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Epidemiological Transition and Emerging Conflicts in Health Care

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ABSTRACT

Epidemiological transition has posed several challenges in the world by bringing radical change in the disease profile. Transition reveals decline in communicable diseases and fast growth of non communicable diseases. The communicable diseases are heavily rooted to the physical environment whereas non communicable diseases are mostly rooted into the individual, their food habits, food philosophy, overall life style, modernity, development and, the wheel of development cannot be reversed back. Therefore the bio medical model of treating the non communicable diseases has very limited role because of the cost. The present model of health care system is grossly incompetent for the masses. The model needed to ensure complete ownership of people for preventing the non communicable diseases and promoting good health by addressing the conflict of different nature in health care delivery system.

KEYWORDS: Non communicable disease, Conflict, Epidemiological transition

Introduction: India is under epidemiological transition. World's focus is changing from communicable to non communicable diseases (NCDs). In 20th century pharmaceutical perspective dominated in bio-medical model of health care where aim is to manage the disease. While managing the disease, health managers undermined the preventive and promotive dimension of health care. Although WHO conceptualized broad and holistic perspective of health. Never the less the treatment of disease occupied the central position of health care worldwide. In 20th century, communicable diseases including maternal and perinatal causes were the leading killers. The scenario in the 21st century is changing drastically as non-communicable diseases are the major killers. The shift in disease pattern is labeled as epidemiological transition (Thakur, 2005).

Burden of Non Communicable Disease in India

According to recent estimates, cases of cardiovascular diseases (CVD) may increase from about 2.9 crore in 2000 to as many as 6.4 crore in 2015, and the number of deaths from CVD will be more than double (NCMH GOI, 2005). Most of this increase will occur on account of coronary heart disease-a mix of conditions that includes acute myocardial infarction, angina pectoris, congestive heart failure and inflammatory heart disease (NCMH GOI, 2005). Data suggest that the prevalence rates of CVD in rural populations will continue to increase, reaching around 13.5% of the rural population in the age group of 60–69 years by 2015 (Mahal, 2005).

According to the Diabetes Atlas 2006 published by the International Diabetes Federation, the number of people with diabetes in India is currently around 40.9 million and is expected to rise to 69.9 million by 2025 (NPCDCS Manual, 2008). Indians succumb to diabetes, high blood pressure and heart attacks 5-10 years earlier than their western counterparts, during their most productive years. It has been estimated that, by the year 2030, India will lose approximately 17.9 million potentially productive years which is higher than the expected combined loss in China, Russia, USA, Portugal and Brazil. This translates into a huge economic loss as high as 237 billion dollars by the year 2015(NPCDCS Manual, 2008).

Worldwide, cancers account for about 5.1% of the disease burden and 12.5% of all deaths. In India, cancers account for about 3.3% of the disease burden and about 9% of all deaths (NCMH GOI, 2005). Nearly 10 lakh new cases of cancer will be diagnosed in 2016, compared to about 8 lakh in 2001. Nearly 6.7 lakh people are expected to die of cancer in India in 2016 (NCMH GOI, 2005). According to a WHO report (2002), cardiovascular diseases (CVDs) will be the largest cause of death and disability in India by 2020. Overall, NCDs are emerging as the leading cause of deaths in India accounting for over 42% of all deaths (Registrar General of India). NCDs cause significant morbidity and mortality both in urban and rural population, with considerable loss in potentially productive years (aged 35–64 years) of life (Operational guidelines NPCDCS).

India's concern to Non-Communicable Diseases (GOI five years plan)

During seventh five year plan (1985-90) focus started on cancer, coronary heart diseases, hypertension, diabetes, and traffic and other accidents as major health problems. The emphasis was to initiate appropriate action for control and containment of NCDs. During the eighth plan (1992-97) emphasis was given for development of models for care and control programmes for non communicable diseases. In ninth five year plan (1998-2002) period an integrated non-communicable disease control programs at primary and secondary care level was thought to be developed with emphasis on prevention of NCD, early diagnosis, management and building up of suitable referral system. Tertiary care centers were strengthened to some extent. Tenth five year plan (2002-2007) has given stress on the morbidity and mortality due to cardiovascular diseases, mental disorders, cancers and trauma. In view of the chronic morbidity and high cost involved in the management of non communicable diseases, attention was focused on prevention, early detection and appropriate management. During eleventh five year plan (2007-2012) period National Program for Prevention and Control of Diabetes, CVD and Stroke (NPCDCS) has been developed to prevent and control common NCDs risk factors. Pilot phase of the National Programme for Prevention and Control of Diabetes, Cardiovascular Diseases and Stroke (NPDCS) was having two components viz. (i) Cancer & (ii) Diabetes, CVDs & Stroke. Up scaling of programme has been undertaken at the end of eleventh five year plan by implementing NPCDCS in 100 districts. The budget outlay in 11th plan period was estimated to be Rs 1230.90 crores. Rs 499.38 crores for interventions on diabetes and cardiovascular diseases & stroke and Rs.731.52 crores for cancer control (Budget outlay 11th plan) However budget allocated during 2011-12 is Rs 125 crores (Budget outlay 2011-12). Funds released to 53 districts were Rs. 60.27 crores for diabetes, CVD and stroke and Rs 38.43 crores for cancer in 47 districts by the government.

Frame work of implementation of NPCDCS in India

NPCDCS is operating through NCD cells in the programme constituted at State and District levels. Funds from Health Society are transferred to the NCD cells. Thus the NPCDCS aims at integration of NCD interventions in the NRHM framework for optimization of scarce resources and provision of seamless services to the end customer. Thus, the institutionalization of NPCDCS at district level within the District Health Society, sharing administrative and financial structure of NRHM becomes a crucial programme strategy for NPCDCS (Operational guidelines NPCDCS)

Critical observations

Although, ideologically, there has been emphasis on preventive and promotive approach in public health care system. Nevertheless, the service delivery system hardly takes care of it at the ground level. The present model of primary health care delivery system operates under three tier systems i.e. sub centre, primary health care, community health centre. People are supposed to visit the nearest centre to

avail the services or to get referred to the next level. At each level very limited services are available, particularly, for the diseases under non communicable category. The mode of treating the patients is heavily dependent on a prescription, tests for diagnosis and irrational medicines. The functional status of present health care model is not sufficient even for common diseases how it could handle increasing load of non-communicable diseases which demand enormous resources and radical changes in the functioning.

The feasibility of the present system's functioning is at great stake, and without making realistic study of the situation, simply the funds flow would hardly meet the expectations. The villagers visiting the centre after hours walk and failing to get desirable health care services hardly come back to the centre again for seeking the services of qualified doctor. They are left with no choice to seek the health care services from Jhola Chhap Doctors (Quacks), who exploit the innocent villagers to the extent possible and mint their meager resources, this is a situation of out of pocket expenditure, which is very high in the Indian context at the moment. In this context, the importance of preventive and promotive approach in public health could get special position. A new model of health care having dominance of preventive and promotive approaches is likely to become reality in the coming years because of several reasons. Present National Health Policy need to be relooked from different perspective where the concept of 'given health' needs to be replaced with the concept of 'acquisition of health'. The emphasis is exclusively on service providers whereas under acquisition of health, people would need to be empowered to understand the importance of health in the context of economic gain and loss rather than a concept of desirability. The complete notion of health need to be crystallized and both service provider and service receiver need to be understand each other's position and contribute each other to create an enabling environment for good health.

Conclusion

Mere provision of resources and gradual addition to it can not be taken as successful model of managing NCDs. The present bio medical model is incompetent to address different conflicts of different nature which has got direct bearing on the health of the people. With transition in philosophy of communicable to non communicable disease different kinds of conflict arose. Today we are in state of conflict. We are internalizing the modern food philosophy under globalization which is in conflict of good health of the people, for example, obesity is on account of consumption of junk food and sedentary life style. Work culture of 24X7 for the development which is again in conflict of good health is resulting in stress and suicidal tendencies. Development related specialized diseases like diabetes, stroke, CVDs are very costly in terms of management, which is again in conflict for larger section of society as they are not able to bear the cost. In such conflicting situations conventional old bio-medical model is going to play a limited role for the people in the country. So, there is need to resolve the conflicts by empowering people about health. The people need to understand that 'health gain' is total 'economic gain' and 'health loss' is economic loss'. This is the core value which needs to inculcate in the society. Unless society at large internalizes such core values, people would not change the life style. Therefore inculcating values of health gain as economic gain has to be made part of health care system. This demands careful designing of preventive and promotive approaches of health care system rather than conventional provision of budgeting and communication strategies. The communication strategies are terribly failing to educate the people. The present forms of health IEC/BCC activities are wastage of resources. People would not respond to sporadic slogans of life style diseases. Health education programme that promotes exercise, weight reduction, early diagnosis, screening are some of the key interventions that need to be promoted at various levels of heath facilities. The already over stretched health system has to absorb the additional burden of chronic diseases, especially in the rural areas. Both preventive and curative strategies along with mobilization of additional resources are needed. It is proposed to integrate these with the regular health care programmes at all levels to achieve the aims and objective of the programme.

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