

Health Perspective of Twenty First Century

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Abstract:

Health care in the new twenty first century is challenging as it poses multiple challenges in front of the world community. For different population World Health Organization and other international health organization has to take different initiatives. For the first world they just play the role of supervisor and advocate. On the other hand for the third world countries they have to collect funds as well help in policy making. Another important perspective of modern health care system is the health care for the minorities. Providing equal health care opportunities for the minorities is another

challenge of this new century. Also in the several part of the world where people are tearing apart each other by war and violence to maintain health care is not only a challenge but also struggle for the health care providers. The international health care organization should be more committed and direct their resources for the under developed countries and population.

Key words: Health care, Third world, War health care

Introduction

The WHO Constitution¹ enshrines the highest attainable standard of health as a fundamental right of every human being. The right to health includes access to timely, acceptable, and affordable health care of appropriate quality. Yet, about 150 million people globally suffer financial catastrophe annually, and 100 million are pushed below the poverty line as a result of health care expenditure. The right to health means that States must generate conditions in which everyone can be as healthy as possible. It does not mean the right to be healthy. Vulnerable and marginalized groups in societies tend to bear an undue proportion of health problems².

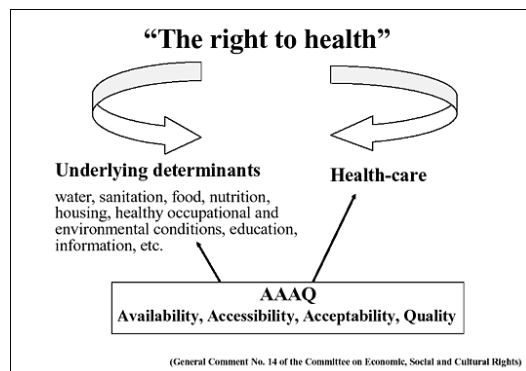


Fig: The right to health motto of WHO

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According to the General Comment, the right to health contains four elements:

- **Availability:** A sufficient quantity of functioning public health and health care facilities, goods and services, as well as programmes
- **Accessibility:** Health facilities, goods and services accessible to everyone. Accessibility has four overlapping dimensions:
 - non-discrimination
 - physical accessibility
 - economical accessibility (affordability)
 - information accessibility
- **Acceptability:** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate as well as sensitive to gender and life-cycle requirements.
- **Quality:** Health facilities, goods and services must be scientifically and medically appropriate and of good quality².

The WHO constitution also described as core content of health care are essential primary health care and also minimum essential and nutritious food. WHO constitution added sanitation and safe water as another core content of health care. Right to get essential in reasonable price is also regarded as another core content of health care¹.

Present status of health care in First world

As an example of health care in first world or developing world country United States of America is given. Health care in the United States is provided by many distinct organizations. Health care facilities are largely owned and operated by private sector businesses. 62% of the hospitals are non-profit, 20% are government owned, and 18% are for-profit. 60–65% of

healthcare provision and spending comes from programs such as Medicare, Medicaid, TRICARE, the Children's Health Insurance Program, and the Veterans Health Administration. Most of the population under 67 is insured by their or a family member's employer, some buy health insurance on their own, and the remainder are uninsured. Health insurance for public sector employees is primarily provided by the government.

The United States life expectancy of 78.4 years at birth, up from 75.2 years in 1990, ranks it 50th among 221 nations, and 27th out of the 34 industrialized OECD countries, down from 20th in 1990⁵. Of 17 high-income countries studied by the National Institutes of Health in 2013, the United States had the highest or near-highest prevalence of infant mortality, heart and lung disease, sexually transmitted infections, adolescent pregnancies, injuries, homicides, and disability. Together, such issues place the U.S. at the bottom of the list for life expectancy. On average, a U.S. male can be expected to live almost four fewer years than those in the top-ranked country.

According to the World Health Organization (WHO), the United States spent more on health care per capita (\$8,608), and more on health care as percentage of its GDP (17.2%), than any other nation in 2011. The Commonwealth Fund ranked the United States last in the quality of health care among similar countries, and notes U.S. care costs the most. In a 2013 Bloomberg ranking of nations with the most efficient health care systems, the United States ranks 46th among the 48 countries included in the study.

The U.S. Census Bureau reported that 49.9 million residents, 16.3% of the population, were uninsured in 2010 (up from 49.0 million residents, 16.1% of the population, in 2009)⁶. A 2004 Institute of Medicine (IOM) report said: "The United States is among the few industrialized nations in the world that does not guarantee access to health care for its population." A 2004 OECD report said: "With the exception of Mexico, Turkey, and the United States, all OECD countries had achieved

universal or near-universal (at least 98.4% insured) coverage of their populations by 1990." Recent evidence demonstrates that lack of health insurance causes some 45,000 to 48,000 unnecessary deaths every year in the United States. In 2007, 62.1% of filers for bankruptcies claimed high medical expenses. A 2013 study found that about 25% of all senior citizens declare bankruptcy due to medical expenses, and 43% are forced to mortgage or sell their primary residence⁷.

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) became law, providing for major changes in health insurance. The medical system will be forced to change normal procedures. They will be required to prepare for upcoming programs to meet federal regulations⁵.

Present status of health care in third world

As an example of third world health care Nigeria will be described here. Health care provision in Nigeria is a concurrent responsibility of the three tiers of government in the country⁸. However, because Nigeria operates a mixed economy, private providers of health care have a visible role to play in health care delivery. The federal government's role is mostly limited to coordinating the affairs of the university teaching hospitals, Federal Medical Centers (tertiary health care) while the state government manages the various general hospitals (secondary health care) and the local government focus on dispensaries (primary health care), (which are regulated by the federal government through NPHCDA). The total expenditure on health care as % of GDP is 4.6, while the percentage of federal government expenditure on health care is about 1.5%. A long run indicator of the ability of the country to provide food sustenance and avoid malnutrition is the rate of growth of per capita food production; from 1970–1990, the rate for Nigeria was 0.25%. Though small, the positive rate of per capita may be due to Nigeria's importation of food products⁹.

Historically, health insurance in Nigeria can be applied to a few instances: free health care provided and financed for all citizens, health care provided by government through a special health insurance scheme for government employees and private firms entering contracts with private health care providers. However, there are few people who fall within the three instances¹⁰.

In May 1999, the government created the National Health Insurance Scheme, the scheme encompasses government employees, the organized private sector and the informal sector. Legislative wise, the scheme also covers children under five, permanently disabled persons and prison inmates. In 2004, the administration of Obasanjo further gave more legislative powers to the scheme with positive amendments to the original 1999 legislative act¹⁰.

In June 2011, the United Nations Population Fund released a report on The State of the World's Midwifery. It contained new data on the midwifery workforce and policies relating to newborn and maternal mortality for 58 countries. The 2010 maternal mortality rate per 100,000 births for Nigeria is 840. This is compared with 608.3 in 2008 and 473.4 in 1990. The under 5 mortality rate, per 1,000 births is 143 and the neonatal mortality as a percentage of under 5's mortality is 28. The aim of this report is to highlight ways in which the Millennium Development Goals can be achieved, particularly Goal 4 – Reduce child mortality and Goal 5 – improve maternal death. In Nigeria the number of midwives per 1,000 live births is unavailable and the lifetime risk of death for pregnant women 1 in 23¹¹.

Present status of health care in ethnic minority

Health care disparity is present between the population and ethnic minority. As an example we have shown health care

disparity present in USA to view how much prevalent this kind of disparity can be¹².

Each year since 2003, the Agency for Healthcare Research and Quality (AHRQ) has reported on progress and opportunities for improving health care quality and reducing health care disparities. As mandated by the U.S. Congress, the National Healthcare Quality Report (NHQR) focuses on "national trends in the quality of health care provided to the American people" while the National Healthcare Disparities Report (NHDR) focuses on "prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations¹³."

Priority populations include racial and ethnic minorities, low-income groups, women, children, older adults, residents of rural areas and inner cities, and individuals with disabilities and special health care needs.

Disparities in quality of care are common:

1. Blacks and AI/ANs received worse care than Whites for about 40% of measures.
2. Asians received worse care than Whites for about 20% of measures.
3. Hispanics received worse care than non-Hispanic Whites for about 60% of core measures.
4. Poor people received worse care than high-income people for about 80% of core measures¹⁴.

Disparities in access are also common, especially among Hispanics and poor people:

1. Blacks had worse access to care than Whites for one-third of core measures.
2. Asians and AI/ANs had worse access to care than Whites for 1 of 5 core measures.
3. Hispanics had worse access to care than non-Hispanic Whites for 5 of 6 core measures.

4. Poor people had worse access to care than high-income people for all 6 core measures.

Few disparities in quality of care are getting better:

1. Fewer than 20% of disparities faced by Blacks, AI/ANs, Hispanics, and poor people showed evidence of narrowing.
2. The Asian-White gap was narrowing for about 30% of core measures, the largest proportion of any group, but most disparities were not changing.

Specific Source of Ongoing Care

1. Overall, 86.1% percent of people had a specific source of ongoing care in 2008.
2. In 2008, the percentage of people with a specific source of ongoing care was lower for Blacks than Whites (84.7% compared with 86.3%) and significantly lower for Hispanics than for non-Hispanic Whites (77.1% compared with 88.6%).
3. In 2008, the percentage of people with a specific source of ongoing care was significantly lower for poor people than for high-income people (77.5% compared with 92.1%).
4. The percentage of people with a specific source of ongoing care was lower for people with less than a high school education and for people with a high school education than for people with at least some college education (74.2% and 82.2%, respectively, compared with 88.9%).

The 2010 NHQR and 2010 NHDR emphasize the need to accelerate progress if the Nation is to achieve higher quality and more equitable health care for all Americans in the near future. Among the themes that emerge from the reports are:

1. Health care quality and access are suboptimal, especially for minority and low-income groups.
2. Quality is improving; access and disparities are not improving.
3. Urgent attention is warranted to ensure improvements in quality and progress on reducing disparities with respect to certain services, geographic areas, and populations, including:
 - a) Cancer screening and management of diabetes.
 - b) States in the central part of the country.
 - c) Residents of inner-city and rural areas.
 - d) Disparities in preventive services and access to care.
 - e) Progress is uneven with respect to eight national priority areas¹⁵.

Present status of health care in vulnerable communities

As an example we have taken Syria to visualize the role of war in health care system.

Before the crisis: Baseline health status:

Health indicators improved considerably in the Syrian Arab Republic over the past three decades according to data from the Syrian Ministry of Health with life expectancy at birth increasing from 56 years in 1970 to 73.1 years in 2009; infant mortality dropped from 132 per 1000 live births in 1970 to 17.9 per 1000 in 2009; under-five mortality dropped significantly from 164 to 21.4 per 1000 live births; and maternal mortality fell from 482 per 100 000 live births in 1970 to 52 in 2009. The Syrian Arab Republic was in epidemiological transition from communicable to non-communicable diseases with the latest data showing that 77% of mortalities were caused by non-communicable diseases¹⁶. Total government expenditure on health as a percentage of Gross Domestic Product was 2.9 in

2009. Despite such low public investment access to health services increased dramatically since the 1980s, with rural populations achieving better equity than before.

International agencies and nongovernmental organizations (NGOs) are striving to provide psychosocial support for people whose mental health has been affected by the conflict.

As stated by Dr. Yanes “The problem is that there is not enough capacity for further interventions,”¹⁷.

Evolution of health care as teaching

In present day when world population has reached 7 billion providing drugs, instruments are not enough. Providing health teaching is more important as it is long-lasting and more helpful for the care seeker. Examples of health teaching are prevalent all over the world. Like cholera epidemic is controlled not only by invention of oral saline but also behavioral education concerning hand washing and other sanitary advices had important role.

Especially in case of non-communicable diseases health care education is more important than drug itself. As health education changes behavior and life style which are prevalent. On the other hand, drugs are matter how safe is not free of side effect and cost consuming. Certain thinking is coming forward that changes the whole view of health care education.

MDG (Millennium Development Goal) and Health care

With only five years remaining to 2015, there are signs of progress in many countries in achieving the health-related Millennium Development Goals (MDGs). In other countries, progress has been limited because of conflict, poor governance, economic or humanitarian crises, and lack of resources. The effects of the global food, energy, financial and economic crises

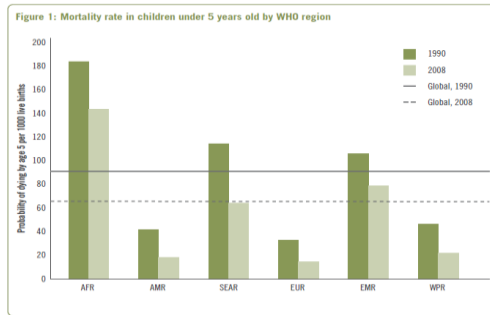
on health are still unfolding, and action is needed to protect the health spending of governments and donors' alike¹⁸.

Under nutrition is an underlying cause in about one third of all child deaths. Over the past year, rising food prices coupled with falling incomes have increased the risk of malnutrition, especially among children. Although the percentage of children under 5 years of age who are underweight (compared to the WHO Child Growth Standards³) declined globally from 25% in 1990 to 18% in 2005, subsequent progress has been uneven.

Globally, child mortality continues to fall. In 2008, the total annual number of deaths in children under 5 years old fell to 8.8 million – down by 30% from the 12.4 million estimated in 1990. Mortality in children under 5 years old in 2008 was estimated at 65 per 1000 live births, which is a 27% reduction from 90 per 1000 live births in 1990 (Figure 1). Recent encouraging trends also indicate an acceleration of the rate of decline in all regions since 2000 (Table 1).

Table 1: Average annual rate of decline (%) in mortality in children under 5 years old – 1990–1999 and 2000–2008

WHO region	1990–1999	2000–2008
African Region	0.9	1.8
Region of the Americas	4.2	4.6
South-East Asia Region	2.5	3.8
European Region	3.6	5.6
Eastern Mediterranean Region	1.5	1.7
Western Pacific Region	2.5	5.7
GLOBAL	1.2	2.3



Discussion

Different responses occur in different country for same effort of the international health organizations. As shown in the Fig 1 that the changes in children mortality rate is highest in the Europe and North American regions. This is due to the difference in socioeconomic condition of two regions. Also different educational conditions play important role for differential response in health care system¹⁹. Also gender difference has important impact in health care responses²⁰.

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