WHO defines health as :

A state of complete phy, mental & social well being and not merely the absense of disease or infirmity.

1998 Def :

In conference, 2009, Netherlands.

Debate was there on

" Is health a state or an ability".

Static $\xrightarrow[2009]{}$ Dynamic

Henriette Van Der Horst (2010) states health can be regarded as a dynamic balance between opportunities & limitations, shifting - - - -

→ curative approach was quite individualistic, as one may even feel sick due to Genetic problems.

Public Health

Paradigm in Health sector has shifted from Curative approach to Preventive approach.

Public Health → Refers to all organized measures (public or private) to prevent diseases, promote Health and prolong life among the population as a whole, rather than focusing on a single individual.

Motto became : " Population should become prosper"

5 p's of public Health :

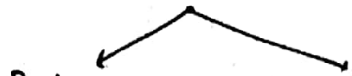
- ~~Partn~~ Prokct →
- Promote → we have to promote healthy habits and make people aware, about what things to do and not do.
- Prevent → Prevent them from falling sick ~~to~~ due to ~~very~~ various communicable diseases and in epidemics.
  Eg: Arsenic in water.
- Provide → they should be provided with basic amenities, and necessities
- Partner → U have to partner with community. There should not be top-down approach; otherwise it would fail. People with in community should ~~be~~ take the responsibility.

→ How do we do it ???

(Pillars of public Health).

- Availability → Do we have enough Health Care centres, clinics, Equipments and facilities in clinics & hospitals, infrastructures, resources in terms of Doctors, nurses, medicines, pathological Labs.
- Accessibility → Is it accessible ~~to~~ / reachable to the required people.
  - → accessibility in terms of physical distances → (far-remote areas, villages, not proper roads, ~~no~~ makes difficult to reach facilities to them).
  - → ~~Access~~ Economic accessibility → Prices ~~to~~ for the available services, bcz of they are very costly. High fee charged by doctors.
  - → Social accessibility → Difference / discrimination to hierarchy, cast & religion; mistreated by doctors. (rude behaviour).

→ Access to Information → People donot have inf of what services to avail and when.



Push Information → what is provided in top-down structure.

Pull Information → what information due to the people want. (There is lack of pull information in our society)

→ Utilization → 3rd pillar of Public Health → Proper utilization of the available and accessible resources.

Health Care

Prevention, treatment & management of illness and preservation of mental and physical well-being through the services offered by the medical and allied health professions.

↓

Doctors, physiotherapist, Nurses, compounders etc.

- Primary Health Care : • Very basic facilities.
  eg: 117 Patna hospital.
  - They are smallest unit in Health care system.
  - PHC is an approach to providing ~~every heac~~ everyday health services that focus on patients, clients, families & communities working with a team of health professionals.
  - ~~To provide~~ Should be very close at hand, physical accessibility should be minimum. Its ultimate goal is better health to all.

  Five key elements to achieve this goal by WHO :

* reduce exclusion & social disparities in health → no discrimination. It should have inclusive approach not exclusive. (universal coverage reforms)

* organizing health services around people's need & expectations (service delivery reforms): Need base facilities should be provided in the community.

Vaccination → more children community.

* Integrating health into all sectors (Public policy reforms):

* Pursuing Collaborative models of policy dialogue (leadership reforms): we have to ensure enough partnership from the community and people are involved.

* Increased Stakeholder Participation:

Stakeholders in Health Care: → You, we, everyone including doctors, nurses etc.

PHC needs to delivered close to the people.

It should include 8 essential components:

- Education for the identification and prevention / control of prevailing health challenges.
-
-
- Immunization against major infectious diseases.

Prevention and control of locally endemic disease

- appropriate treatment
- promotion of mental, emotional & spiritual health.
- provision of essential drugs.

15/1/2020

Health Disparities (differences) (Inequality)

* Differences in the incidence, prevalance, mortality & burden of diseases and other adverse health conditions that exist among specific population groups.

mortality → (death)

morbidity → (disease / ill-health)

HRSA defines health disparities as population – specific differences in:

- presence of disease → genetic disease.
- health Outcomes → how often; they are less-likely to fall ill. (status of how healthy a person is).
- Quality of Health Care: (Private clinics, gov. clinics) ~~access to health care services~~).
- access to health care services:

What makes some people have better health than others ?

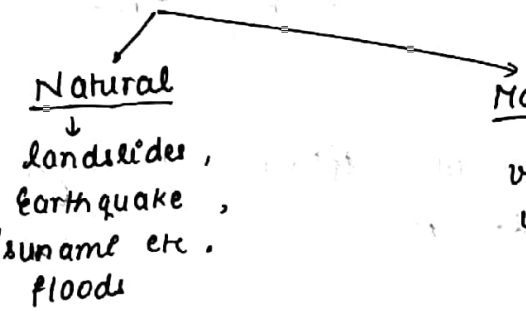
Disparities include :

- Racial & ethnic minorities.
- Resident of rural areas
  - ↳ have less access and availability of health care services.
- Women, children, & Elderly ~~PwD~~ (health disparities)
  - ↳ more vulnerable groups to fall sick.
  - bez they are clubbed at socially disadvantage people.
- PwD
  - ↳ socially dependent people on others.

* Causes of Health Disparities :

* Poverty → • not a too good health status
- Improper diet
- Very less access to health care due to economic problems.

- Environmental threats :



→ Even for a healthy person, these environmental threats, affect to their health status. (prolong for long term)

Manmade threats are continous phenomenon, but, Environmental threats are discontinous and occur for a limited specific time in different series of trauma.

- Inadequate access to health care :
  - rural & slum areas.

- Individual & behavioural facts :
  - ⟶ lifestyle patterns (Eating habits, hygeine etc)
  - ⟶ consumption of Junk foods.
- Educational inequalities :
  - ⟶ Educated people are more aware of availing basic health care services, vaccination, early detection and curing of diseases (like cancer etc. when u know the symptoms etc).

Health Inequality in India.

- Regional Variation & among states :
  - ⟶ MMR in UP → 517
    " kerala → 110

    regional disparities among states.

Demographic
Ashish Bosle → BIMARU states ⟶ low literacy rate
⟶ high IMR
⟶ high MMR

Now, Govt. of India has used different acronym for EACH state which lag in these factors.

- Place of residence :
  - Urban slums
  - village / rural areas but people (all people) living in rural areas are not poor or unaccessible to health facilities.

→ People living in high income neighbourhood have good health status than people living in low income neighbourhood.

↗ up-market Neighbourhood → Supermarkets, packaged items etc.
↘ low-market Neighbourhood → Kirana stores, fresh vegetables etc.

- Age & sex ~~and~~ group of the population.
  - Kuposhan Bharat Chodo. (42% children in India are malnourished).
    - ↳ stunting
    - ↳ malnutrition
    - ↳ obesity &
    - ↳ addiction to mobile phone at a small age.

[1975] (1) ICDS policy by government
- ↳ To improve nutritional & health status of children in age group 0-6.
- ↳ To ensure pyschological, physical, social well being of the children.
- ↳ To reduce mortality & malnutrition among children.

Example:

(2) • In India, mid-may meal served → khicdi
• In us,
• schools in
- ↗ low income neighbourhood → Pizza, burger in meals
- ↘ high income neighbourhood → limited cooked, fresh meal.

(3) • Pre school non formal Education (Aganwaadi)

(4) • Double referral system for treatment.

1, 2, 3, 4 → government policies.

- Sanitations (Improper)
  - → Lack of proper drinking water.
  - → Way of defecation & improper water management.

Solution

HEALTH EQUITY :

Equity in health in the absence of systematic disparities in health.

eg :- Refugees donot have same equity to good health status as others.

It states that nobody ~~else~~ should be prevented from having good health or avail health status irrespective or any discrimination or historical injustice.

Health equity is achieving the highest level of health for all people. It entails focused societal efforts to address avoidable inequalities by equalizing the conditions for health of all groups.

Elements of various definitions of Health Equity :

- → H. Ineq. are unjust, unnatural and avoidable differences in health status.
- → They are beyond the control of individuals, meaning they are systematic problems.
- → They are sustained over time and generations and are beyond the control of individuals.

→ EQUITY vs EQUALITY

[giving people according to their need]

↓ Equality on the basis of need.

↓ Eg: If u are not hungry, u get only 1 bread, and if u are more hungary, u get 6 bread.

↓ means giving same thing to everyone.

Eg: In mess; everyone is given 4 bread & 1 glass milk irrespective of hunger.

* Right to Vote → Equality
* PDS availability → Equitity
* Subsidy Cylinder → Equitity

Def. (equity): Involves trying to understand and give people what they need to enjoy full, healthy lives.

Def (Equality): Aims to ensure, that every one gets the same things in order to enjoy full, healthy lives.

Equity is the means, Equality is the Outcome.

Health Equity

- Cost → Cost cutting; but also quality is being cut down, quality of groceries in PDS is lower. Parents don't send their children to gov. schools, because of low quality.
- Access: fake BPL Card by APL people to avail PDS facilities. People who actually deserve it, donot have access to it, while, others rich people have access to it
- Quality: High Quality.

factors responsible for making some healthy & some unhealthy and How can we create a society in which ~~everyhoo~~ everyone has ~~change~~ chance of equal health.

The range of personal, social, economic and environmental factors that influence health status are known as determinants of health.

Categorised into :

- Demographic Characteristics
- Social Characteristics
- Economic "

DC : ~~Deals~~ Demography (numerical) deals with study of population i.e. population size, composition (M, F, T), (M, M, S, C), & population Growth ~~Ra~~ rate.

Population Distribution
- population size.
- Growth rate → +ve growth, -ve growth } of population

Population Composition
- Age structures. → some age groups are more vulnerable to diseases, while some are less.
- Sex structure → Male, female, LGBT } Study

Population Distribution :

Population is dynamic (not stable).

- **population Change :**

Factors that influence population Change :

→ Fertility
→ Mortality
→ Migration (movement of people from one demographical area to other).
  └ migration can lead to Inc. as well as dec. in population (It has dual influence on the population).

⇒ **Demographic Transition** : It is a model that describes a population change over time.
This was developed by demographer ~~Woven~~ Warren Thompson (1929).

It represents the transition from high birth and death rates to low birth and death rates as a country develops from pre-industrial to mature industrial and post industrial stage.

Crude Birth rate ← CBR } per 1000 population
Crude death Rate ← CDR }

CDR initially used to be high because people at that time did not know about the art of storing grains and no technologies were there to ~~overwelt~~ overwhelm harsh conditions.
  └ • IMR was high. • ~~low~~ very few medical technologies.
High CBR → • children were seen as economic assets (labour force)

* In pre-modern time. [stage 1]

- High CBR
- High CDR

} no gap.

- Low population (stable) (→)

- Stage 2 (urbanization / industrialization)

- High CBR
- reduced CDR

} → gap b/w CBR & CDR was high.

→ development of innovation & medical technologies

- Inc in population (↗)

* Mature Industrial : [stage 3]

- Reduced CBR
- Low CDR

} → gap reduced b/w CBR & CDR

Reasons → • Women Empowerment • Literacy Inc. ↑

- Children became Economic liabilities (no more seen as Economic asset / labour force.

- Sharpe Inc. in population (↗)

* Post Industrial : [stage 4] :

very less gap. {

- Low CBR
- Low CDR { CDR is slightly increasing } because no one is immortal.

- High stable Population (→)

THE DEMOGRAPHIC TRANSITION MODEL [American European Subcontinent]

27/01/2020

LAST CLASS

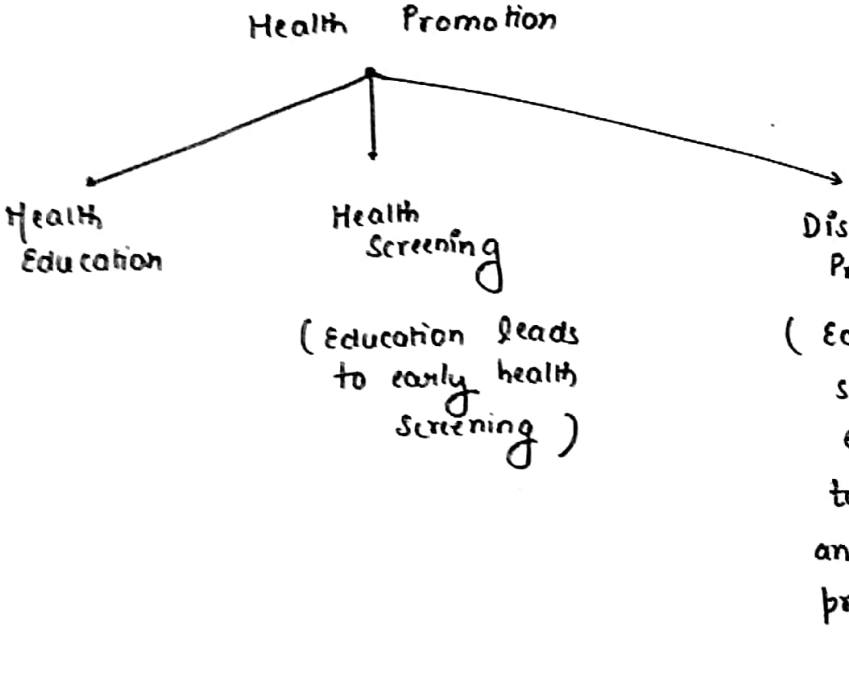
Social Determinants of Health

- Educational Status : talking not only about status of education but also level of education attained.

  Higher Educational status has positive impact on health.

  " Better Education ⟶ Better health status.

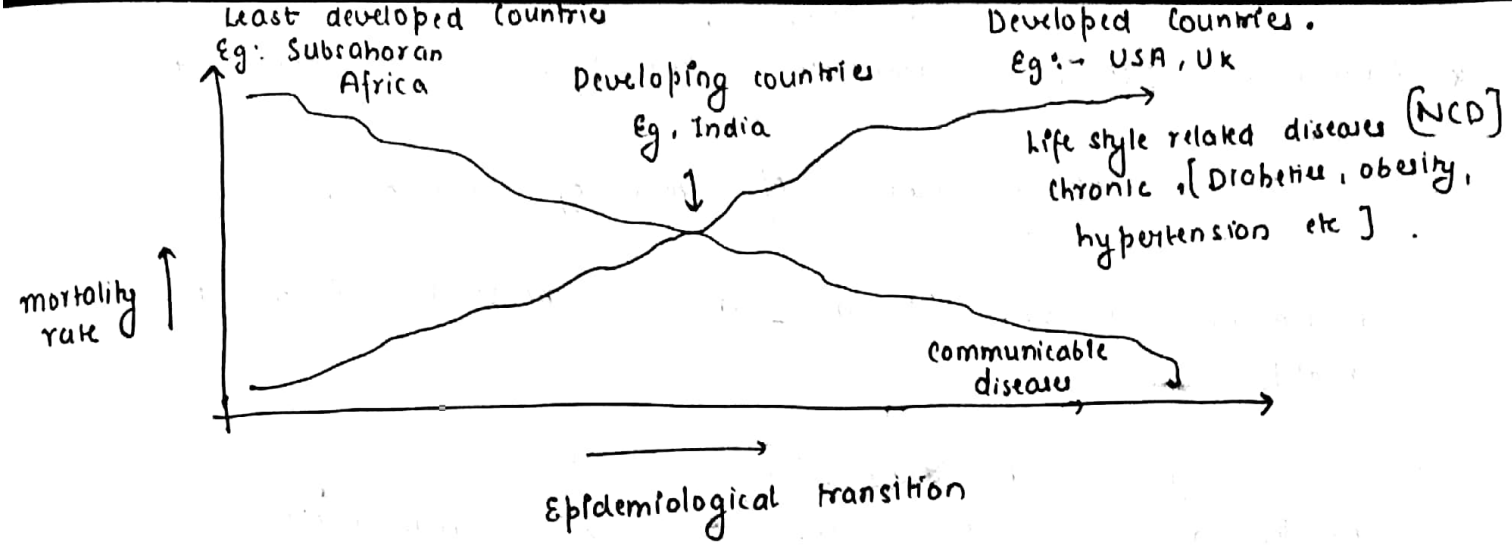
- Quality of Education : cheating, corruption in education → people have lots of degree, but we lack of real knowledge.



EPIDEMIOLOGICAL TRANSISTION

A theory stating :

the prevailing forms of illness changed from infectious to degenerative types as the demographic transition occured.



Curative Approach ⟶ Preventive approach

(Earlier times) (present time)

Era of Health Promotion

Technology is the most prominent factor in health promotion.

* use of treadmills
* Infrared mosquito killer.
*

- Health - Disparity is a major concern in public health.
- Ottawa Charter in 1986 pioneered Health Promotion.

↷ Enable people to deal with their health issues and to overcome the existing health disparities.

→ Amalgamation of advances in knowledge, increasing concerns about human rights & tackling emerging threats of health.

Aims at building capability of individuals by inculcating skills & confidence among them through Health education.

Health Education.

* Education provides information, knowledge & wisdom to people.
* making aware of need of vaccination.

⇒ Education is one of the most important contributors to health.

→ Purpose of health education is to positively influence health behaviour of individuals & communities as well as living & working conditions that influence their health.

Health Education is often visible and tangible as it often includes educational programs, and skill building group of individual activities.

Eg :- Advertisments., poster, banners etc

Health ed. is not providied in a formal way (i.e, not only in school & college) but through different ways too