means) private donor or charitable funds;
- Statutorily requiring those involved in medical businesses such as pharmaceutical companies and other health care providers to reinvest a proportion of revenues into health research. Each of these strategies has both positive potential and associated difficulties. None of them need be adopted in isolation; rather, they can be combined to varying degrees.

Patent Regimes

The currently dominant means of dealing with the public good-related problems of social underproduction of medical knowledge is the assignment of private rights through patent regimes. The advantage of this is that, by allowing benefits to be channeled to private agents in the form of monopoly or licensing rights, it encourages more private investment in medical knowledge production than would otherwise have occurred. The basic problem of this method is that the research and investment agenda then tends to be set by private industry, which is influenced by interests of commercial profitability rather than social need. Further, once such research and development is completed and placed under the control of private agents, there is the further problem of the possibility of monopolistic behavior and high prices of the results of such research. In addition, private drug markets typically suffer from various forms of market failure. These include informational imbalances - thus, for example, consumers are not in a position to judge the quality and efficacy of drugs, which creates the need for a social monitoring and surveillance system; lack of competition created by patent protection, brand loyalty and market segmentation; besides the obvious externalities in the form of substantial social benefits of drug consumption.

This is why there have been concerns relating to strict implementation of the TRIPS regime with respect to drug patents in particular, and growing recognition that such a regime may not in fact be a Global Public Good as supposed by its protagonists, but rather a regime which needs substantial revision before it can meet public health concerns. These concerns about the enforcement of the TRIPS agreement emerge particularly with reference to health conditions in developing countries, since the agreement is seen as increasing the power of large corporations who may be in a position to capture patents, vis-à-vis state regulatory authorities.

Some of the most frequently expressed concerns include the following:

- Increased patent protection leads to higher drug prices and other monopolistic practices, even as while the number of patented drugs of importance from a public health perspective is likely to increase in the coming years.

- The access gap between developed and developing countries, and between rich and poor in all countries, will continue to increase, especially as producers in developing countries would have to wait for 20 years before they can have access to innovations.
- The shift from process to product patents in certain developing countries will have adverse effects on local manufacturing capacity and remove a source of generic innovative quality drugs on which the poorer countries depend.

Growing public concern about the effects of TRIPs prompted the WTO Doha Declaration on TRIPs and Public Health, of December 2001. While this did not go far enough in terms of providing legally binding commitments and is a political document rather than a legal one, it still provides a framework for dealing with the use of the TRIPs agreement by large companies in the developed world, especially in matters relating to public health. Similarly, while it is still vague about the possibilities for export of cheaper drugs produced using compulsory licensing, it leaves open the chance that this can be decided positively by the TRIPs Council eventually. Thus, it emphasized that (a) each member country has the right to grant compulsory licenses and the freedom to determine the grounds upon which such licenses are granted; and (b) each member country has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency.

However, there are still many other possibilities in terms of changing the TRIPs agreement to render it more open to meeting global public health concerns and avoiding the monopoly and exclusion aspects that it currently provides to producers of medicines as GPGH. Within such an approach, several articles may require revision, for instance, Article 27.1 in order to exclude the patentability of "essential medicines" listed by WHO; Article 30 so as to incorporate an explicit recognition of an "early working" exception for the approval of generic products before the expiration of a patent; and, Article 31 in order to clarify the right to grant and the scope of compulsory licenses for public health reasons; decreasing the life of patents from the currently proposed 20 years; etc.

Private and public investment in knowledge production for health

Over the past two decades, there has been an important shift in the responsibility for knowledge production for health, with greater reliance on private activity in this area. This has been associated with a change in research patterns themselves, moving at the margin away from areas of greater social importance to those of currently higher profitability. Disease research has been increasingly oriented towards the curative aspects of disease rather than prevention, and has dealt more with diseases that are more common or more potentially dangerous in the rich societies. By contrast, the diseases common among the poor in developing countries are not the focus of private research and investment. Only 4 out of 1223 new drugs developed by private industry between 1975 and 1997 were relevant for tropical diseases. (Pecoul et al 1999, page 361.)

Similarly, even within diseases or treatment of more general relevance, there is a disproportionate emphasis on non-essential treatment such as cosmetic surgery or drugs like Viagra. Private pharmaceutical investments tend to focus R&D on products that may be attractive from a commercial point of view but which add little to therapeutic innovation. Many “new” formulations tend to be “me-too” products that imitate existing drugs and do not provide significant therapeutic improvement. This amounts to a global public “bad”, because of the associated waste of resources. Privatisation of much medical research may give rise to conflicts of interest, which may become significant enough to affect the quality of the research and certainly of the results of the clinical trials of certain drugs or investigative methods. This affects not just the direction of research but even the very quality and efficacy of the research, which can have extremely adverse health implications in the medium and long term.

The growing commercialization of medical research done in US universities has raised fears – and provided several instances – of private corporations funding medically relevant research, trying to influence the results or determine the nature of publication. Often, researchers themselves are encouraged to have a financial stake in the process, because they have taken shares in the companies concerned. One cross-border implication of the commercialization of research is the attempt by private companies to find least cost methods of clinical testing, which is typically one of the more expensive aspects of drug development. There is growing evidence of companies moving to undertake such tests on poorer populations in developing countries, especially in Africa and India, where regulation and surveillance standards are lower, the patents involved do not have full knowledge of the risks involved, etc. Not only is this ethically problematic, it also can reduce the quality of the results provided, and affect populations in other countries who then take the drug so tested.

Finally, there are concerns that when medical research is left to private agents, the costs, especially of drug development, can be greatly exaggerated. While information about the costs of developing new drugs vary widely, and tend to be shrouded in secrecy, these unreliable estimates form the basis of important public policy decisions. James Love (2000, 2001) points out that there can be confusion surrounding the actual costs of drug research and development because of (a) the extent of allowance for risk and the opportunity cost of capital (b) varying definitions of what is a new drug and the description of "me-too" products as completely new innovations (c) private agents taking credit for research and expenses not actually borne by them, such as when they purchase rights to or otherwise appropriate the fruits of publicly funded research or traditional knowledge (d) skewed samples and therefore misleading averages of costs and expenses incurred. Some estimates suggest that even according to the drug companies own data, the level of R&D expenditure is not enough to warrant high monopoly prices being charged.

All this suggests that, if most medical research is to be in the private domain, there is need for much stronger regulatory mechanisms than currently exist, to control and monitor private research. These mechanisms need to be international in scope, so WHO can play a useful role in ensuring the adoption and enforcement of universal standards in this regard. Indeed, global regulation and incentive creation for such research is clearly a GPGH, given the inability of many individual governments to undertake it, and the cross-border implications of such research. So there is a strong case for changing the overall orientation of medical research, towards much greater public involvement. It is important to remember that even in the United States, until the mid to late 1980s, most such research was actually funded by governmental and quasi-governmental agencies, other public bodies and universities, rather than by corporations. Even today, much of the final research on medicines done (and patented) by private companies, remains based on the research carried out by public agencies or under public funding. Indeed, there are increasing concerns that public funds have been substantially used to develop drugs or therapeutic techniques, which have subsequently been allowed to be patented privately. With increased public activity in the funding and direction of medical research, the control over such technologies would also need to remain in the public domain. For many drugs, it is important that this domain be a global public domain with open access.

The problem with public funding of research that is most widely discussed is that it can lead to some misdirection of resources given the possibilities of mistakes (another example of "government failure"). There are questions relating to the efficient functioning of government-run labs and research institutions, to which types of research and development activities to fund, whom to fund, and so on. While these may be problems, usually the losses associated with some possibly wasted resources are far outweighed by the benefits in terms of increased production and access to medical knowledge. Further, when global funding for medical knowledge is considered, these problems are less apparent.

Incentives for Private Investment and Development

The use of fiscal incentives (tax breaks, subsidies, and so on) to promote medical research and development is an established practice in many countries. But there are cross-border issues here, which make public intervention at the international level desirable. To begin with, many developing country governments do not have the fiscal means to provide the necessary incentives for desired medical investment. This is associated with the type of problem mentioned earlier, of inadequate investment in knowledge which relates to diseases of the poor. Secondly, because of the global or cross-border effects of some research, even individual country governments which can afford to, are unlikely to spend as much in the form of subsidies or other incentives for private investors, to enable investment in knowledge production to the extent that is socially desirable. Thirdly, many developing countries do not have the infrastructure or resources to enable adequate testing of drugs to ensure safety and public knowledge of effects and side-effects, and therefore can be at a disadvantage when confronted with the superior lobbying and advertising power of multinational drug companies. There is therefore clearly a case for international or joint action in this regard, which should be led by the UN, WHO and other organizations with contributions from national governments.

Some possible international measures include

- Pre-purchase agreements which would ensure markets and therefore profitability for investment into and subsequent manufacture of particular drugs or diagnostic and therapeutic techniques. (see WHO Bulletin,)
- international organization-led funding for medical research, bringing together research teams in universities and other private labs based in different countries
- International level surveillance and regulation, with internationally organized testing institutions; recognized criteria for drug acceptance and wide publication/dissemination of knowledge relating to the drugs.

Obviously, public intervention is required even at the national level. For example, the clinical trials necessary to allow the wider use of drugs may not be undertaken if sufficient commercial profitability is not anticipated. This is the case not only for drugs of those resident in poor developing countries, but even for drugs with only a limited expected market in developed or high per capita income countries. This explains the provision of incentives for the development and production of such drugs, such as in the form of tax credits for clinical trial expenditure and/or exclusive marketing rights to the product. While these are seen as national measures, a GPGH perspective shows that in fact they can have significant cross-border implications. The US Orphan Drug Act is one such attempt. Designed to encourage the private development of drugs for which the market may otherwise be too small for profitable commercial exploitation, it provides for tax credits and exclusive marketing for a period, as recompense for testing expenses for drugs, vaccines, diagnostic drugs, or preventive drugs, used to treat rare diseases or conditions. The right to patents and data exclusivity becomes especially significant in cases when the company cannot claim a patentable invention. The infamous case of the drug paclitaxel (Taxol), for which the company Bristol Myers Squibb has received tax benefits and exclusive marketing rights even though it contributed very little to the actual development of the drug, has added to the controversy surrounding the Orphan Drug Act. It has been criticized for creating undesirable monopolies and rewarding private agents for what they have not done. (Love, 2000) It has also led to the company attempting to establish exclusive marketing control even in other countries. Thus, such legislation can lead to global monopolistic practices with respect to essential or important drugs, and can even operate to inhibit further innovation in other countries as well. The Taxol case has shown that national level incentives can have cross-border effects, suggesting the need to consider even such intervention from a GPGH perspective, and allow for international co-ordination and monitoring of such practices.

Thus the key issue in terms of dissemination/consumption of medical knowledge is excludability. There are two types of exclusion which are relevant: (a) exclusion from the medical knowledge itself, which can result from monopolistic control (as in patent regimes) or from inadequate dissemination (as in the case of traditional knowledge); and (b) exclusion from the products resulting from such knowledge, such as medicines or other medical techniques. Obviously, the emergence of new knowledge or even of new drugs and therapeutic techniques, is in itself not enough to ensure universal access, or even access to those who may be in the most need of it. This problem has led, for example, to concerns about the effects of excessive patenting, and over-zealous interpretations of the TRIPs agreement.

The effects of the patent regime are dramatically illustrated when the drug prices in countries with different patent regimes are compared. The Indian Patents Act, which even to date (that is, until the expected TRIPs-compatible revisions occurs through legal change) recognizes only process patents in pharmaceuticals, allows for reverse engineering for chemical products, that is working out a process to manufacture using the end-product only. This patent regime, which has been in operation since the 1970s, has contributed to the major price advantage that Indian companies are able to offer, both because of the ability to engage in reverse engineering and because of the consequently more competitive nature of the domestic industry. This allows for very substantial differences in drug prices between India and other developing countries. 5 Clearly, the absence of generic competition allows for much higher prices than may be warranted by the actual expenditure involved in R&D for the drug. The prohibitive costs of anti-viral drugs for the treatment of HIV-AIDS in the countries with the largest populations exposed to such threat, have been widely discussed and are now quite well known, as are the controversies involved in reducing the market power of patent holders of such drugs. (see Chandrasekhar and Ghosh, 2001, for a summary.) However, there are other drugs relevant for diseases which affect many poor people, especially in developing countries, which are also very highly priced because they are relatively new and therefore still covered by patent protection.

The problems associated with access to essential drugs are especially disturbing given the nature of the international drug market. The world market for drugs is a huge one, but it is dominated by only 3 countries - the United States, Japan and Germany - which make up more than two-thirds of total sales. In fact, only 15 per cent of the world' population accounts for 86 per cent of drug spending, while the remaining 85 per cent of the world's population get only 14 per cent share. [Pecoul et al, 1997]. Obviously, this majority is mainly in developing countries.

The importance of purchasing power in affecting not just the development of a drug but even its continued production is dramatically illustrated in the case of eflornithine (or DFMO) which is a drug to treat sleeping sickness. This disease, which is transmitted by the tsetse fly, is currently estimated to kill 150,000 people every year, mainly in Africa. The drug is currently not produced, because of "lack of commercial opportunities". Similarly, the drug for treating bacterial meningitis ceased being produced between 1995 and 1998 because of poor profitability (that is, low incomes of those affected by the disease) despite hundreds of thousands of sufferers each year, mainly in poor developing countries. (Pecoul et al, 1997) By contrast, the fastest growing segments of world drug production are non-essential drugs such as Viagra and anti-depressants, which are not life-saving drugs. Therefore, whether knowledge translates into products which can be effectively used, depends upon international distribution. But this need not remain only a problem for the current victims, since lack of control of disease can have spiraling, cross-border and inter-generational effects.

The difficulty of ensuring even a minimum degree of democratic access to life-saving drugs is compounded by the high degree of concentration in the international drug industry. This is associated with a range of monopolistic practices, including the use of brand names to generate market power and charge higher than warranted prices on many drugs. The issue is especially complicated because of the asymmetric information which characterizes the drug market – since consumers do not know the actual composition of the drugs they are taking, often they rely on brand names to ensure quality or homogeneity. This may be warranted where other manufacturers are providing spurious combinations or cheaper substitutes, but this cannot be predetermined or claimed to be true in all cases. As a result, established manufacturers often use the advantage of the brand name to charge much higher prices even when other generic manufacturers are producing the same or equivalent drugs at much cheaper prices. Together, brand names and patents insulate drug companies from price competition. Market segmentation allows for wide variation in prices of the same drug charged not only by different companies and even by the same company in different markets.

The experience with the National Drug Policy in Bangladesh in the 1980s and early 1990s provides some indication of just how much brand names play a role in higher drug prices. The Drug Policy came into effect in 1982, specifying a list of 45 essential drugs at the primary health centre level, which were to be manufactured and/or sold under their generic names only. MNCs were prevented from manufacturing simple products like common analgesics, vitamins, antacids, and so on. Prices of finished drugs were controlled. A decade later, it was found that essential drugs increased from 30 to 80 per cent of local production; drug prices fell in real terms; the proportion of drugs found to be substandard declined sharply from 36 per cent to only 9 per cent. (Zafrullah Chowdhury 1995) Price discrimination strategies by drug companies can continue especially where policies of compulsory licensing and parallel imports are not used to break such market segmentation. However, it should be remembered that these two strategies in themselves are not solutions to the basic problems of drug development, pricing and access, although they should certainly be supported as part of a broader public health package.

Summary

What emerges from this discussion is that a GPGH perspective is useful and important in the case of medical knowledge? The public good characteristics of knowledge mean that investment in knowledge cannot be left to the market or private agents alone (because it would then be below socially desired levels and the direction also need not be socially optimal). Further, since many of the positive and negative effects of investment in knowledge are cross-border in nature, even individual governments need not intervene to the extent that is socially desirable, and there is clearly a case for coordinated joint action or intervention by international bodies such as the WHO. Some of the possible interventions have been outlined in the previous section. However, this area of investigation is one which is largely unexplored in terms of research. Therefore, there needs to be more analysis of both the existing problems and possible solutions in this area. Some of the issues and questions that could form part of a future research agenda covering medical knowledge as a GPGH include the following

- The nature of medical innovation itself, and the degree to which it is actually influenced by the extent of private appropriability, or, more simply, do patents actually encourage more innovation?
- The role played by international monopolies – both public and private – in limiting access to innovation and knowledge, and particularly access in developing countries.
- The experience of international regulation in other areas, and the lessons they can provide for international co-operation and joint regulation in this area.
- The extent to which varying national standards of medical regulation and control spill over in terms of cross-border effects on the efficacy of disease control.
- The scope for new international incentives for developing on and disseminating the fruits of traditional knowledge.

Keywords

Bio politics, Political economy of medical knowledge.

SelfAssessment

1. …….refers to a branch of social sciences that focuses on relationships between individuals, governments, and public policy.

A. Sociology
B. Political science
C. Political economy
D. Economics

2. Father of economics ………………

A. Adam smith
B. Max Webber
C. Karl Marx
D. Emile Durkheim

3. TermPolitical economy is contributed by French economist

A. Thomas Muller
B. Neymar da Silva Santos
C. Antoine de Montchrestien
D. Thomas Mun

4. Who wrote the book "Traité de l'économiepolitique," which translates to the treaty of the political economy is ………………

A. Antoine de Montchrestien
B. Adam smith
C. Will smith
D. Narendra Modi

5. ……….. is concerned with how political and economic domains interact and shape individual and population health outcomes.

A. Social economy of health
B. Political economy of health
C. Cultural economy of health
D. Psychological economy of health

6. ………..had done an analysis of the political economy of health financing reform shows that while each country's context differs, so there are some key strategies that can be used to strategically manage reform processes.
A. UNESCO
B. WHO
C. UNICEF
D. WTO

7. The role of the political economy of health in driving by………….. makes the case for political attention to healthcare, through increased investments, healthcare reforms and improved capacity to deliver health, both public health and curative.
A. Health outcomes and the financial burden of health
B. Health deficiency
C. Inequality
D. Unemployment

8. Expansion of UHC is
A. University Health centre
B. University Human centre
C. Universal Health Coverage
D. Universal Human centre

9. ………..factors have been shown to influence who accesses healthcare, quality of healthcare delivery, and health outcomes and its prioritization within policy processes.
A. Cultural and Social
B. Social and economic
C. Economic and technological
D. Political and economic

10. Who commented hhealth policies can be seen as a complex political process (rather than just technical), driven as much if not more, by 'interests' than by evidence?
A. Michael R. Reich
B. Michael Jackson
C. Michael Jordan
D. Michael Clarke

11. The scholars observed that despite persistent demand to increase budgetary allocations to healthcare in India as well as potential economic benefits from investments in healthcare budgetary allocations to health have remained ……………….
A. High
B. Medium
C. Low

D. Excellent

12. Concept of Bio politics is contributed by ……………
A. Michael Jackson
B. Michael Jordan
C. Michael Faraday
D. Michel Foucault

13. The knowledge economy is a system of consumption and production that is based on…….
A. Intellectual capital
B. Social Capital
C. Cultural Capital
D. Economical Capital

14. ………………is referred to the ability to capitalize on scientific discoveries and applied research.
A. Political Economy
B. Medical knowledge
C. Political economy of health
D. Political economy of medical knowledge

15. The world market for drugs is a huge one, but it is dominated by only 3 countries - the United States, Japan and Germany - which make up more than two-thirds of total sales. The above mentioned statement
A. Partially true
B. False
C. True
D. None of the above answers.

Answers for SelfAssessment

1.	C	2.	A	3.	C	4.	A	5.	B
6.	B	7.	A	8.	C	9.	D	10.	A
11.	C	12.	D	13.	A	14.	D	15.	C

Review Questions

1. Discuss briefly about Political economy approach to health?
2. Briefly outline M. Foucault's concept of bio-politics and how that is related to health?
3. What is the concept of Political economy of medical knowledge?
4. List out the challenges in the Indian Healthcare Sector.
5. Briefly explain your view on involving the private investment and health development in India.

Further Readings

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Unit 12: The State and Health

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Objectives

- To know Health as a Fundamental Right.
- To know Health policy of government of India.
- To know about Medical Council of India.
- To understand Health insurance, food and Drug adulteration, issues of consumer protection of government.

Introduction

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition. It is the responsibility of the government to prevent and treat illness, provide proper health facilities like health centres, hospitals, laboratories for testing, ambulance services, blood bank and so on for all people. At the State level the Health Care Delivery System is under the State Department of Health and Family Welfare, headed by a Minister and with a Secretariat under the charge of Secretary/ Commissioner (Health and Family Welfare). It consists of political head, administrative head & technical head. Public health is a State subject, the primary responsibility to provide quality health care services to the people including in rural, tribal and hilly areas lies with State/UT Governments. There are five main aspects of personal health: physical, emotional, social, spiritual, and intellectual. Health is important to live life to the fullest. When a person leads a healthy lifestyle, the body remains healthy and the mind is active and fresh. Living a healthy life would extend longevity and also regenerate the body and mind. Having good health is of core importance to human happiness. Health is political because, like any other resource or commodity under a neo-liberal economic system, some social groups have more of it than others. Health is political because its social determinants are amenable to political interventions and are thereby dependent on political action (or more usually, inaction). Pressure began to mount on Government. Finally the Public Health Act of 1875, forced councils to carry out improvements. These included the provision of clean water, proper drainage and sewage systems and the appointment of a Medical Officer of Health in every area. The political determinants of health create the social drivers - including poor environmental conditions, inadequate transportation, unsafe neighborhoods, and lack of healthy food options - that affect all other dynamics of health. Health comes under concurrent list, according to the constitution of India. Both government, central and state can make policy on it. But if confusion arises between central and state government then the policy of central government will be implemented. So both governments are responsible for public health. The Federal Government is also involved, mainly through funding, in many things largely carried out by the States, such as health, education, environmental issues, industrial relations, etc. Responsibility for health should be a collaborative effort among individuals and the societies in which they live. Individuals should care for their own health and help to pay for their own healthcare, and societies should promote health and help to finance the costs of healthcare. Healthcare Administrators Are Critical to Organizational Success. Because healthcare administrators are responsible for keeping organizations working from both the business and healthcare delivery side of things, they play a critical role in virtually every healthcare organization. Healthcare administrators oversee the day-to-day administrative operations of hospitals and other healthcare facilities. Their responsibilities include planning and supervising all medical services—including monitoring budgets and updating health records. Public health administrators are concerned with health and disease prevention programs. They administer educational campaigns and try to keep the people they serve healthy. Other health professionals have similar aims of maintaining health but often are restorative or curative rather than preventive. The 1848 Public Health Act was the first step on the road to improved public health. One of the individuals who played an important role in its creation was Edwin Chadwick, a social reformer. In the United States, the first public health organization based on a state health department and local boards of health was founded in New York City in 1866. The objectives of this chapter are Health as a Fundamental Right, Health policy of government of India, Medical Council of India, Health insurance, food and Drug adulteration, issues of consumer protection and the government.

12.1 Health as a Fundamental Right

The right to health was first articulated in the WHO Constitution (1946) which states that: “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being”. The preamble of the Constitution defines health as: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. In 1948 Universal Declaration of Human Rights mentioned health as part of the right to an adequate standard of living (article 25). It was again recognized as a human right in 1966 in the International Covenant on Economic, Social and Cultural Rights, Article12: “1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

a. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
b. The improvement of all aspects of environmental and industrial hygiene;
c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.”

The Committee on Economic, Social and Cultural Rights (CESCR) is the body of 18 independent experts that monitors implementation of the International Covenant on Economic, Social and Cultural Rights by its State parties. The Covenant enshrines economic, social and cultural rights such as the rights to adequate food, adequate housing, education, health, social security, water and sanitation, and work. The Committee seeks to develop a constructive dialogue with State parties, determine whether the Covenant’s norms are being applied, and assess how the implementation and enforcement of the Covenant could be improved so all people can enjoy these rights in full.

The right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health (Paragraph 11).

The right to health is relevant to all States: every State has ratified at least one international human rights treaty that recognizes the right to health. The right to health for all people means that everyone should have access to the health services they need, when and where they need them, without suffering financial hardship. No one should get sick and die just because they are poor, or because they cannot access the health services they need. Right to Health is a part and parcel of Right to Life and therefore right to health is a fundamental right guaranteed to every citizen of India under Article 21 of the Constitution of India.

12.2 Health Policy of Government of India

The Constitution of India does not expressly guarantee a fundamental right to health. However, there are multiple references in the Constitution to public health and on the role of the State in the provision of healthcare to citizens. The Directive Principles of State Policy in Part IV of the India Constitution provide a basis for the right to health. Article 39 (E) directs the State to secure health of workers, Article 42 directs the State to just and humane conditions of work and maternity relief, Article 47 casts a duty on the State to raise the nutrition levels and standard of living of people and to improve public health. Moreover, the Constitution does not only oblige the State to enhance public health, it also endows the Panchayats and Municipalities to strengthen public health under Article 24 Given no explicit recognition of the right to health or healthcare under the Constitution, the Supreme Court of India in Bandhua Mukti Morcha Vs Union of India & others (1997) interpreted the right to health under Article 21 which guarantees the right to life. In its judgment, the Court discussed the importance of protecting children's rights to education, health, and development in ensuring India's progress as a democracy. While recognizing that child labor could not be abolished immediately due to economic necessity, the Court found that pragmatic steps could be taken to protect and promote the rights of children in the poverty-stricken and vulnerable populations of Indian society. In support of its conclusion, the Court referred to various fundamental rights and directive principles of the Indian Constitution including, Article 21 (the right to life and personal liberty), Article 24 (prohibits employment of children younger than 14 in factories, mines, or other hazardous industries), Article 39 (e) (prohibits forcing citizens into vocations unsuited for their age or strength), Article 39(f) (describes the State's duties to protect children from exploitation and to ensure children the opportunities and facilities to develop in a healthy manner), and Article 45 (mandates the State to provide free compulsory education for all children below 14 years). The Court also noted India's obligations under the Universal Declaration of Human Rights (UDHR) and the Convention on the Rights of the Child to provide free primary education for all children in the country, and to protect children against economic exploitation.

Whereas, the State of Punjab &Ors Vs Mohinder Singh Chawla (1997) the apex court reaffirmed that the right to health is fundamental to the right to life and should be put on record that the government had a constitutional obligation to provide health services.The right to health was placed at the higher ground above any rhetoric government policy bounding the state of Punjab under a constitutional obligation to reimburse the claimed amounts.

In State of Punjab &Ors Vs Ram Lubhaya Baga (1998) the court went on to endorse the State's responsibility to maintain health services. In September 2019, a High Level Group on the health sector constituted under the 15th Finance Commission had recommended that the right to health be declared a fundamental right. It also put forward a recommendation to shift the subject of health from the State List to the Concurrent List. The recommendation to declare the right to health a fundamental right, if implemented, will strengthen people's access. However, the latter recommendation to shift health to the Concurrent List will lead to a constitutional conundrum on whether the centralisation of public health will be helpful in the context of Indian cooperative federalism. At present, the subject of "public health and sanitation; hospitals and dispensaries" falls under the State List of the 7th Schedule of the Constitution of India - which means that state governments enjoy constitutional directives to adopt, enact and enforce public health regulations.

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A 2019, NITTI Ayog report highlighted that states in India had unequal public health systems. This imbalance was primarily due to restricted technical expertise and fiscal constraints. While fiscal dependence of states on the centre continues to be a major challenge, if the subject of health was moved to the Concurrent List, it would lead to excessive bureaucracy, red tape and institutional constraints. Even as the policy decision of states would continue to remain subjective to the political orientation of the federal executive, this centralisation would rip states of their constitutional rights.

Furthermore, a uniform strategy would not provide the specialized attention that states across India need.

Through the Directive Principles of State Policy, the Constitution has made a forceful appeal to the State to provide a decent standard of living. Several legal precedents have dictated that the state is responsible for citizens' healthcare. India's commitment to international legal treaties and conventions also binds it, as a state party, to enhance and provide adequate public services and a minimum standard of universal health care. Existing constitutional guarantees, legal precedents and global commitments form a solid basis for a fundamental right to health in India. A legislatively guaranteed right will make access to health legally binding and ensure accountability. A constitutional amendment on the lines of the 93rd Amendment to the Constitution which provided a constitutional sanction to the right to education, should be adopted for providing adequate healthcare in India.

National Health Policy

After the National Health Policy 1983 and National Health Policy 2002 served well in guiding the approach for the health sector in the Five-year plans, the Union Government approved the National Health Policy in March 2017. The 2017 policy aims to project an incremental assurance-based approach that expounds on the need for a new health policy to account for changing priorities in India's abysmal healthcare delivery system. This involves building a more 'robust health care industry', reducing 'catastrophic expenditure' in the form of out-of-pocket healthcare costs and enhancing 'fiscal capacity' to meet a widening healthcare financing deficit (Mohan, 2017). Some of the specific goals and objectives as laid out by the policy are:

- Increase Life Expectancy at birth from 67.5 to 70 by 2025.
- Reduce infant mortality rate to 28 by 2019.
- Increase utilization of public health facilities by 50% from current levels by 2025.
- Meet need of family planning above 90% at national and sub national level by 2025.
- Access to safe water and sanitation to all by 2020 (Swachh Bharat Mission).
- Increase health expenditure by Government as a percentage of GDP from the existing 1.15
- Percent to 2.5 percent by 2025. Increase State sector health spending to > 8% of their budget by 2020.
- Establish primary and secondary care facility as per norms in high priority districts (population as well as time to reach norms) by 2025.
- Ensure district-level electronic database of information on health system components by 2020.
- Strengthen the health surveillance system and establish registries for diseases of public health importance by 2020.
- Establish federated integrated health information architecture, Health Information Exchanges and National Health Information Network by 2025.

Under the organisation of public healthcare delivery, the policy thrust is on comprehensive care, system of referrals for regulating patient flows, output-based purchasing of private services to fill gaps, supply of free drugs, diagnostics and emergency services in all public facilities, scaling up urban health, strengthening of infrastructure and manpower in underserved areas, and integrating all national health programmes and making Ayush services an option.

12.3 Medical Council of India

The Medical Council of India (MCI) was established in 1934 under the Indian Medical Council (IMC) Act of 1933. At the time, its primary function was to standardise both training in medicine and the accreditation of medical and surgical proficiency. In 1956, the original IMC Act was repealed and redesigned. It has subsequently received face-lifts with amendments enacted in 1964, 1993, and 2001. The Council is composed of one representative from each State (appointed by the

Central Government), one medical faculty member from each University (appointed by the Senate of the public University), one representative of each State which maintains a Medical Register (elected by members on the register), seven members enrolled on any of the State Medical Registers (elected from amongst themselves) and eight Central Government representatives (appointed by the Central Government). The MCI elect its President and Vice-President.

The Medical Council's main objectives are:

1. Maintenance of uniform standards of medical education, both undergraduate and postgraduate.
2. Recommendation for recognition/de-recognition of medical qualifications of medical institutions of India or foreign countries.
3. Permanent registration/provisional registration of doctors with recognised medical qualifications.
4. Reciprocity with foreign countries in the matter of mutual recognition of medical qualifications.
5. Regulating professional conduct of Doctors registered under the Indian Medical Council Act, 1956.

National Medical Commission (NMC) is an Indian regulatory body of 33 members which regulates medical education and medical professionals. It replaced the Medical Council of India on 25 September 2020. The main functions of the MCI were listed as: Establish and maintain uniform standards for undergraduate medical education. Regulate postgraduate medical education in medical colleges accredited by it. (The National Board of Examinations is another statutory body for postgraduate medical education in India). MCI has been found guilty in some falsified practices, this as a result has led to eradication of MCI completely. On the contrary, the National Medical Commission abbreviated as NMC is the government allied regulatory body.

12.4 Health Insurance

Health insurance is a contract between a company and a consumer. The company agrees to pay all or some of the insured person's healthcare costs in return for payment of a monthly premium. The contract is usually a one-year agreement, during which the insurer will be responsible for paying specific expenses related to illness, injury, pregnancy, or preventative care.

Types of Health Insurance

Every individual is different and has a unique set of needs. A single health insurance product is not enough to cover every person's individual requirements. This is precisely where there are a number of different types of health insurance plans available. Let's take a look at what they are:

a. Individual Health Insurance- You can purchase an individual health insurance policy to provide cover for yourself, your spouse, your children and your parents. These policies typically cover all kinds of medical expenses, including hospitalization, daycare procedures, hospital room rent and more. Under an individual health insurance plan, each member has their own sum insured amount. So, let's say you've taken an individual plan for yourself, your spouse and both your parents with a sum insured of INR 8 lakhs. Each of you will be able to claim a maximum amount of 8 lakhs per policy year against your health insurance.

b. Family Floater Health Insurance - A family floater plan allows you to cover your family members under a single policy and everybody shares the sum insured amount. These plans are typically more affordable than individual plans since the sum insured is shared. Let's say you purchase a family floater plan for you and your spouse with a sum insured of INR 8 lakhs. In a single policy year, you can make claims worth only INR 8 lakhs. Your spouse may make claims worth INR 6 lakhs and you could make claims worth INR 2 lakhs or vice-versa. Typically, family floater plans are ideal for young nuclear families.

c. Senior Citizens Health Insurance -These health plans have been designed specifically keeping the medical needs and requirements of senior citizens in mind. Most senior citizens policies offer additional cover, such as domiciliary hospitalisation and even some psychiatric benefits. Since older citizens are more likely to have health issues, these policies may require a full medical check-up beforehand and could be more expensive than regular insurance policies.

d. Critical Illness Insurance-There are a number of lifestyle-related diseases that are on the rise. Health issues such as cancer, stroke, kidney failure and cardiac diseases can be very expensive to deal with and manage long-term. This is precisely why critical illness insurance policies have been created. They can either be purchased as a rider or add-on with your regular health insurance plan or separately as their own plan. These policies offer cover for very specific issues and often provide claim payouts as a single lump sum payment after the diagnosis of a critical illness.

e. Group Health Insurance -Unlike individual and family floater policies, group health insurance plans can be purchased by a group manager for a large number of individuals. For example, an employer can purchase group insurance for all their employees or a building secretary may purchase such a plan for all the residents of the building. These plans are fairly affordable, but they often only provide cover for basic health issues. Employers often purchase these plans as an additional benefit for employees.

Benefits of Health Insurance

Purchasing health insurance is crucial for a number of reasons. Let's take a look at the most important benefits of our health insurance policies:

a. Helps Deal with Rising Medical Costs- People purchase health insurance policies to safeguard their finances against ever-rising medical costs. An accident or medical emergency could end up costing you more than a few thousand rupees. With a medical insurance plan, you enjoy cover for everything from ambulance charges to daycare procedures, making it easier for you to get the care you need to recover.

b. Critical Illness Cover-Many health insurance policies will also offer cover for critical illnesses at an additional cost. Given the rising incidence of lifestyle-related diseases today, this is another crucial cover to have. You will be provided with a lump sum payout in case you are diagnosed with any of the covered critical illnesses. These issues are often very expensive to deal with and manage, so critical illness cover is another vital benefit of having health insurance.

c. Easy Cashless Claims- Every health insurance provider will tie-up with a number of network hospitals where you can enjoy cashless claims. This makes the entire process of receiving emergency medical care much easier. At a network hospital, you aren't really required to pay for any of the covered treatments. For all valid claims, we'll take care of the medical costs, without you having to pay for anything, except non-covered expenses and the mandatory deductibles.

d. Added Protection-If you enjoy cover under a group health insurance plan, you may wonder why you should purchase your own health insurance policy. Well, individual health insurance plans offer provider more and better cover than group plans. Additionally, if you happen to leave the group at any time, you risk losing the cover, which could make you and your finances vulnerable.

e. Tax Savings-Under Section 80D of the Income Tax Act, 1961, premiums paid towards the upkeep of health insurance policies are eligible for tax deductions. For a policy for yourself, your spouse, your children and parents below the age of 60, you can claim a deduction of up to INR 25,000 per year from your taxable income. If you've also purchased a policy for a parent who is over the age of 60, you can claim an additional deduction of INR 50,000.

How Health Insurance Works?

Like every kind of insurance policy, health insurance also helps you deal with the financial repercussions of an accident or emergency. Let's take a look at how health insurance actually works. The process starts when you apply to purchase a plan. Depending on your age, medical background, sum insured required and the type of plan you’ve selected, you will be provided with premium quotes. In some cases, you might be asked to do a few medical tests before the insurance provider decides whether they'd like to provide you with the required cover. Once the terms and conditions are finalized, you will be provided with a policy. Each policy comes with a few waiting periods. The initial waiting period is only for a few weeks or a month. During this time, you will not be able to make any non-emergency claims. Let's say that you require some kind of surgery after the waiting period. If you're able to get the treatment in a network hospital, you can let us know about the surgery, and we'll get in touch with the hospital directly to settle all the payments. When you're discharged from the hospital, you will only have to pay for additional expenses that are not covered and the voluntary co-pay amount, if any. If you're getting treatment in a non-network hospital, you can make all the payments and then file for a reimbursement claim. Either way, you can get the treatment you require without fretting about burning a hole through your pocket.

Need for Health Insurance

Medicare or medical costs are rising year on year. As a matter of fact, inflation in Medicare is higher than inflation in food and other articles. While inflation in food and clothing is in single digits, Medicare costs usually escalate in double digits. For an individual who hasn't saved that much money, arranging for funds at the eleventh hour can be a task. This is particularly daunting for seniors, given that most ailments strike at an advanced age.

One way to provide for health-related / medical emergencies is by taking health insurance. Health insurance offers considerable flexibility in terms of disease / ailment coverage. For instance, certain health insurance plans cover as many as 30 critical illnesses and over 80 surgical procedures. The insurance plan disburses the payment towards surgery/illness regardless of actual medical expenses. The policy continues even after the benefit payment on selected illnesses. With health insurance, you are assured of a more secure future both health-wise and money-wise. This makes health insurance policies critical for individuals, especially if they are responsible for the financial well-being of the family.

12.5 Food and Drug Adulteration

Food adulteration refers to the act of intentionally debasing the quality of food by either adding or replacing the food substances with undeclared alternative components, or by the removal of some valuable components. This is usually done to lower the cost or increase the bulk of a given food product. Whereas Drug adulteration is a practice of substituting original crude drug partially or wholly with other similar looking substances but the latter is either free from or inferior in chemical and therapeutic properties. It usually occurs when the drug is scarce or when its price is normally high, through there may not be any scarcity. And the adulterants must be some material which is both cheap and be available in large quantity. So, availability and price therefore limit the range of substitutes from which the adulterants are selected. Adulteration is done deliberately and the motives for it are commercial one and to get more profits. Although in some cases adulteration may be occur accidentally. Adulteration involves different conditions such as deterioration, admixture, sophistication, substitution, inferiority and spoilage. Section 275: Sale of Adulterated Drugs: Anyone who knowingly sells or offers to sell any adulterated drug or medicine shall be punished with imprisonment for a term which may go up to six months, or with a fine which may extend to Rs 1000, or with both.

Food adulteration is the addition of contaminants into food items or beverages to increase the quantity and decrease the price of the commodity. It is a major issue in India which lowers the quality of food and leads to serious illnesses in both humans and animals. To restrict these problems, it was necessary to form laws that could prevent such contamination. In India, since 1899, the food adulteration laws have been in legislation. Since it was the pre-independence era, states and provinces had their own rules and regulations for the prevention of food adulteration. Some of those acts are –

- The Calcutta Municipal Act, 1923
- The UP Pure Food Act, 1950
- The Punjab Pure Food Act, 1929
- The Bihar Prevention of Food Adulteration Act, 1948

These state or province-specific acts had different laws and regulations that did not have any uniformity. This created a barrier for interstate food promotion and transportation. There was a difference between the methods of analysis, punishment, implementation and standards. This made way for a more centrally organised law for the prevention of food adulteration.

Eventually, the Government of India approved the Food Adulteration Committee in 1943. The committee studied and reviewed the subject of Food Adulteration and hence advised for a central legislation. Thus, the Prevention of Food Adulteration Act (PFA) finally came into force in 1954.

The Prevention of Food Adulteration Act, 1954 extends to the entire country of India and it came into effect on June 15th, 1955. The act defines adulteration or deems an item to be adulterated when –

- If the item sold by the vendor does not meet the standards of the customer or the standards the article purports to be.
- If the item contains any element that lowers the quality of the article.
- If the article has been manufactured or stored in unhygienic conditions.
- If the item contains any element that is unfit for human consumption such as putrid, decomposed or rotten plant or animal substances.
- If the article contains an element taken from a diseased animal.
- If the article contains any poisonous or injurious substances.
- If the container of the article is made up from any injurious substance.
- If any colouring agent other than the prescribed ones are added in the article.
- If the article consists of any prohibited preservative or preservative quantity above the prescribed limit.
- If the quality and purity of the article does not meet the standards set by the committee whether it is injurious or non-injurious to health.

Under this act, vendors can also opt for enrichment of items such as iodisation of salt, adding minerals and vitamins to breads or cereals, and addition of vitamin C.

Article	Adulterant
Baking Powder	Citric Acid
Spices	Lead or lead chromate in haldi, sawdust, sand
Starchy Foods	Arrowroot powder, sand and dust
Coffee and tea	Chicory, husk, used tea dust, grit
Milk	Water, abstraction of fat
Vanaspati	Excessive hydrogenation, animal fat
Non-alcoholic beverages	Saccharin, copper, lead and arsenic.

Table 12(1)

Table of Adulterants

Penalty for the food adulteration

Upon violation of the laws found under the act, there are penalties that are levied on the vendor. Let us look at some of those circumstances –

- On breaking the law for the first time the vendor can get imprisoned for a duration of 6 months to 1 year or can be fined with 2000 rupees (depending on the situation).
- On breaking the law for a second time, there can be imprisonment for up to 6 years and also cancellation of licence.
- When an adulterated food is injurious to health, the vendor can be punished under the Section 320 of the penal code.

Responsibilities of Central Government

The prevention of food adulteration act looks to prevent the adulteration of the food and beverage items to be fit for human consumption, except water and drugs. This act gives the central government a variety of responsibilities which are stated below.

- To set up a Central Committee for Food Standards and central food laboratories for analysing and testing all kinds of articles.
- To review the sections of the PFA act along with the central committee for food standards.
- Organising training programmes for different sections of the act.
- Approving the state PFA rules.
- To check on the implementation of rules in states and union territories by collecting frequent reports and visitation.
- Conducting exams for appointing officials as analysts under the act.
- To approve the infant food labels.
- To check the quality of food being imported to India.
- Creating awareness among the consumers.
- To keep a check on the quantity and quality of food laboratories.

Food Inspectors

The central government or the state government can appoint an official representative by notifying them in the official gazette. The food inspector should have qualifications for the post and should not hold any financial position in the article he is investigating. The food inspector is deemed to be a public servant under section 21 of the Indian Penal Code.

The food inspector is authorised to collect samples from the vendors and send them to the laboratory for analysis. He/she can stop the article from being sold if it does not meet the food standards.

12.6 Issues of Consumer Protection and Government

Consumer rights are a set of rights governed by the law that gives allows customers to have the necessary information about goods and services while purchasing. Similarly, consumer responsibilities indicate that customers have a specific responsibility towards the society and other consumers and help them to fight against the unfair practice or at least be aware of it. These rights and responsibilities are registered under the Consumer Protection Act 1986.

Consumer Rights

- **Right to Safety-** Before buying, a consumer can insist on the quality and guarantee of the goods. They should ideally purchase a certified product like ISI or AGMARK.
- **Right to Choose-** Consumer should have the right to choose from a variety of goods and in a competitive price

- **Right to be informed-** The buyers should be informed with all the necessary details of the product, make her/him act wise, and change the buying decision.
- **Right to Consumer Education-** Consumer should be aware of his/her rights and avoid exploitation. Ignorance can cost them more.
- **Right to be heard-** This means the consumer will get due attention to express their grievances at a suitable forum.
- **Right to seek compensation-** The defines that the consumer has the right to seek redress against unfair and cruel practices or exploitation of the consumer.

Consumer Responsibilities

- Responsibility to be aware – A consumer has to be mindful of the safety and quality of products and services before purchasing.
- Responsibility to think independently– Consumer should be well concerned about what they want and need and therefore make independent choices.
- Responsibility to speak out- Buyer should be fearless to speak out their grievances and tell traders what they exactly want
- Responsibility to complain- its consumer responsibility to express and file a complaint about their dissatisfaction with goods or services in a sincere and fair manner.
- Responsibility to be an Ethical Consumer- They should be fair and not engage themselves with any deceptive practice.

The significance of Consumer Awareness

Consumer awareness is a process of making an individual or consumer awareness of their rights and responsibilities when purchasing goods and services. Awareness is essential for all customers so that they take the right decision and make the right choice about the products and services being sold and sold. One of the examples of Consumer Awareness Example in India is "Jago Grahak Jago'.

Consumer Protection Act

The Consumer Protection Act, implemented in 1986, gives easy and fast compensation to consumer grievances. It safeguards and encourages consumers to speak against insufficiency and flaws in goods and services. If traders and manufacturers practice any illegal trade, this act protects their rights as a consumer. The primary motivation of this forum is to bestow aid to both the parties and eliminate lengthy lawsuits. This Protection Act covers all goods and services of all public, private, or cooperative sectors, except those exempted by the central government. The act provides a platform for a consumer where they can file their complaint, and the forum takes action against the concerned supplier and compensation is granted to the consumer for the hassle he/she has encountered. The new Consumer Protection Act was passed by Parliament in 2019. It came into force in July 2020 and replaced the Consumer Protection Act, 1986.

Summary

This unit highlights the rights of Health, which is the most important factor in national development. It is a condition of a person's physical and mental state and signifies freedom from any disease or pain. Right to health is a vital right without which none can exercise one's basic human rights. The Government is under obligation to protect the health of the people because there is close nexus between Health and the quality of life of a person. There are various provisions under the Constitution of India which deal with the Health of the Public at large. The founding fathers of the Indian Constitution rightly inserted Directive principles of State Policy (DPSP) with a view to protect the health of the public at large. Health is the most precious prerequisite for happiness. The second part of the chapter exposed to the prevention of Food Adulteration Act & rules made there under –national legislation to prevent adulteration of food and provide food safety and fair trade practices. Central Committee for Food Standards (CCFS) is responsible for advising the Central Government and State Government on matters arising out of the administration of the Act. The Statutory Committee recommends the specifications for various food articles including maximum levels of contaminants, use of additives and their maximum levels including pesticide residues, procedures for drawing up samples, sending to the laboratories, functions of public analyst and of appellate laboratories (Central Food Laboratory), labeling and licensing Rules etc. This act and its amendments aim at preventing any sort of adulteration on food articles and in food processing.'

Keywords

Health as a fundamental rights, Food Adulteration, Contamination

Self Assessment

1. The right to health was first articulated by ……………………

A. UNESCO

B. UNICEF

C. WTO

D. WHO

2. The preamble of the Constitution defines……….. as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

A. Illness

B. Wellness

C. Health

D. Wealth

3. In 1948 Universal Declaration of Human Rights mentioned health as part of the right to an adequate standard of living was described in……………….

A. Article 02

B. Article 25

C. Article 05

D. Article 23

4. The Committee on Economic, Social and Cultural Rights (CESCR) is the body of ……..independent experts that monitors implementation of the International Covenant on Economic, Social and Cultural Rights by its State parties.

A. 18

B. 22

C. 05

D. 12

5. It was a high-level group (HLG) on health sector constituted by the ……..Finance Commission has recommended that 'Right to Health' be declared a fundamental right and the Constitution be amended to shift the subject of health from the state list to the concurrent list.

A. First

B. Fifteenth

C. Second

D. Thirteenth

6. From the below option which is the famous judgements, that is not related to health rights.

A. BandhuaMukti Morcha Vs Union of India & others (1997)
B. The State of Punjab &Ors Vs Mohinder Singh Chawla (1997)
C. State of Punjab &Ors Vs Ram Lubhaya Baga (1998)
D. Kesavananda Bharati v. State of Kerala (1973)

7. In 2019 ……….highlighted that states in India had unequal public health systems.
A. NITTI Ayog report
B. WHO Report
C. Indian Medical council Report
D. Constitution of India

8. The Medical Council of India (MCI) was established in ……. under the Indian Medical Council (IMC) Act of 1933.
A. 2022
B. 1950
C. 1934
D. 1997

9. ………………holds its primary function was to standardise both training in medicine and the accreditation of medical and surgical proficiency.
A. The Medical Council of India
B. Primary Health Centers
C. Community Health centers
D. Medical Colleges.

10. The original IMC Act of 1956 Act was repealed and redesigned. It has subsequently received face-lifts with amendments enacted in …………..
A. 1950,1991,1999
B. 1964,1993,2001
C. 1947,1950,1998
D. 1885, 1900,1991

11. National Medical Commission (NMC) is an Indian regulatory body of ……which regulates medical education and medical professionals. It replaced the Medical Council of India on 25 September 2020.
A. 12 members
B. 22 members
C. 33 members
D. 05 members

12. ……….is a contract between a company and a consumer.
A. Health card
B. Vaccination
C. Health chart
D. Health insurance

13. …….is the addition of contaminants into food items or beverages to increase the quantity and decrease the price of the commodity.

A. Food adulteration
B. Proper Diet
C. Health chart
D. Balanced Diet

14. The acts like The Calcutta Municipal Act, 1923, The UP Pure Food Act, 1950, The Punjab Pure Food Act, 1929, The Bihar Prevention of Food Adulteration Act, 1948

A. The above mentioned statement is True
B. The above mentioned statement is False
C. The above mentioned statement is not related to Question.
D. None of the above.

15. The Government of India approved the Food Adulteration Committee in 1943.

A. 1990
B. 1987
C. 1943
D. 1880

Answers for Self Assessment

1.	D	2.	C	3.	B	4.	A	5.	B
6.	D	7.	A	8.	C	9.	A	10.	B
11.	C	12.	D	13.	A	14.	B	15.	C

Review Questions

1. Health as a fundamental rights. Discuss?
2. How Indian constitution looks towards the Health as a fundamental right?
3. Discuss the role and significance of The Medical Council of India (MCI).
4. Discuss the significance of Health insurance in India.
5. Discuss the role and connection of health inspector in providing good health.

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Unit 13: Therapy and Rehabilitation

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Objectives

- To know about Conceptual differentiation between Therapy and Rehabilitation.
- To understand about the Rehabilitation Agencies: State and Nation, Rights and Care of handicapped

Introduction

Rehabilitation refers to restoration or recovery of the biological, psychological and social functioning of an individual which was lost or impaired due to injury or disability. It is founded on the premise that all individuals have inherent worth and have their right to be experts in their own health care. The aim of rehabilitation is to regain maximal functioning, and independence of the client.

Rehabilitation goals are the desired outcomes for each rehabilitation client (Habel, 1993). Therefore, the goals of rehabilitation are required to be mutually established by the rehabilitation professionals in consultation with the client and his family members. The interdisciplinary team of rehabilitation professionals regularly meet to decide the immediate and long-term goals. Realistic goals are set in consultation with the client and the family members and other caregivers. The ultimate purpose is to enhance the client's wellbeing. In this context, it should be noted that there is a difference in the focus in acute care and rehabilitation care. Mauk (2012) makes a careful distinction between acute care and rehabilitation care. In acute care, the participant's survival is the primary focus and the care is provided through activities of daily living for the person; whereas in rehabilitation, the focus is on educating persons to be able to perform activities of daily living for themselves. The purpose of rehabilitation may be precisely stated as follows: (1) Promotion of self-care, (2) Maximising independence, (3) Maintaining and restoring functions, (4) Preventing complications, and (5) Encouraging adaptation (Habel, 2012).

Promotion of Self-Care

Disability causes not only physical problems but also emotional challenges. The client has to adapt to them. Physical problems restrict the individual's activities of daily living (ADL) (e.g., skills such as brushing, grooming, toileting or speaking), as often seen in case of traumatic head injuries, sensory-motor disabilities, severe or profound mental retardation. Some of these problems are overcome by use of augmentative and alternative devices. Augmentative devices are those which enhance the existing capabilities of the people with disabilities (for instance, spectacles enhancing vision, hearing aids for hearing or mobility aids for movement); whereas, alternative devices are those which are used in developing a parallel or alternative forms of executing certain functions of a client that are lost due to injury or disability (e.g., communication devices such as, speech synthesizers for those who have lost their speech, the aphasics; braille for reading of the visually handicapped, and wheel chairs for the ones with severe locomotors disability involving the lower limbs). Such improvised ADL kits and appliances compensate the loss to a large extent. However, while suggesting alternative devices, the rehabilitation professionals should look into the possibility of using augmentative methods that can enhance their functions, or behavioral training in which effort is made to teach alternative ways of responding. Providing prosthetic environment by modification of the existing ones can also be incorporated as a part of rehabilitation training. Adherence to an alternative method or device for ADL reduces the chance of using the residual skills. This has an impact on adaptation. Therefore, the option for using alternative is required to be exercised carefully. The primary caregivers and family members play a significant role in promoting self-care. When the injury is severe enough, it is difficult to expect that the functions can be restored completely to the premorbid level. The client has to adapt and adjust to the natural environment (e.g. home, vocational and social environment).

13.2 Social Components in Therapy and Rehabilitation

The central goal of rehabilitation is to restore the health and dignity of someone affected by an illness that may have caused physical, mental, or emotional hurt and that may have led to social problems, such as the loss of a job or the disruption of close relationships. This goal is sometimes referred to as tertiary prevention (primary prevention means that a person never develops the disease at all; secondary prevention involves treatment of an illness so that no lasting damage occurs; tertiary prevention seeks to minimize the effects of any permanent damage caused by an illness). Leprosy is a disease that leads to a variety of well-known physical problems, described elsewhere in this book, but the social and emotional consequences are often far more deep-seated and disruptive, lasting a lifetime. Rehabilitation in the field of leprosy is therefore an immense and wide-ranging challenge.

The ways in which a disease affects a person have been classified and defined as shown in the below given diagram. This diagram helps in understanding which aspects of a person's life are affected by an illness and need restoring. The diagram shows that an illness may damage a part of the body or a particular function and cause an impairment, such as a loss of sensation on the sole of the foot or a paralysis of muscles in the hand. Some impairments make it difficult to do certain activities, such as holding a cup, and thus put a limit on activities that are a normal part of life. Social participation may be restricted simply because of the disease itself, or because of a visible impairment (such as a skin lesion causing stigma and loss of acceptance in the community), or because of an activity limitation (such as being unable to walk).

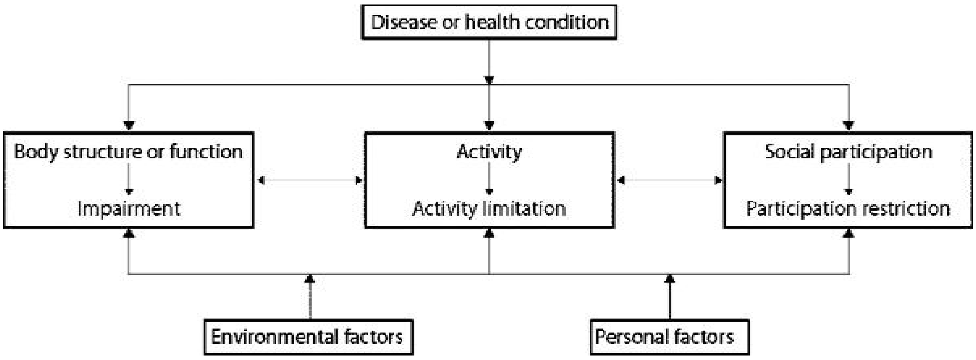

Fig. 13(1)

The International Classification of Functioning, Disability and Health. WHO 2001.

External factors in the environment may influence how a person is affected, and personal factors greatly influence how someone copes with these issues. Modifying a building's environment to make it wheelchair-friendly, for example, greatly reduces the restrictions—one could also say 'increases the freedom of movement'—experienced by someone who is unable to walk. A strong feeling of shame and self-stigma may be a personal factor that prevents someone with leprosy from attending public events.

Rehabilitation involves interventions to reverse the forces leading to impairment, activity limitation, and participation restriction. In general, medical and surgical interventions focus directly on impairments, but their goal is to mitigate the effect of those impairments on activity and participation. Hand surgery in leprosy, for example, may restore some aspect of hand function such as opposition of the thumb and forefinger. If successful, the surgery will enable that person to pick up and manipulate objects, and perhaps restore his or her ability to work, an important aspect of participation. If a medical or surgical intervention is not possible, activity limitations may be ameliorated by other strategies such as special training, the use of aids (such as a wheelchair or adapted footwear), or environmental modifications that make it easier for a disabled person to get around. These interventions have been pioneered by a range of professionals, including physical and occupational therapists. In a similar way, a wide range of interventions seek to directly reduce participation restrictions faced by those affected by leprosy, including enabling them to be more financially independent, either though employment or a disability pension. Encouraging employment is done in many different ways, from vocational training, to the provision of microcredit, to advocacy and counselling.

The organization of rehabilitation interventions has changed dramatically in recent years. In the past, the focus was very much on the professional, biomedical remedies organized by hospitals and similar institutions. This approach was costly and underutilized resources that may have been available in the community.

Initiatives by individuals and groups in the community gradually led to what is known as community-based rehabilitation (CBR). CBR has grown in scope over the years and now has strong links with community development and poverty alleviation—poverty and disability being very closely associated for obvious reasons.A further development within the field of rehabilitation in leprosy is the realization that, in order to be truly restored to lives of dignity, those affected need to feel that they have more control over key areas of their lives. A certain level of empowerment is needed to provide the motivation for change, leading to normalization. This realization forms the basis for the self-care and self-help movements that have started to spread in areas where leprosy remains endemic.

13.3 Importance of therapy and Rehabilitation

For the wellbeing, caring of health is very important as the health academia's and health professionals keep connecting the rehabilitation and therapy together. But when the conceptual understanding of both brings a different perspectives in the arena of health. As per the WHO, Rehabilitation addresses the impact of a health condition on a person's everyday life by optimizing their functioning and reducing their experience of disability. Rehabilitation expands the focus of health beyond preventative and curative care to ensure people with a health condition can remain as independent as possible and participate in education, work and meaningful life roles. Anyone may need rehabilitation at some point in their lives, whether they have experienced an injury, disease, illness, or because their functioning has declined with age. Globally, 1 in 3 people today are estimated to be living with a health condition that would benefit from rehabilitation. This need is predicted to increase in the coming years due to changes in the health and characteristics of the population. For example, people are living longer but with more chronic disease and disability. Emergencies, including conflicts, disasters and outbreaks can all create surges in rehabilitation needs. Globally, many people are living with mid- and long-term consequences of COVID-19 and may be in need of rehabilitation to support their recovery from the disease.

Therapy and Therapeutics

The concept of Therapy and Therapeutics is widely used but on conceptual understanding both are having different meaning. Therapy is an act, a profession and a researched field that utilises science concepts. It is provided by a qualified therapist and revolves around establishing and designing treatment plans and goals with expected outcomes. Therapeutic, on the other hand, involves feeling good, engaging in pleasurable activities, calming or grounding in nature. Therapeutic activities do not have goals and are not stable. Therapeutic activities can be enjoyed as a part of routine or self-care. Therapy, on the other hand, is a longer-term commitment towards healing. Psychotherapy deals with taking or working with different mediums such as dance, art or music to understand patterns of thoughts and behaviours. It involves examining emotions and external relationships, and factors that influence your mental health. Therapeutic, on the other hand, works on enhancing your mood and feelings for a short period of time, plausibly related to contextual events and situations. For example, taking a weekend off to spend some time with family members who stay in a different place or go on a long drive is therapeutic. However, these therapeutic activities are limited to actions and behaviors that seek comfort in nature.

Therapy aims to discover, rediscover, learn and unlearn different aspects of your personality. Whilst therapeutic is external, therapy is inner work. Therapeutic activities are always soothing, whereas therapy can be excruciating, messy and complex and, at the same time, advantageous in the long term. Another important difference between the two, of course, is the presence of a therapist. While therapeutic activities do not require a trained professional, therapy requires a safe and stable connection with a qualified professional. To briefly summarize, recreational activities can feel therapeutic; unexpected small acts of kindness or compassion towards oneself or others can also feel therapeutic. However, psychotherapy focuses on the range of emotions an individual may bring into the session; components of empathy and validation form the crux of a therapeutic relationship. Progress in terms of therapy is measured through the goals set or behavioral or emotional patterns that may have been broken or changed during the process of therapy.

Therapeutic activities can be shared on a macro-level and remain public, whereas therapy is a private process unless it involves family or couples' therapy. The reflections associated with a therapy session are confidential in nature and bound by ethical codes from the therapist's side. Likewise, therapeutic activities can be tangible and shared through pictures on social media, while therapy cannot.

Thus, therapeutic activities may generally be associated with external products, such as going in a car, eating a favorite meal, listening to certain songs etc., which stimulates neural activities. At the same time, therapy is a process that includes verbally processing and reflecting on a multitude of things. These fundamental differences need to be emphasized within the language we use whilst discussing topics related to mental health since it involves subjectivity and nuance pertaining to emotional health.

Social Therapy

Social therapy is defined as "a group-oriented approach" to psychotherapy which pertains to "the group, rather than individuals, as the fundamental unit of development." In a nutshell, this type of therapy was developed to help individuals improve their social functions and interactions with other human beings. Social Therapy was originated in the 1970s at the East Side Institute in New York as a result of the work and findings of psychotherapist Fred Newman. While the earlier days of social therapy in the Institute largely focused upon the inner workings of the individual, today's version of this psychology practice seeks to address both the individual and how they can function in various social settings.

The ultimate goal of social therapy is to aid patients in successfully functioning in everyday life. This includes, but is not necessarily limited to, school, university, the workplace, social settings, interpersonal relationships, etc. In many cases, patients who seek social therapy may be dealing with various issues which are adversely impacting their ability to thrive in various social settings. An example of the issues in question includes, but are not always mutually exclusive to, divorce, loss of employment, childhood or youth traumas, mental health issues, difficulty with social skills and interaction, death of a loved one, etc. To help patients via social therapy, their psychologist must first get to know them. This is where the therapist gets to know the needs, situations, hopes, and dynamics which exist in the lives of their patient, whether they are a child or adult. Based on the discoveries which are made from the life of the patient, the social therapist is then able to determine which route to take in terms of rehabilitation programs or therapies. Of course, the best solutions vary from patient to patient and depend upon a variety of factors. What works for one patient may not work for another.

The significance of social therapy is contemporary as it largely deals with how individuals are impacted by their environment, as well as their relationship with other people and their community. It's important to note that social therapy is very different from sociology; while sociology pertains to society and the research of groups of people as a whole, social therapy focuses upon how people and their development are impacted by various parts of and interactions with society. Due to the wide range of patients, developmental matters, issues and various reasons why one may suffer in a social setting, there are a variety of solutions which are associated with social therapy. It's important to note that solutions come after the social therapist has gotten to a point where they know the client deeply and the issues which they are living. Cognitive-behavioural therapy (CBT) is one of the most common solutions which is used within social therapy. Put simply, practicing CBT focuses upon the thoughts and conduct which cause or contribute to the issues that afflicted clients are dealing with. The prior experiences and interaction which children and grownups have can easily have lasting impacts on their current experiences, development, learning, and how they can function in the world around them. If CBT proves successful, the social therapist will be able to guide the patient in changing unproductive thoughts and behavior patterns. This method of treatment within social therapy can work if the patient is open to learn and change, receptive to feedback and willing to talk openly with their therapist. While social therapy is a great form of treatment, the results which patients experience from this treatment largely depends upon them.

Benefits of Social Therapy

In today's world, there are an enormous amount of benefits which come from social therapy. We live in a society where relationships, interactions with other human beings and the ability to function in a productive manner matters. Likewise, understanding human behaviour, development, and the motivating factors behind these behaviours greatly impacts how society can perform.

- Betterment of Mental Health
- Stress Management
- Provision Of Diagnoses
- Great Sounding Boards

Thus, Social therapy has played an immense role in our society and continues to do so. Understanding the history and applications of social therapy is only beneficial in continuing to maximize its impacts within the modern world. We live in a world which is ever-changing and the services of mental health specialists, such as social therapists, make a difference for so many lives.

Rehabilitation

Etymology of Rehabilitation, from the Medieval Latin root word rehabilitare , literally means "to restore to a rank." From the aforementioned definition, rehabilitation is a broad conceptual term used to describe restoration of physical function. Physical rehabilitation reverses various physical conditions associated with injury or dysfunction. As per WHO, Rehabilitation is defined as "a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment". Put simply, rehabilitation helps a child, adult or older person to be as independent as possible in everyday activities and enables participation in education, work, recreation and meaningful life roles such as taking care of family. It does so by addressing underlying conditions (such as pain) and improving the way an individual functions in everyday life, supporting them to overcome difficulties with thinking, seeing, hearing, communicating, eating or moving around. Anybody may need rehabilitation at some point in their lives, following an injury, surgery, disease or illness, or because their functioning has declined with age.

Some examples of rehabilitation include:

- Exercises to improve a person's speech, language and communication after a brain injury.
- Modifying an older person's home environment to improve their safety and independence at home and to reduce their risk of falls.
- Exercise training and education on healthy living for a person with a heart disease.
- Making, fitting and educating an individual to use a prosthesis after a leg amputation.
- Positioning and splinting techniques to assist with skin healing, reduce swelling, and to regain movement after burn surgery.
- Prescribing medicine to reduce muscle stiffness for a child with cerebral palsy.
- Psychological support for a person with depression.
- Training in the use of a white cane, for a person with vision loss.

Rehabilitation is highly person-centered, meaning that the interventions and approach selected for each individual depends on their goals and preferences. Rehabilitation can be provided in many different settings, from inpatient or outpatient hospital settings, to private clinics, or community settings such as an individual's home.The rehabilitation workforce is made up of different health workers, including but not limited to physiotherapists, occupational therapists, speech and language therapists and audiologists, orthoptists and prosthetists, clinical psychologists, physical medicine and rehabilitation doctors, and rehabilitation nurses.

The Benefits of Rehabilitation

Rehabilitation can reduce the impact of a broad range of health conditions, including diseases (acute or chronic), illnesses or injuries. It can also complement other health interventions, such as medical and surgical interventions, helping to achieve the best outcome possible. For example, rehabilitation can help to reduce, manage or prevent complications associated with many health conditions, such as spinal cord injury, stroke, or a fracture.Rehabilitation helps to minimize or slow down the disabling effects of chronic health conditions, such as cardiovascular disease, cancer and diabetes by equipping people with self-management strategies and the assistive products they require, or by addressing pain or other complications.Rehabilitation is an investment, with cost benefits for both the individuals and society. It can help to avoid costly hospitalization, reduce hospital length of stay, and prevent re-admissions. Rehabilitation also enables individuals to participate in education and gainful employment, remain independent at home, and minimize the need for financial or caregiver support.Rehabilitation is an important part of universal health coverage and is a key strategy for achieving Sustainable Development Goal 3 – "Ensure healthy lives and promote well-being for all at all ages".

Misconceptions about Rehabilitation

Rehabilitation is not only for people with long-term or physical impairments. Rather, rehabilitation is a core health service for anyone with an acute or chronic health condition, impairment or injury that limits functioning, and as such should be available for anyone who needs it. Rehabilitation is not a luxury health service that is available only for those who can afford it. Nor is it an optional service to try only when other interventions to prevent or cure a health condition fail. For the full extent of the social, economic and health benefits of rehabilitation to be realized, timely, high quality and affordable rehabilitation interventions should be available to all. In many cases, this means starting rehabilitation as soon as a health condition is noted and continuing to deliver rehabilitation alongside other health interventions.

Unmet Global Need for Rehabilitation

Globally, about 2.4 billion people are currently living with a health condition that benefits from rehabilitation. With changes taking place in the health and characteristics of the population worldwide, this estimated need for rehabilitation is only going to increase in the coming years.People are living longer, with the number of people over 60 years of age predicted to double by 2050, and more people are living with chronic diseases such as diabetes, stroke and cancer. At the same time, the ongoing incidence of injury (such as a burn) and child developmental conditions (such as cerebral palsy) persist. These health conditions can impact an individual's functioning and are linked to increased levels of disability, for which rehabilitation can be beneficial.In many parts of the world, this increasing need for rehabilitation is going largely unmet. More than half of people living in some low- and middle-income countries who require rehabilitation services do not receive them. Rehabilitation services are consistently amongst the health services most severely disrupted by the COVID-19 pandemic.

Global rehabilitation needs continue to be unmet due to multiple factors, including:

- Lack of prioritization, funding, policies and plans for rehabilitation at a national level.
- Lack of available rehabilitation services outside urban areas, and long waiting times.
- High out-of-pocket expenses and non-existent or inadequate means of funding.
- Lack of trained rehabilitation professionals, with less than 10 skilled practitioners per 1 million populations in many low- and middle-income settings.
- Lack of resources, including assistive technology, equipment and consumables.
- The need for more research and data on rehabilitation.
- Ineffective and under-utilized referral pathways to rehabilitation.

Rehabilitation in Emergencies

Natural hazards such as earthquakes or disease outbreaks and human induced hazards including conflict, terrorism or industrial accidents can generate overwhelming rehabilitation needs as a result of injury or illness. They also simultaneously disrupt existing services and have the greatest impact on the most vulnerable populations and the weakest health systems.While the important role of rehabilitation in emergencies is recognized in clinical and humanitarian guidelines, it is rarely considered as part of health system preparedness and early response. The result is that pre-existing limitations in rehabilitation services are magnified, health service delivery is less efficient, and people directly affected are at risk of increased impairment and disability.

WHO Response

For rehabilitation to reach its full potential, efforts should be directed towards strengthening the health system as a whole and making rehabilitation part of health care at all levels of the health system, and as part of universal health coverage.

In 2017, WHO launched the Rehabilitation 2030 initiative, which emphasizes the need for health system strengthening, and calls for all stakeholders worldwide to come together to work on different priority areas, including: improving leadership and governance; developing a strong multidisciplinary rehabilitation workforce; expanding financing for rehabilitation; and improving data collection and research on rehabilitation.

WHO is responding to the identified challenges and promoting health system strengthening for rehabilitation through:

- Providing technical support and building capacity at country level
- Increasing leadership, prioritization and resource mobilization
- Developing norms, standards and technical guidance
- Shaping the research agenda and monitoring progress

13.4 Principles of Rehabilitation

The vast benefits of rehabilitation stem from a robust foundation that is hinged on rehabilitation principles. These principles are essential aspects of rehabilitation that distinguishes the medical approach to treatment from the rehabilitation approach. Thus, it is responsible for the orientation and uniqueness of rehabilitation and its professionals.

Principles direct the discharge of rehabilitation care. These principles guide the rehabilitation professional in developing the plan of care for the individual undergoing rehabilitation. Also, rehabilitation principles need to be understood by all rehabilitation team members to obtain desirable outcomes in the process of rehabilitation. The following principles guide rehabilitation;

- Promote Adoption- The challenges that accompany impairments and loss of function are often overwhelming for the patient and often include physical, social and emotional challenges. Due to this, to obtain desired results in rehabilitation, there must be an understanding of the overall individual's condition. This understanding must be channeled to support, encourage and build strength and resourcefulness. It is also essential for rehabilitation practitioners to understand that total recovery may not always be the end goal for rehabilitation for many individuals, but rather to maximize function. Therefore, they must know that rehabilitation helps individuals adjust to challenging health conditions and not only “recover” from them. The term “recovery,” often gets misunderstood by the individual as different from what a health professional may intend. Therefore, the use of “adaptation” may create more realistic suggestions to the individual to enable them to cope and make adjustments with alterations, which have occurred following a health condition especially conditions that involve making lifelong changes.Indeed, reduction in activity, limitations and increase in community participation and reintegration occurs with rehabilitation, yet, creating a sense of adaptation in the patient increases their level of self-confidence and improves their acceptance of their self-image and adjustment to roles following health challenges.
- Emphasis ability- Rehabilitation emphasizes an optimistic perspective for individuals who have undergone different health challenges based on life-altering conditions. Therefore, rehabilitation focuses not on what is lost but what can be regained and achieved through mutual goal-setting by the rehabilitation professional and the individual.
- Treat the whole person- A foundation principle in rehabilitation is a holistic approach to treatment. It has to be remembered at all times that an individual is being treated and not the disease. This means that an individual's preferences, background, culture, religious beliefs, social support, physical abilities, developmental stages, psychology must be considered as plans of care are being developed by the rehabilitation team members.

- Time - The impact of time on rehabilitation has been widely studied from the best period to commence rehabilitation to the duration necessary for rehabilitation to achieve the greatest benefits. Broadly time is important in rehabilitation. Early commencement of rehabilitation can reduce the risk of readmission for certain conditions like chronic obstructive pulmonary diseases, improve motor function in spinal cord injury and stroke and so on.
- Educate-Rehabilitation is not a magic pill, and education is the vital aspect of the rehabilitation process throughout all stages that ensure the individual and their support structures have a good understanding of what is going on, in order to set realistic expectations and set SMART goals. Education of the individual in rehabilitation enables that person to assume responsibility for their health, promotes patient-centred care, and promotes the greatest level of independence in activities and involvement in rehabilitation plans.
- People cantered care- An approach to care that consciously adopts individuals, caregivers, families and community's perspectives as participants in and beneficiaries of trusted health systems that are organised around the comprehensive needs of people rather than individual diseases and respects social preferences. People-centred care also requires that patients have the education and support they need to make decisions and participate in their own care and that caregivers are able to attain maximal function within a supportive working environment. People-centred care is broader than patient and person-centred care, encompassing not only clinical encounters but also including attention to the health of people in their communities and their crucial role in shaping health policy and health services.

13.5 Rehabilitation Agencies: State and Nation

Rehabilitation agency means an agency providing an integrated multi–disciplinary program of services designed to upgrade the physical functioning of handicapped, disabled individuals by bringing together as a team specialized rehabilitation personnel to provide these services, the services at a minimum consisting of physical therapy or speech pathology services and a rehabilitation program which, in addition to physical therapy or speech pathology services, includes social or vocational adjustment services. As these rehabilitation agencies do special healthcare services that help a person regain physical, mental, and/or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury, or treatment. Rehabilitation services help people return to daily life and live in a normal or near-normal way. These services may include physical therapy, occupational therapy, speech and language therapy, cognitive therapy, and mental health rehabilitation services.

The Rehabilitation Council of India (RCI)

The Rehabilitation Council of India(RCI) was set up as a registered society in 1986.On September,1992 the RCI Act was enacted by Parliament and it became a Statutory Body on 22 June 1993.The Act was amended by Parliament in 2000 to make it more broad based. The mandate given to RCI is to regulate and monitor services given to persons with disability, to standardize syllabi and to maintain a Central Rehabilitation Register of all qualified professionals and personnel working in the field of Rehabilitation and Special Education. The Act also prescribes punitive action against unqualified persons delivering services to persons with disability.

The council functions with the following objectives

1. To regulate the training policies and programmes in the field of rehabilitation of persons with disabilities
2. To bring about standardization of training courses for professionals dealing with persons with disabilities
3. To prescribe minimum standards of education and training of various categories of professionals/ personnel dealing with people with disabilities
4. To regulate these standards in all training institutions uniformly throughout the country

5. To recognize institutions/ organizations/ universities running master's degree/ bachelor's degree/ P.G.Diploma/ Diploma/ Certificate courses in the field of rehabilitation of persons with disabilities
6. To recognize degree/diploma/certificate awarded by foreign universities/ institutions on reciprocal basis
7. To promote research in Rehabilitation and Special Education
8. To maintain Central Rehabilitation Register for registration of professionals/ personnel
9. To collect information on a regular basis on education and training in the field of rehabilitation of people with disabilities from institutions in India and abroad
10. To encourage continuing education in the field of rehabilitation and special education by way of collaboration with organizations working in the field of disability.
11. To recognize Vocational Rehabilitation Centres as manpower development centres
12. To register vocational instructors and other personnel working in the Vocational Rehabilitation Centres
13. To recognize the national institutes and apex institutions on disability as manpower development centres
14. To register personnel working in national institutes and apex institutions on disability under the Ministry of Social Justice & Empowerment

The Rehabilitation Council of India (RCI) has been set up under the Rehabilitation Council of India Act, 1992 enacted by the parliament with mandate to standardize, regulate and monitor the training programmes in the field of special education and disability rehabilitation.

The main functions of the Council are to prescribe minimum standards of education & training for 16 categories of professionals / personnel allocated to RCI, maintenance of Central Rehabilitation Register (CRR) and promote research in disability sector. After the implementation of Rights of Persons with Disabilities Act (RPwD), 2016 by the Govt. of India and the provisions envisaged in the NEP-2020, it becomes essential for the Council to prepare a roadmap for transforming Human Resource Development in the field of Special Education & Disability Rehabilitation.

Rights and Care of Handicapped

Persons with Disability (PWD) are those who have long-term impairment in terms of physical, mental, sensory and psychological conditions which can stop their equal participation in all aspects. As per Census 2011, in India, out of the total population of 121 crore, about 2.68 Cr persons are 'Disabled' (2.21% of the total population)

- Out of 2.68 crore, 1.5 crore are males and 1.18 crore are females
- Majority (69%) of the disabled population resided in rural areas of society if met with various barriers.

Types of Disability

Fig. 13(2)

The types of disability can be narrow down to autism spectrum disorder, blindness, cerebral palsy, Chronic neurological conditions, deaf blindness, haemophilia, hearing impairment, intellectual disability, leprosy cured, locomotor disability, low vision, mental illness, muscular dystrophy, multiple sclerosis, Specific learning disability, Speech and language disability, Thalassemia; and multiple disabilities.

Rights of Persons with Disabilities Act, 2016

The act focuses on the prevention of disabilities, the physical and economic rehabilitation measures for disabled persons. The policy is to be implemented by Government and other agencies. Various steps had also been taken in the past for the welfare and rehabilitation of persons with disabilities. I.e. listed as

- It is the duty of the involved government to ensure that basic rights like the right to equality, life with dignity, and respect for his or her integrity equally with others are enjoyed by the people with disabilities.
- To provide an appropriate environment for the effective development of the efficiency of the person with disabilities
- Discrimination on any grounds of any person with a disability shall be met with stringent actions
- No person shall be deprived of his or her personal liberty only on the ground of disability.

Programs for Disabled in India

- **DeenDayal Disabled Rehabilitation Scheme**: Under the scheme financial assistance is provided to NGOs for providing various services to Persons with Disabilities, like special schools, vocational training centers, community-based rehabilitation, pre-school and early intervention, etc.
- **Assistance to Disabled Persons for Purchase / Fitting of Aids and Appliances (ADIP)**: The Scheme aims at helping disabled persons by bringing suitable, durable, scientifically-manufactured, modern, standard aids and appliances within their reach.
- **Accessible India Campaign: Creation of Accessible Environment for PwDs**: A nation-wide flagship campaign for achieving universal accessibility that will enable persons with disabilities to gain access to equal opportunity and live independently and participate fully in all aspects of life in an inclusive society. The campaign targets at enhancing the accessibility of built environment, transport system and Information & communication ecosystem. Know in detail about the Accessible India Campaign on the given link.
- **National Fellowship for Students with Disabilities (RGMF)**

The scheme aims to increase opportunities to students with disabilities for pursuing higher education. Under the Scheme, 200 Fellowships per year are granted to students with disability. Schemes of the National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities.

The Department of Empowerment of Persons with Disabilities

During the year 1985-86, the erstwhile Ministry of Welfare was bifurcated into the Department of Women and Child Development and the Department of Welfare. Simultaneously, the Scheduled Castes Development Division, Tribal Development Division and the Minorities and Backward Classes Welfare Division were moved from the Ministry of Home Affairs and also the Wakf Division from the Ministry of Law to form the then Ministry of Welfare. Subsequently, the name of the Ministry was changed to the Ministry of Social Justice & Empowerment (M/o SJ&E) in May, 1998. Further, in October, 1999, the Tribal Development Division had moved out to form a separate Ministry of Tribal Affairs. In January, 2007, the Minorities Division along with Wakf Unit have been moved out of the Ministry and formed as a separate Ministry, and the Women and Child Development Department has become Ministry of Women & Child Development.

Though the subject of "Disability" figures in the State List in the Seventh Schedule of the Constitution, the Government of India has always been proactive in the disability sector. It is not only running eight National Institutes (NIs) dealing with various types on disabilities and twenty

Composite Regional Centers (CRCs), which provide rehabilitation services to Persons with Disabilities (PwDs) and run courses for rehabilitation professional but also funds a large number of NGOs for similar services and also a National Handicapped Finance & Development Corporation (NHFDC) which provides loans at concession rates of interest to PwDs for self-employment. Besides, the Union Government is a party to (i) Proclamation on the Full Participation and Equality of People with Disabilities in the Asian and the Pacific Region - adopted at Beijing in December, 1992, and (ii) The UN Convention on the Rights of Persons with Disabilities (UNCRPD), which came into effect in May, 2008.

The subject received attention in various States Governments in varying degrees. At the Central level also disability being one of the several responsibilities and being looked after by just one bureau, has resulted in inadequate attention, as most of its time and energy is spent only on implementing Ministry's own schemes, meeting their expenditure and physical targets, and organize annual time-bound activities like the National Awards for empowerment of PwDs.

In the above background, it was stated in the 11th Five Year Plan that "The 'Disability Division' of the Ministry of Social Justice & Empowerment will be strengthened by converting it into a separate Department, so that it can liaise effectively with all the other concerned Ministries/Departments and fulfill its responsibilities towards the disabled". Looking to the specialize nature of the subject on "Disability", the wide ranging work to be done in the light of the UNCRPD, and the inadequacy of existing implementation structure, the time came to upgrade the existing Disability Bureau in the M/o SJ&E. The decision to create a separate Department of Disability Affairs within the M/o SJ&E was taken up by the Government, in principle on 3rd January, 2012. This was also announced by the President before both Houses of Parliament on 12th March, 2012.

Two departments were created under the Ministry of Social Justice & Empowerment vide notification dated 12.5.2012, namely:-

1. Department of Social Justice a and Empowerment (Samajik Nyaya and Adhikarita Vibhag)
2. Department of Disability Affairs (Nishaktata Karya Vibhag)

Thus the Department of Empowerment of Persons with Disabilities in the Ministry of Social Justice & Empowerment facilitates empowerment of the persons with disabilities, who as per Census 2011 are 2.68 crore and are 2.21 percent of the total population of the Country. These include persons with Visual, Hearing, Speech & Locomotive disability, Mental Retardation, Mental Illness, Multiple Disability and any other disabilities.

Summary

Rehabilitation is a process of restoration of the functioning of an individual which was lost or impaired due to injury or disability. You learned that the aim of rehabilitation is to ensure maximal functioning, and independence of the client to facilitate his adaptation to the natural environment. One of the basic objectives of rehabilitation is to prevent complications and encourage adaptation. You also learned that the disability-induced stress demands a good deal of coping skills from the client and his family members as it drastically changes the life style, even for those who have developmental disabilities. This is due to their chronic experience of infirmity. You learned about the importance of cognitive-behavioral rehabilitation, role of family and community in the rehabilitation process. Community-based rehabilitation (CBR) is a distinct philosophy of modern rehabilitation which is closely linked with the conceptualization of disability as a social construct. CBR has been recognized as an important option for rehabilitation in view of increasing human care need of the society and cost of rehabilitation particularly in developing economies like India. Finally you learned that certifying competencies of the rehabilitation professionals is required for preventing malpractice, delivery of substandard services and unethical treatment of people with disability. The Rehabilitation Council of India is the apex body in this regard that regulates the training and certification for the rehabilitation professionals.

Keywords

Acute care, community-based rehabilitation,

Self Assessment

1. ………. refers to restoration or recovery of the biological, psychological and social functioning of an individual which was lost or impaired due to injury or disability.

A. Revaluation
B. Retardation
C. Rehabilitation
D. Revolution

2. Etymology of Rehabilitation, from the Medieval …… "rehabilitare", literally means "to restore to a rank."

A. Spanish
B. Latin
C. Arabic
D. Sanskrit

3. ………..the participant's survival is the primary focus and the care is provided through activities of daily living for the person whereas in rehabilitation, the focus is on educating persons to be able to perform activities of daily living for themselves.

A. Acute care
B. Active care
C. Domestic care
D. Geriatric care

4. The central goal of rehabilitation is to ……the health and dignity of someone affected by an illness that may have caused physical, mental, or emotional hurt and that may have led to social problems, such as the loss of a job or the disruption of close relationships.

A. Redistribute
B. Restore
C. Destroy
D. Static

5. ………seeks to minimize the effects of any permanent damage caused by an illness.

A. Primary prevention
B. Secondary prevention
C. Tertiary prevention
D. None of the above

6. Initiatives by individuals and groups in the community gradually led to what is known as…...

A. Community Kitchen
B. Community-based rehabilitation
C. Community Hall
D. Community Welfare.

7. ………is an act, a profession and a researched field that utilises science concepts.

A. Thematic
B. Theology

C. Theme
D. Therapy

8. ……...involves feeling good, engaging in pleasurable activities, calming or grounding in nature.

A. Therapy
B. Counselling
C. Therapeutic
D. Hypnotism

9. ……. focuses on the range of emotions an individual may bring into the sessions, i.e. components of empathy and validation form the crux of a therapeutic relationship.

A. Physiotherapy
B. Psychology
C. Psychiatry
D. Psychotherapy

10. Social therapy is defined as ……. to psychotherapy which pertains to "the group, rather than individuals, as the fundamental unit of development.

A. Group-oriented approach
B. Individual oriented approach
C. Community oriented approach
D. Income oriented approach

11. Social Therapy was originated in the 1970s at the East Side Institute in New York as a result of the work and findings of……………

A. Fred Newman
B. Natalie Portman
C. Morgan Freeman
D. Jawaharlal Nehru

12. The Rehabilitation Council of India (RCI) was set up as a registered society in…….

A. 2022
B. 1900
C. 1986
D. 1933

13. The Rehabilitation Council of India (RCI) has been set up under the ………. enacted by the parliament with mandate to standardize, regulate and monitor the training programmes in the field of special education and disability rehabilitation.

A. Rehabilitation Council of India Act, 1992
B. The Rights of Persons with Disabilities (RPwD) Act, 2016
C. The Protection of Women from Domestic Violence Act 2005
D. Dowry Prohibition Act, 1961

14. As per Census 2011, in India, out of the total population of 121 crore, about 2.68 Cr persons are 'Disabled' i.e. the ………..2.21% of the total population)

A. 100 % of total population
B. 2.21 % of total population
C. 0% of total population
D. 25 % total population.

15. Thesubject of "Disability" figures in the State List in the …….of the Constitution.
A. Twelfth Schedule
B. Second Schedule
C. Seventh Schedule
D. None of the above

Answers for SelfAssessment

1.	C	2.	B	3.	A	4.	B	5.	C
6.	B	7.	D	8.	C	9.	D	10.	A
11.	A	12.	C	13.	A	14.	B	15.	C

Review Questions

1. Discuss the role of Rehabilitation Council of India in the disability field.
2. What is rehabilitation? Discuss its goals and purpose.
3. Briefly discuss about the Programs for Disabled in India.
4. Discuss the benefits rehabilitation.
5. Discuss about the concept and types of disability.

Further Readings

- https://www.who.int/news-room/fact-sheets/detail/rehabilitation
- Rehabilitation Council of India (rehabcouncil.nic.in)
- Feldblum, C (2000): "Definition of Disability under Federal Antidiscrimination Law: What Happened? Why? and What Can We Do About It?", 21, Berkeley Journal of Labour and Employment Law, 91.
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Unit 14: Social Inclusion and Exclusion in health

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Objectives

After completing this Unit, you shall be able to:

- To understand the meaning of Social Inclusion and Exclusion in Health among vulnerable communities especially among the Scheduled caste, Scheduled tribe, women and LGBTQ
- To have an overview about pandemic and illness.

Introduction

Enshrined in the 2030 Agenda is the principle that every person should reap the benefits of prosperity and enjoy minimum standards of well-being. This is captured in the 17 Sustainable Development Goals that are aimed at freeing all nations and people and all segments of society from poverty and hunger and to ensure, among other things, healthy lives and access to education, modern energy and information. Recognizing that these goals are difficult to achieve without making institutions work for those who are deepest in poverty and most vulnerable, the Agenda embraces broad targets aimed at promoting the rule of law, ensuring equal access to justice and broadly fostering inclusive and participatory decision-making. These goals and targets, when effectively translated into action and properly benchmarked, represent essential elements of social inclusion processes. However, social inclusion encompasses a broader set of concerns than those reflected in the Sustainable Development Goals. No single global, goal-setting agenda can adequately address the multiple dimensions of exclusion or comprehensively promote inclusion, particularly given the diversity of circumstances around the globe. This chapter presents working definitions of social exclusion and social inclusion and discusses concepts as well as measurement issues. Different places have different histories, cultures and institutions, which shape norms, values and therefore different approaches to social inclusion. It is contended, however, that the goal of achieving a society for all must conform to some general principles, even if the country-specific and evolving nature of social exclusion concerns and approaches to inclusion is recognized.

14.1 Meaning of Social Inclusion and Exclusion in Health

The term social exclusion and social inclusionare two terms most widely used in recent years by politicians, social scientists and the public as well. Social exclusion and inclusion are multi-dimensional terms and their definitions, meanings and connotations are context-dependent.Social exclusion‟ as a concept has its origin in Europe, more specifically in France, and therefore the issues addressed in the social exclusion context were specific to Europe. Subsequently, the concept was introduced in India where it has primarily focused on inequalities and exploitation based on membership in particular social groups and is seen in terms of exclusionary processes based on caste, gender, tribe, and religious identities.

While the Constitution of India has been categorical in its emphasis on addressing the issues of marginalized and excluded groups like the Dalits, tribals, and other resource-poor groups through exclusive protective and developmental measures, the issue has not received the requisite political visibility and academic rigour in the general development discourse. As a result, the issue though crucial has always remained part of a general analysis of caste and class, and the perspectives of these communities have hardly received due recognition in the process of major policy formulation and analysis and the implementation of various protective and developmental measures initiated for them.

The Indian economy has witnessed enormous changes in the past two decades. The overall rate of poverty in the country has declined steadily and the country’s Human Development Index rank of 130, places it among the group of countries with medium levels of human development. The country’s rank was 135 according to a 2014 report (UNDP, 2015). Although the level of inequality has decreased over time, in part as a result of government policies to tackle discrimination and social exclusion, reservations and various empowerment measures access to services and economic opportunities are highly influenced by deep-rooted exclusion and discrimination based on caste, religion and gender.Figures cannot communicate what 'living in poverty means or how it affects human dignity. Mehta and Shah have rightly viewed that poverty seems to be disproportionately high among historically marginalized groups such as scheduled castes and scheduled tribes. There is therefore a need not only to recognize the perspectives of these resource-poor communities but also to include them in the development process. This is where social inclusion comes into play. It is a concept with universal appeal.

To promote social inclusion, it is important to understand the processes through which individuals or groups are excluded, as the promotion of inclusion can only be possible by tackling exclusion. The process of social inclusion needs to take place simultaneously at multiple levels, from the individual, community and local levels, to the regional and national levels, as social inclusion is a subject which concerns all stakeholders in society. It is a process through which the dignity of each individual is recognized, the needs and concerns of all people are reflected, the rights of all people are not only guaranteed in legislation, but also respected, and people can participate actively in life activities. While social inclusion involves formal (societal) level engagements, ensuring that institutions in society reflect, uphold, respect, and activate the inclusive processes within society, it at the same time, addresses the informal (individual) level of engagements, and as such, perceptions and experiences of individuals, how they think and feel, also need to be taken into account. Social inclusion reflects, on the one hand, an individual’s experience of and possibilities for self-actualization, and on the other hand, societal capacities to eliminate causes of exclusion and ensure equal opportunities for all.

Social Inclusion and Social Exclusion

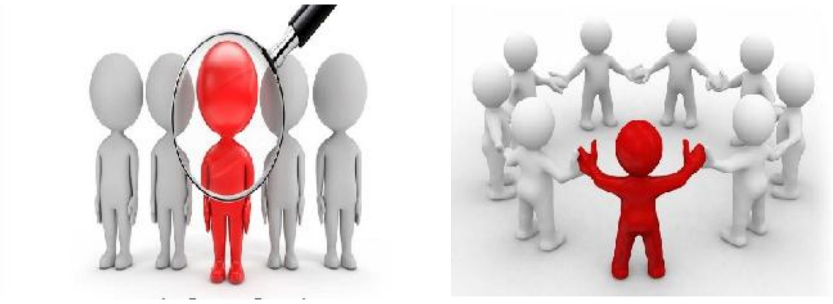

Fig.14 (1)
Social Exclusion and Social Inclusion

The concept of Social exclusion describes a process by which certain groups are systematically disadvantaged because they are discriminated against based on their ethnicity, race, religion, sexual orientation, caste, descent, gender, age, disability, HIV status, migrant status or where they live. Discrimination occurs in public institutions, such as the legal system or education and health services, as well as social institutions like the household, and the community". Social exclusion is a dynamic process that "precludes full participation in the normatively prescribed activities of a given society and denies access to information, resources, sociability, recognition, and identity, eroding self-respect and reducing capabilities to achieve personal goals". Social exclusion is a multi-dimensional phenomenon. Economically excluded citizens do not have access to jobs, incomes and material resources to function appropriately in society. At the same time, the socially excluded interiorize the distance they feel towards other groups, a distance that may be measured through the level of residential segregation, the probability of belonging to the same social networks, the incidence of intermarrying and degrees of interaction within social organisations.

Social exclusion is understood as the condition (barriers and processes) that impede social inclusion. Social exclusion is a process through which individuals or groups are wholly or partially excluded from fully participating in all aspects of the life of the society, in which they live, on the grounds of their social identities, such as age, gender, race, ethnicity, culture or language, and/or physical, economic, social disadvantages. Social exclusion may mean a lack of voice, lack of recognition, or lack of capacity for active participation. It may also mean exclusion from decent work, assets, land, opportunities, access to social services and/or political representation. Paugam (1996) suggested that social exclusion represents a dynamic process or a "spiral of precariousness", where one form of deprivation leads to one or more other forms of deprivation. He argues that social exclusion is not simply about the precariousness of employment (having an insecure job or being unemployed), but the strength of the correlation between employment situation and other aspects of economic and social life (e.g. family, income, living conditions, and social networks). The focus on deprivation as a process allows identifying a series of factors that contribute to people's exclusion.

In India, social exclusion is commonly used to discuss the social relations and institutions that exclude, discriminate or deprive certain social groups based on a broad range of group identities".The structure of the caste system and the implications of this for employment, education and the rules of social and economic exchange are distinctive in India and exclusion based on caste, tribe, religion and gender is increasingly receiving attention in research and policymaking.

But compared to the social exclusion, Social inclusion is understood as a process by which efforts are made to ensure equal opportunities, for all, regardless of their background, so they can achieve their full potential in life. It is a multi-dimensional process aimed at creating conditions which enable full and active participation of every member of the society, in all aspects of life, including civic, social, economic and political activities, as well as participation in decision-making processes. It is understood as a process by which societies combat poverty and social exclusion.

Inclusion emphasizes encouraging participation and moving beyond merely appreciating diversity, toward leveraging and integrating diversity into everyday work life. A situation where „individuals or areas do not suffer from the negative effects of unemployment, poor skills, low income, poor housing, crime, bad health, family problems, limited access to services".“The process of improving the ability, opportunity, and dignity of people disadvantaged based on their identity to take part in society.19 Inclusion is a mutually beneficial state for both the community and the individual. When people rely upon each other and the success of their interactions, that responsibility and interdependence create a commitment to the social processes in a community. The depiction of social inclusion at the local level is useful as it addresses inclusion at a manageable and feasible level. In a smaller geographicregion than the nation, there is a much greater opportunity to develop inclusive systems, economically and socially as well as politically. An inclusive society is a society that overrides differences of race, gender, class, generation, and geography, and ensures inclusion, equality of opportunity as well as the capability of all members of the society to determine an agreed set of social institutions that govern social interaction.

At the core of most definitions of social inclusion lies the concept of full participation in all aspects of life, while exclusion refers to the conditions (barriers and processes) that impede inclusion. Participation is most significant as it denotes an active involvement in the process, not merely having access to society's activities, but engaging in them, and building and maintaining a social network. Participation also creates a sense of responsibility towards others, a community or an institution, and influences decisions or enable individuals to have access to the decision-making processes.

The challenge of measuring social exclusion

Identifying a set of criteria to determine who is excluded and in what ways is key to tracking progress, assessing the impact of measures undertaken to promote inclusion and ultimately ensuring that no one is left behind. Yet quantifying social exclusion presents considerable challenges. People are excluded from many domains of life − social, economic, political, civic and spatial − and the salience of each domain depends strongly on the country and local contexts as well as on the stage of a person's life course. That is to say, the concepts of social inclusion and social exclusion are multidimensional and context-dependent. Consequently, translating them into a limited set of indicators constitutes a considerable challenge. National definitions and measurement are thus the starting point for monitoring and analysis, although a limited set of measurable attributes applicable across countries is also necessary for global monitoring and analysis.

Furthermore, adequately assessing who is being left behind and how not only requires "objective" indicators of the status of individuals and social groups but also must take into account their subjective judgments and perceptions. Exclusion is, after all, a personal experience, and the views of those affected by it or at risk of being left behind cannot be disregarded (United Nations, 2010). Relational issues, such as the presence of discrimination, the level of personal safety or the extent of participation in political processesor social life must also be factored into key dimensions of inclusion and exclusion processes.

Given the multiple dimensions of social exclusion, data to measure it generally comes from a variety of sources that are different in scope and purpose. National population censuses and some internationally standardized surveys, including labour force surveys, demographic and health surveys, multiple indicator cluster surveys and living standard measurement surveys, as well as selected opinion polls, are available for a large number of countries and are fairly comparable across countries. However, each of these sources is designed for a specific purpose and none of them alone allows for comprehensive international assessments of social exclusion. Only limited attempts have been made to link microdata from different sources, although it is increasingly possible to do so.15 Thus indicators of social exclusion have rarely been combined at the individual level into one composite index.16 Assessing changes in indicators of exclusion over time results in additional challenges, as some data sources are available for one point in time only and comparability issues arise even between censuses or surveys of the same type. Even though cross-country assessments can hardly gauge the multiple dimensions of exclusion, in-depth, quantitative indicators should, whenever possible, be accompanied by qualitative evidence, including participatory assessments and in-depth interviews. There are important elements of the exclusion experience that cannot be reduced to statistical analyses.

Ideally, empirical studies should determine which individual characteristics or combinations thereof increase the risk of disadvantage and exclusion. However, lacking the information necessary for individual-level analysis, most studies of social exclusion, including the present one, pre-select some criteria that have been proven empirically to increase the risk of exclusion − most often age, sex, ethnic background, income, nationality or place of birth.17 While grouping is a fundamental tool of social analysis, aggregate-level approaches based on traditional criteria run the risk of missing new forms of exclusion and are limited in their capacity to examine intersecting inequalities. As Brubaker (2002, p. 165) noted, the tendency to partition the social world into deeply constituted, quasi-natural groups "is a key part of what we want to explain, not what we want to explain things with; it belongs to our empirical data, not our analytical toolkit". While statistical groups are useful analytical categories, it is important to note that they are not necessarily factual entities with the common agency or even common purposes.

Fig.14 (2)
Symptoms of Social Exclusion

Thus it is clear that the extent of social exclusion and the groups affected by it varies by context and over time. Historically, exclusion has sometimes been condoned and institutionalized by government, religious, community or other authorities. At other times, it has persisted unsanctioned among members of society in subtle, insidious ways. Even where racism and other forms of prejudice have been formally redressed, their legacies may continue to adversely affect the well-being of excluded groups. Colonization has also created various forms of exclusion. Indigenous peoples, against whom mass atrocities had been committed. Many indigenous peoples continue to live amid long standing conflicts or hostility with governments, dominant population groups and industries. They have been subject to displacement and dispossession of their lands and resources, marginalization, denial of their cultural rights and of their voice in political processes.

14.2 Social Inclusion and Exclusion in health among SC, ST.

The Hindu caste system is divided into multiple levels according to the origin and history of our ancestors beyond the usual 'varna system'. The Scheduled Castes, Scheduled Tribes, and Other Backward Classes differ from the typical varna system. These castes and tribes are collectively known as backward classes because of their long history of struggle for equal rights in Indian society. They have been socially and economically disadvantaged and continue to be so in some parts of the country.However, people from other classes are gradually doing away with these prejudices and learning to give them back their place in society. The practice of reservation by the government ensures that a certain percentage of people from these backward classes secure admissions and jobs in government sectors.

Scheduled Caste and Scheduled tribe

Scheduled Castes are a part of Indian society that has had to deal with oppression and discrimination in the past and on several occasions, even now. According to the Constitution Order, of 1950, only marginalised Hindu communities can be considered Scheduled Castes. Sometimes referred to as 'Dalits,' people of the Scheduled Castes are regarded as untouchables even today. The Hindu varna system states that there are four major varnas, namely, the Brahmins, Kshatriyas, Vaishyas, and Shudras. Those who belong to one of those four varnas are called 'savanna.' However, the Scheduled Castes are often regarded as 'avarnas' or people who do not fall into the category of these four varnas.Like those who belong to Scheduled Castes, those classified as Scheduled Tribes have also had a long history of oppression and struggle. They, too, are 'avarnas' and are given the name 'Scheduled' as they fall under one of the schedules of the Constitution of India. Adivasis usually comprise the Scheduled Tribes.

Poverty and social exclusion are important socio-economic variables which are often taken for granted while considering ill-health effects. Social exclusion mainly refers to the inability of our society to keep all groups and individuals within reach of what we expect as a society to realize their full potential. Marginalization of certain groups or classes occurs in most societies including developed countries and perhaps it is more pronounced in underdeveloped countries. In the Indian context, caste may be considered broadly as a proxy for socioeconomic status and poverty. In the identification of the poor, scheduled caste and scheduled tribes and in some cases the other backward castes are considered as socially disadvantaged groups and such groups have a higher probability of living under adverse conditions and poverty. The health status and utilization patterns of such groups give an indication of their social exclusion as well as an idea of the linkages between poverty and health.

Constitutional Provisions to safeguard the Scheduled Castes and Scheduled Tribes

The Constitution of India provides for a number of safeguards for the Scheduled Castes and Scheduled Tribes which are its unique features. The safeguards have apparently helped these communities in protecting their legitimate interests and accelerated their socioeconomic development. The credit for incorporating these safeguards in the Constitution of India goes to Dr Bhimrao Ramji Ambedkar, Chairman of the Drafting Committee of the Constitution would not have had this distinctive dimension. To Baba Saheb Dr B.R. Ambedkar, nothing was dearer than the welfare of the downtrodden. Thorat writes: "The founding fathers of the Constitution decided to secure social, economic and political justice for all citizens. They analyzed that the inequitable forces embedded in the socio-economic system and also political organizations had resulted in deprivation and disadvantages for the poor and weaker sections of the society. The Constituent Assembly passed some of the provisions, like Article 46, which embodied the new policy, and its messages of hope for millions of our citizens hitherto neglected. Out of Article 46 flow all safeguards or weaker sections including Scheduled Castes and Scheduled Tribes".

Article 46: Promotion of educational and economic interests of Scheduled Castes, Scheduled Tribes and Other Weaker sections— The State shall promote with special care the educational and economic interests of the weaker sections of the people, and in particular, of the Scheduled Castes and the Scheduled Tribes, and shall protect them from social injustice and all forms of exploitation. The Constitution came into effect on the 26th of January, 1950. The Constitution of India is the basic and supreme law of our country. It, however, governs almost all aspects of our social life. It constitutes India into a sovereign socialist secular Democratic Republic and pledges to secure for the entire citizens, including Scheduled Castes and Scheduled Tribes, justice, liberty and equality. , therefore, certain measures in the form of Constitutional safeguards are enshrined in the Constitution of India for those who were deliberately deprived of justice, liberty and equality since time immemorial. The main objective of these safeguards was to level up, socially and economically backward classes, particularly the Scheduled Castes and Scheduled Tribes in an as short time as possible.

The policy of reservation to improve the socio-economic conditions of SCs and STs Over five decades has been a failure. But we have to admit that the reservation has come to stay in our society. It was in the past, it is, and it will remain. But the question is how to make it effective to bring the SC and ST to the level of other sections of society. The Preamble to the Constitution of India reveals the philosophy of the Constitution. It is as under: "We, the people of India, having solemnly resolved to constitute India into a Sovereign Socialist Secular Democratic Republic and to secure to all its citizens— Justice: social, economic and political; Liberty of thoughts, expression, belief, faith and worship; Equality of status and opportunity and to promote among them all fraternity, assuring the dignity of the individual and integrity of the nation. In our Constituent Assembly this twenty-sixth day of November 1949, do adopt, enact and give to ourselves this Constitution." Several safeguards have been provided for the Scheduled Castes and Scheduled Tribes in Indian Constitution.

However, the above terms have not been defined anywhere in the Constitution. Scheduled Castes is defined in Article 340: Appointment of a Commission to investigate the conditions of Backward Classes— (1) The President may by order appoint a Commission consisting of such persons as he thinks fit to investigate the conditions of socially and educationally backward classes within the territory of India and the difficulties under which they labour and to make recommendations as to the steps that should be taken by the Union or any State to remove such difficulties and to improve their condition and as to the grants that should be made for the purpose by the Union or any State and the conditions subject to which such grants should be made, and the order appointing such Commission shall define the procedure to be followed by the Commission. (2) A Commission so appointed shall investigate the matters referred to them and present to the President a report setting out the facts as found by them and making such recommendations as they think proper. (3) The President shall cause a copy of the report so presented together with a memorandum explaining the action taken thereon to be laid before each House of Parliament.

Article 341: Scheduled Castes— (1) The President may with respect to any State or Union Territory, and where it is a State, after consultation with the Governor. Thereof, by public notification, specify the castes, races or tribes or parts of or groups within castes, races or tribes which shall for the purposes of this Constitution be deemed to be Scheduled Castes in relation to that State or Union territory, as the case may be.

Article 342: Scheduled Tribes— (1) The President 21 May with respect to any State or Union territory and where it is a State, after consultation with the Governor thereof, by public notification, specify the tribes or tribal communities or parts of or groups within tribes or tribal communities which shall for the purposes of this Constitution be deemed to be Scheduled Tribes in relation to that State or Union territory, as the case may be. (2) Parliament may by law include in or exclude from the list of Scheduled Tribes specified in a notification issued under clause (1) any tribe or tribal community or part of or group within any tribe or tribal community, but save as aforesaid a notification issued under the said clause shall not be varied by any subsequent notification.

Article 366: In this Constitution, unless the context otherwise requires, the following expressions have the meanings hereby respectively assigned to them, that is to say, Schedule means a Schedule to this Constitution. Scheduled Castes means such castes, races or tribes or parts of or groups within such castes, races or tribes as are deemed under Article 341 to be Scheduled Castes for the purposes of this Constitution; Scheduled Tribes means such tribes or tribal communities or parts or groups within such tribes or tribal communities as are deemed under Article 342 to be Scheduled Tribes for the purposes of this Constitution. All these safeguards have, apparently, been provided to facilitate the implementation of the Directive Principle contained in Article 46 of the Constitution, which reads as follows: The State shall promote with special care the educational and economic interest of the weaker sections of the people, and, in particular of the Scheduled Castes and Scheduled Tribes, and shall protect them from social injustice and all forms of exploitation.

14.3 Women empowerment and LGBT community in Health

As India progresses economically, there are calls for the country to pay more attention to social and human development, including women's empowermentand LGBT community with reference to Health. The women empowerment is stated as efforts that include "advocating for women's and girls' human rights, combating discriminatory practices and challenging the roles and stereotypes that create inequalities and exclusion". Women's empowerment is a critical aspect of achieving gender equality, where both men and women have equal power and opportunities for education, healthcare, economic participation and personal development.

While Scandinavian countries such as Iceland, Sweden, Finland and Norway have made strides in narrowing the gender gap, significant economic and social disparities run deep in the Middle East, South Asia and Africa. India's journey towards women's empowerment has its share of highs and lows. It has made gains by ratifying international conventions and formulating domestic policies intended to end gender inequality. The government has created the space for international agencies to work with state governments, local non-government organisations and private corporations on a plethora of projects to support women from different socio-economic backgrounds. Despite these efforts, India's ranking on global surveys of gender equality has not improved significantly over the years.

Brief History of Women Empowerment

Equal rights for men and women are enshrined under Articles 14 to 16 in the Indian constitution, which came into effect on 26 January 1950. Discrimination based on gender is strictly prohibited. Indian women received universal suffrage during India's independence in 1947, long before several Western countries granted women the right to vote. India was the second country in modern history to have a female leader, Indira Gandhi, in 1966 after another South Asian state, Sri Lanka, elected Sirimavo Bandaranaike in 1960.

New Delhi has also taken a concerted effort to ratify key international conventions to end discrimination against women. It is a founding member of the International Labour Organisation (ILO) and has ratified 47 conventions and one protocol. It signed the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1980 and ratified it in 1993 with some reservations. It has yet to ratify the Optional Protocol of the CEDAW and National Action Plan on Women, Peace and Security. Within the country, the Dowry Prohibition Act, of 1961 and the Protection of Women from Domestic Violence Act, of 2005 have been enacted to criminalise instances of dowry and domestic violence. The government also increased maternity leave from 12 weeks to 26 weeks under the Maternity Benefit Act in 2017 for the private sector.

The Women's Reservation Bill gives 33 per cent reservation for women seats in all levels of Indian politics. This is an attempt to increase female political participation. The bill was first introduced on 12 September 1996 by the Deve Gowda government. Successive governments tried to push for the bill but it took 14 years to get it passed in the Rajya Sabha (Upper House of Parliament). The bill has yet to be passed in the Lok Sabha (Lower House of Parliament) and all state legislative assemblies. The introduction of the bill was a historic attempt to alter gender demographics in the Indian polity. Proponents of the quota system argue that it is a necessary step to increase women's effective and meaningful participation in the political system. It could help to expedite a process that usually takes generations by incorporating women's voices in governance. In contrast, sceptics think that the bill would only benefit elite women. While a 33 per cent female reservation is a bold step, the Trinamool Congress, one of the ardent supporters of the bill, went a step further by reserving 40 per cent of seats for women to contest in the 2019 Lok Sabha elections.

The World Health Organization announced multiple commitments to drive change for gender equality and the empowerment of women and girls in all their diversity at the Generation Equality Forum, held last week in Paris. The WHO commitments focused on ending gender-based violence; advancing sexual and reproductive health and rights; and supporting health workers as well as feminist movements and leadership. These commitments shape a progressive and transformative blueprint for advancing gender equality, health equity, human rights and the empowerment of women and girls globally. Gender equality is not only a fundamental human right, but a necessary foundation for a peaceful, prosperous and sustainable world. There has been progress over the last decades, but the world is not on track to achieve gender equality by 2030.Women's health services, already poorly funded, have faced major disruptions. Violence against women remains endemic. And despite women's leadership in responding to COVID-19, they still trail men in securing the decision-making positions they deserve.Commitment and bold action are needed to accelerate progress, including through the promotion of laws, policies, budgets and institutions that advance gender equality. Greater investment in gender statistics is vital, since less than half of the data required to monitor Goal 5 are currently available.The Forum, marking the twenty-fifth anniversary of the Beijing Declaration and Platform for Action on Women, came at a critical moment, with COVID-19 having exacerbated existing gender inequalities. WHO-led in two key areas of the Forum: the Action Coalition on Gender-Based Violence (co-led with UN Women and other partners) and the Gender Equal Health and Care Workforce Initiative between France, Women in Global Health and WHO.

India's journey on women empowerment and gender equality started when it became a sovereign state in 1947. While visible gains have been made through legal reforms, human development and grassroots initiatives, New Delhi still has a long way to go in many areas of women empowerment. A more concerted effort is needed to close the urban-rural divide and ensure that women in rural areas enjoy the same access to education, employment, healthcare and decision-making as their urban counterparts. The hardest challenge will be to change attitudes, given that many barriers to women empowerment are attributed to patriarchal and patrilineal traditions that are deeply entrenched in many South Asian societies.

Social inclusion of LGBTQ

Lesbian, gay, bisexual, and transgender (LGBTQ) is an umbrella term which includes several groups: lesbian (homosexual woman), gay (homosexual man or woman), bisexual (person who is attracted to both genders), transgender (person who identifies his gender as different from their biological one), queer (a synonym for gay; some people prefer to identify themselves as queer to empower themselves and take their identity "back from the bullies"), questioning (people who are unsure about their gender identity/sexuality), intersex (people with two sets of genitalia), asexual (people who are not sexually attracted to anyone and who don't identify with any orientation), allies (the loving supporters of the community, though not necessarily part of it), two spirits (a tradition in many First Nations that considers sexual minorities to have both male and female spirits), and pansexual (person sexually attracted to others of any sex or gender).

Fig. 14 (3)

LGBTQ+ identities (vocabularies)

Discriminatory laws and socio-cultural norms continue to marginalize and exclude lesbian, gay, bisexual, Trans and gender-diverse persons from education, health care, housing, employment and occupation, and other sectors. This environment of exclusion lends itself to violence and discrimination. Exclusion also leads to inequality of opportunity and access to resources.Twelve UN entities expressed concern about these issues in a joint statement released in 2015: "Discrimination and violence contribute to the marginalization of LGBTI people and their vulnerability to ill health including HIV infection, yet they face denial of care, discriminatory attitudes and pathologizing in medical and other settings... The exclusion of LGBTI people from the design, implementation and monitoring of laws and policies that affect them perpetuates their social and economic marginalization."

Dynamics of exclusion in different contexts

Political campaigns, parliamentary debates and public manifestations reveal social prejudice and misconceptions about the nature and moral character of LGBT persons in all regions of the world. Ultraconservative and ultranationalist groups are also on the rise, reclaiming so-called identities at the expense of sexual and gender minorities, challenging advances, and preventing the development of laws and policies inclusive of LGBT people. LGBT issues are often instrumentalized by political and religious leaders as a threat to national cohesion, culture and tradition, in particular during periods of political and socio-economic instability.LGBTI persons become the "other", the "foreign", whose sole purpose is to undermine the national project from within. All these have an impact on the social inclusion of LGBT individuals, negatively affecting their access to health care, education, housing, employment, political participation, personal security and freedom from violence.

LGBT persons also face health disparities, at higher rates of breast and cervical cancer and HIV infection, and mental health concerns such as anxiety, depression, self-harm and suicide. Barriers such as the criminalization of consensual same-sex sexual activities and pathologization too often render health services unavailable, inaccessible, or unacceptable. Far too often, LGBT people also face discriminatory attitudes from health-care providers and disrespect or violation of medical privacy that deter them from seeking services.

The current COVID-19 pandemic has exacerbated pre-existing inequalities prevalent worldwide. The response to the pandemic reproduces and exacerbates the patterns of discrimination, social exclusion and violence. The existence of criminalization laws, for example, further exposes LGBT persons to police abuse and arbitrary arrest or detention and deters them from fully accessing aid programs and services put in place by States. While contributing to social isolation recommendations by staying at home, LGBT children, youths and elders are forced to endure prolonged exposure to unaccepting family members, which aggravates rates of domestic violence, physical and emotional abuse, as well as damage to mental health. In many jurisdictions, LGBT persons overwhelmingly rely on informal economies heavily affected by COVID-19 restrictions. The reallocation of health resources has also intensified shortages of antiretroviral for those living with HIV and impacted the ability of Trans-men and women to receive hormonal therapy or gender-affirming care.

Further, the pandemic has created a context conducive to increased persecution. Hate speech inciting violence against LGBT persons has been on the rise, including discourse by prominent political or religious leaders blaming the pandemic on the existence of LGBT persons. Some States have also enacted measures which intentionally target LGBT persons under the guise of public health.

14.4 Concept of illness and pandemic

The term "Health" is best defined by the World Health Organization (WHO). According to WHO "health" is "a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity". According to the Webster's Dictionary (1913) health is defined as "the state of being hale, sound, or whole, in body, mind, or soul; especially, the state of being free from physical disease or pain". Illness on the other hand is defined is seen by Kleinman (1978) as the socio-cultural dimension within which a person experiences disease.Susser in 1973 tried to define the term "illness" by referring to the inner sense of an individual's feeling unwell. According to him, illness does not refer to any explicit pathology but refers to a person's subjective understanding of it, such as discomfort, tiredness, or general malaise. We can even regard the concept of sickness as a notion that combines the biomedical model (disease) with the socio-cultural context of the patient (illness).

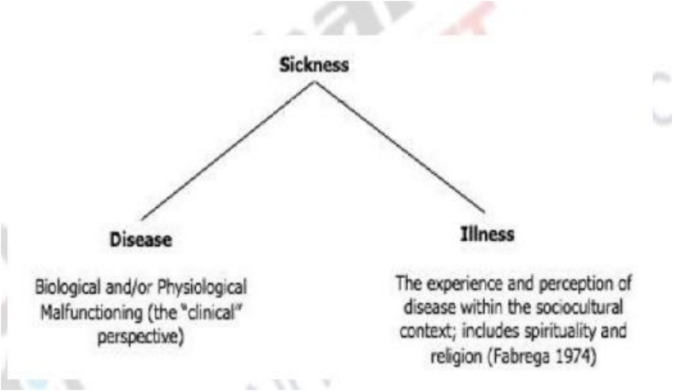

Fig 14(4)

Coming down to the concept of disease, we can presume that disease is an abnormal, pathological state that affects either part of a human being or all the parts of an individual. According to the Dorland Medical Dictionary, the disease is often interpreted as a medical condition that is associated with explicit indicators and signs. The disease is a pathological process which makes an individual deviate from his normal state of being.

But compared to this Pandemics are for the most part disease outbreaks that become widespread as a result of the spread of human-to-human infection. There have been many significant disease outbreaks and pandemics recorded in history, including Spanish Flu, Hong Kong Flu, SARS, H7N9, Ebola, and Zika (WHO, 2011b) (Rewar, Mirdha, &Rewar, 2015) (Maurice,2016).The term "pandemic" has not been defined by many medical texts, but there are some key features of a pandemic, including wide geographic extension, disease movement, novelty, severity, high attack rates and explosiveness, minimal population immunity, infectiousness and contagiousness, which help us to understand the concept better, if we examine similarities and differences among them. The pandemic-related crises have been associated with enormous negative impacts on health, the economy, society and the security of national and global communities. As well, they have caused significant political and social disruption.

Infectious disease outbreaks can easily cross borders to threaten economic and regional stability, as has been demonstrated by the HIV, H1N1, H5N1, and SARS epidemics and pandemics (Verikios, Sullivan, Stojanovski, Giesecke, & Woo, 2015). Beyond the debilitating, sometimes fatal, consequences for those directly affected, pandemics have a range of negative social, economic and political consequences (Davies, 2013a). As an example, "The impact of pandemic influenza ie. H1N1 in 2009 was not just on mortality, but also on health-care systems, animal health, agriculture, education, transport, tourism and the financial sector.

In short, a pandemic event threatens all aspects of the economic and social fabric" (Drake, Chalabi, & Coker, 2012). For another example, the SARS in 2003and the Ebola pandemics, in 2013 and 2015 respectively, disrupted the economies and social order in China and West Africa as well as caused death and illness. Ebola and other pandemics have reduced the life quality of families and communities, and Ebola has disrupted essential services such as education, transport, and tourism, reduced the West African economies and isolated populations, which had impacts beyond Africa too due to the global effort to containing the outbreak (Nabarro &Wannous, 2016).

There have been many significant pandemics recorded in human history, and the pandemic-related crises have caused enormous negative impacts on health, economies, and even national security in the world. However the term "pandemic" has a long history, it is still not defined by many medical texts, and the conception is still changing. But there are some key features of a pandemic, including wide geographic extension, disease movement, novelty, severity, high attack rates and explosiveness, minimal population immunity, infectiousness and contagiousness, which help us to understand what pandemics are.

The negative impacts of the pandemic are serious. Pandemics have infected millions of people, causing widespread serious illness in a large population and thousands of deaths. It represents a serious threat not only to the population of the world but also to its economy. The impact of economic loss can result in instability of the economy, which is through direct costs, long-term burdens, and indirect costs. The social impacts of pandemics were severe, including travel is strictly limited, and schools closing, markets and sporting being closed. All these are a likely reality should a pandemic with true potential for high morbidity and mortality emerge. The security threat of pandemic influenza is not a recent phenomenon. Global security is threatened from pandemics, in terms of lives and economic stability.

An effective and efficient emergency response can reduce avoidable mortality and morbidity and reduce the types of economic and social impacts. How to have effective and efficient emergency management will be a critical task for governments to deal effectively with disease outbreaks and a pandemic now and future.

Summary

Inequality is one of the most defining characteristics of Indian society and economy. An area that demonstrates this is healthcare – health outcomes in India continue to be closely tied to socio-economic status, identity and community. Combinations of complex barriers are responsible for the exclusion of the most vulnerable communities from access to healthcare. While some barriers, such as poverty or distance to healthcare centres, are simpler to understand, others such as systemic discrimination or policy gaps require a more complex analysis.The outcome of social exclusion is individuals" inability to access jobs, decent incomes, education and other training opportunities, as well as social and community activities. Socially excluded citizens have reduced access to power and decision-making bodies and, as a result, often feel powerless and unable to take charge of the decisions that affect their lives daily. The concept of social exclusion offers a framework for understanding and analyzing complex interdependencies between complex life circumstances, social problems and social categories. Social inclusion gives people the platform to voice in an unhindered way to ensure effective problem solving, decision making, creativity, and enhanced performance in multiple ways. Fostering inclusion is neither easy nor straightforward. Inclusion is not a neutral concept as it involves shifts in decision-making power between the state and local communities and between deferent segments of the community.

Keywords

Social Inclusion and Social Exclusion, Pandemic, Illness, Women empowerment, LGBTQ communities.

SelfAssessment

1 ………..refers to ways in which individuals may become cut off from full involvement in the wider society.

A. Social exclusion
B. Social inclusion
C. Discrimination
D. Social development

2 The concept of ………describes a process by which certain groups are systematically disadvantaged because they are discriminated against based on their ethnicity, race, religion, sexual orientation, caste, descent, gender, age, disability, HIV status, migrant status or where they live.

A. Social Inclusion
B. Social exclusion
C. Displacement
D. Discrimination

3 …………is the process of improving the terms on which individuals and groups take part in society.

A. Social inclusion
B. Displacement
C. Discrimination
D. Social Exclusion

4 ………..are for the most part disease outbreaks that become widespread as a result of the spread of human-to-human infection.

A. Illness
B. Disease
C. Pandemics
D. Sickness

5 …….by referring to the inner sense of an individual's feeling unwell.

A. Disease
B. Pandemics
C. Sickness
D. Illness

6 The concept of……is a notion that combines the biomedical model (disease) with the socio-cultural context of the patient (illness).

A. Sickness
B. Illness
C. Memory
D. Health

7 Who defined "health" is "a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity".

A. IMF
B. UFO
C. WHO

D. UNICEF

8 The practice of untouchability was an example of ……….

A. Empowerment
B. Social Exclusion
C. Social mobility
D. Social Inclusion

9 Constitution of India considered Scheduled Caste and Scheduled tribe as ……….

A. Depressed class
B. Elite Class
C. Middle Class
D. None of the above

10 From the above list who is associated with the Scheduled Caste more

A. Aamir Khan
B. Sachin Tendulkar
C. B. R. Ambedkar
D. Bhagat Singh

11 ……..can be defined to promoting women's sense of self-worth, their ability to determine their own choices, and their right to influence social change for themselves and others.

A. Child empowerment
B. Tribal empowerment
C. Women's empowerment
D. Dalit Empowerment

12 …………refers to a disease event in which there are more cases of a disease than expected spread over several countries or continents, usually involving person-to-person transmission and affecting a large number of people.

A. Pandemic
B. Epidemic
C. Disease
D. Sickness

13 Covid 19 is a ………………..

A. Sickness
B. Health project
C. Pandemic
D. Empowerment plan

14 LGBTQ includes ……………..

A. Lesbian & Gays
B. Queer people
C. Bisexuals & Transgender
D. All the above

15 Check the statement "Empowerment means people having power and control over their own lives.

A. True

B. False

C. Partially true

D. Partially false

Answers for Self Assessment

l.	A	2.	B	3.	A	4.	C	5.	D
6.	A	7.	C	8.	B	9.	A	10.	C
11.	C	12.	C	13.	C	14.	D	15.	CA

Review Questions

1. Differentiate between Social exclusion and Social inclusion with referring to the Health.
2. Discuss health hazards of LGBTQ people in the time of Covid 19.
3. How Women empowerment and women health are related.
4. Discuss the differences in concepts between Epidemic and Pandemics
5. How the constitution of India protects the scheduled tribes and Scheduled caste's Health.

Further Readings

Further Readings

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