Global Health Management: Addressing Health Disparities And Inequalities

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KEYWORDS

Public Health, management, Health Policy.

ABSTRACT

It is the state's responsibility to provide access to public health care management for the poor and vulnerable, as the cost of curative care is disproportionately higher among lower income groups, the majority of whom are Dalits. India's population health has significantly improved during the past 70 years. The disparity across social groupings is still rather large, though. Low health status is clearly associated with poverty, being a woman, living in a rural area, belonging to a tribal ethnic group, being a scheduled caste (SC), and belonging to particular minority groups. In order to guarantee health fairness, it is necessary to review the environment and policy implementation regime. The purpose of this article is to provide context for relevant healthcare concerns and challenges by examining a few key health, poverty, illness-related costs, and coping techniques across social groupings indicators. The conceptual foundation for the health effects of public health care management's globalisation is described in this study. An examination of the main social determinants influencing population health is known as the social determinant of health.

1. Introduction

A group's or individual's independence from disease and capacity to reach their full potential are conferred by good health. Therefore, the ideal way to conceptualise health is as the essential foundation for determining an individual's feeling of wellbeing. Because greater health frees up more time for productive or income-generating activities, good health plays a role in the production of consumable services [1]. Thus, the provision of health care to all citizens is crucial to a nation's overall economic growth. It is important to distinguish between health and health care, with the former being considered as a direct result of the latter. Health care includes all aspects of prophylactic care in addition to medical care. Compared to developed nations, India has extremely low out-of-pocket expenses, which significantly lowers the cost of paying for medical care. A strong political economy, progress made in reducing inequality, providing health care to the impoverished, creating gainful and high-quality jobs (which help people take personal responsibility for their health and can be paid for with their earnings), public information and development communication, and individual lifestyle modifications can all improve health care. [2].

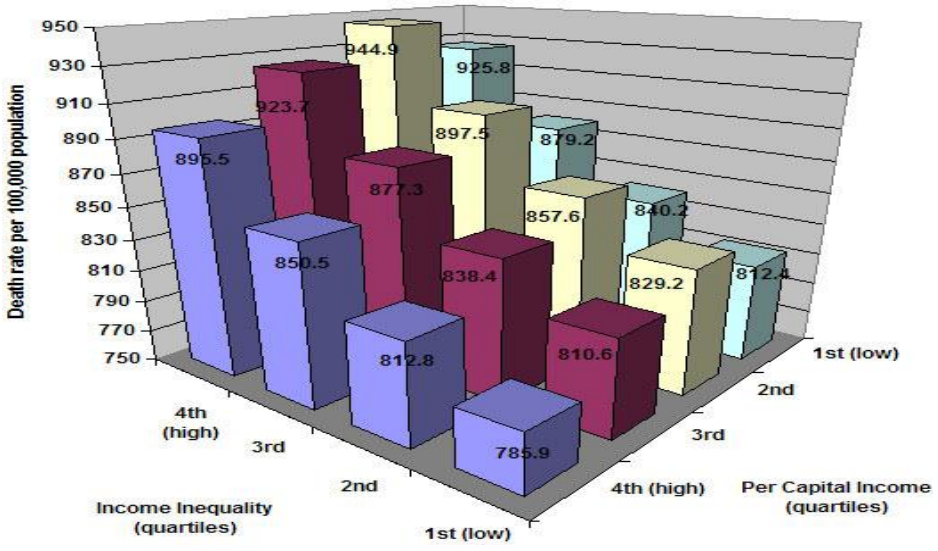

Figure 1: Population health management statistics

It is true that poverty's accumulation and persistence have a direct impact on health. Those who are impoverished or who, in spite of their best efforts, stay impoverished are typically plagued by illness and exorbitant medical costs. Lack of access to quality healthcare threatens social wellbeing because untreated illness causes poverty to worsen and spread [15]. Compared to the rich, the poor experience a disproportionately greater burden of illness, injury, and disease. They experience poor health for a variety of reasons, such as inadequate nutrition, which impairs their capacity to work and weakens their resistance to illness [11]. Since their bodies are frequently their primary source of income, illness and disability have a major negative impact on their capacity to work and earn a living, which is made worse by their inability to access quality medical treatment [5]. Poor families are often forced to borrow money in order to pay for medical expenses and lost wages, which depletes their savings and assets and increases their risk of falling into a vicious cycle of poverty, disease, and poor health. Unemployment and poverty might result from a lack of capabilities, which can be primarily caused by poor health. These healthcare providers are businesses or private individuals that provide public health care.

In this case, the introduction is examined in section 1 of the article while the pertinent literature is examined in section 2. Section 3 and 4 explains the goal of the work, Section 5 shows the discussion of the work, and Section 6 concludes the project.

2. Literature Review

Numerous research endeavours have emphasised the matter of resource efficiency in the healthcare industry, with a particular emphasis on the overall performance of the health system and its influence on health outcomes [4]. These initiatives have produced an idealised yardstick by applying frontier efficiency measuring methodologies to assess the health system's economic performance. According to additional research, the overall effectiveness of the public health delivery system is still low because of significant differences between districts in the availability and use of resources, such as the per capita availability of beds, hospitals, and labour, which has a negative impact on life expectancy [12]. There is a significant difference in the healthcare infrastructure between rural and urban areas [7]. For example, there are more hospitals, beds, and dispensaries in urban areas than in rural ones, which leads to higher per capita availability in urban areas. PHCs and SCs, two types of rural infrastructure, lack the required inputs to support them effectively. It demonstrates how physical infrastructure inadequacies and a lack of machinery and equipment may be overcome to improve rural public health facilities [6].

Health disparities have two dimensions, as [13] noted. First, there is horizontal equality, which prioritises equal access for people in equal need and stresses treating equals similarly. It guarantees that the concept of need—rather than financial capacity—should guide the provision of health services. The horizontal equality dimension encompasses the treatment of health status, access, and utilisation of health care. Second, vertical equity emphasises the need to address inequality differently, meaning that wealthier individuals should contribute a larger percentage of their income to health care services than do impoverished individuals. Public Health care management facilities can be improved with following components [3].

- Firstly, strengthening rural health facilities,
- Secondly deficiencies in manpower which related to provisioning of health care at the household level through the Accredited Social Health Activist,
- Thirdly decentralizing the health sector by enhancing the capacity of panchayats to control and manage the provisioning of health services and lastly positioning of a health management information system.

The efficiency of health care spending determines the quality of public health care services. The definition of health cost varies depending on whether family welfare, water supply, sanitation, and

nutrition are included or if solely medical and public health expenses are included. The amount spent on public health and medicine has a direct effect on people's health, but the poor's health is greatly improved indirectly by spending on nutrition, water supply, and sanitation. The purpose of this study was to identify disparities in service utilisation and self-reported health status.

3. GLOBAL PERSPECTIVE IN HEALTH AND HEALTH CARE MANAGEMENT.

In wealthy countries, health spending as a percentage of GDP is much greater, more than twice as high as in India (4.1 percent). In affluent nations, public health spending is quite high relative to total health spending, while it is relatively low in underdeveloped nations. Generally speaking, the percentage of private health spending in low-income countries is larger than that of middle- and high-income ones. Exorbitant out-of-pocket costs can deter patients from seeking preventative or therapeutic care and make households who cannot afford quality medical care poorer [8].

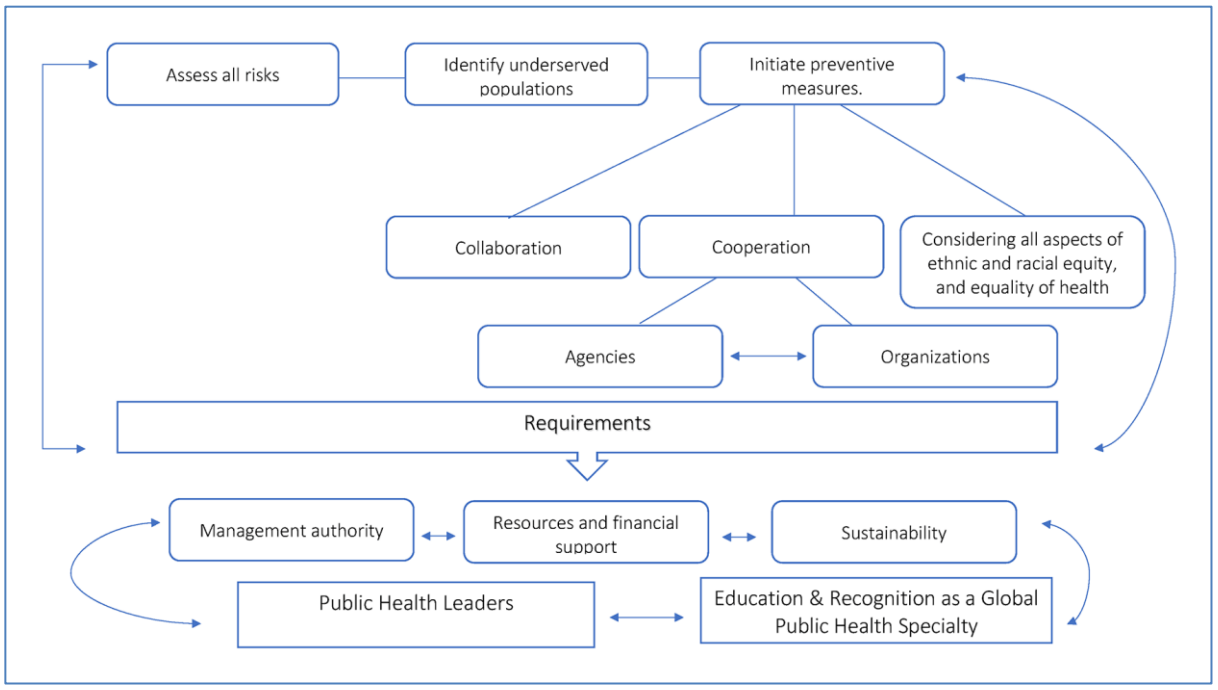

Figure 2: Global Health Management

The industrialised world outperforms the poor world in terms of health profile. When compared to other developing nations, Sri Lanka has one of the best health profiles; its life expectancy at birth (LEB), infant mortality rate (IMR), total fertility rate (TFR), and maternal mortality ratio (MMR) are all comparable to those of industrialised nations. The infant mortality rate in industrialised nations is one or two deaths per 1000 live births, while it is two or more in underdeveloped nations. Both high-income and low-income nations have some difficulties. Advanced economies and high-income nations deal with a number of problems brought on by an ageing population, falling fertility rates, and altered dietary and lifestyle choices. Two additional issues associated with an ageing population are the need for changes to the health care delivery system and the possibility of a faster growth in health care costs. Because childrearing tends to be tough for women in industrialised nations and they are more focused on their careers, fertility rates are decreasing. The diets and habits of individuals in wealthy nations have changed. Because of this, obesity has become recognised as a significant health issue that can result in a variety of chronic conditions over time, including diabetes, high blood pressure, and cardiovascular disease.

Inter-State Health Care Disparity In India

Even after 67 years of independence, India continues to rank among the world's sickest nations. Because potentialities are being inappropriately utilised regardless of their capacity, interstate

disparities in health care are growing. With 16% of the global population, India is responsible for 30% of newborn and child deaths worldwide. The nation's maternal mortality rate is much greater than its population proportion would indicate. The average Indian's life expectancy at birth is only 64 years old, which is almost 15 years less than what Western nations have already attained. Anaemia and calcium insufficiency affect about 50% of Indian women, leading to a high prevalence of morbidity. Malnutrition affects over half of Indian children under three at different levels.

This demonstrates India's dismal health characteristics. There is still a lot of interstate inequality and disparity in India when it comes to health outcomes, access to care, and the distribution of public health spending. The total health expenditure as a percentage of GDP is only about 4%, and the private health expenditure as a percentage of total health expenditure is about 75%. These figures can be considered as the biggest disaster for the Indian economy and a heavy burden on the impoverished citizens of the nation. While public spending varies greatly as a percentage of total expenditure, health spending as a percentage of total expenditure varies very little among the 14 major states. India has some of the lowest public health spending in the world, but some of the highest private health spending percentages. North-East India's healthcare facilities continue to differ from those in other parts of the nation [14]. Although it has great economic potential and is well-known for having an abundance of natural resources, North-East India is not expanding as quickly as anticipated. The states are economically backward because of their challenging topography and geographical circumstances [9]. The health results are not acceptable, even though North-East India is one of the special priority states and receives a 10% budget for family welfare and health. Compared to other Indian states, North-East India has the lowest average availability of health workers, such as the total number of government-employed allopathic physicians, registered nurses, and paramedics.

4. Results and discussion

The underprivileged have been compelled to seek unregulated private healthcare, which has had grave negative effects, due to the inadequate status of public health infrastructure. In particular, inadequate public expenditure has led to a deficient infrastructure for preventative healthcare. In addition, because it promotes stable work, increases productivity, and eases the transition of the population, access to preventative and protective health care increases the impoverished's entitlements. Additional investigation reveals that an adequate equalisation scheme and interstate differences in health spending guarantee an equitable allocation of resources throughout the states [10]. Efficiency and accountability shouldn't have to be sacrificed in the equalisation strategy that is chosen. States with large concentrations of poverty and low per capita incomes typically have very low per capita public spending on family welfare and health. It is clear that high out-of-pocket expenses are a result of low per capita spending in jurisdictions where poverty is more concentrated. Due to the highly regressive nature of out-of-pocket expenses, the poor have limited access to health care services. The per capita spending of the low-income states is significantly lower when they set aside a larger percentage of their GSDP for health expenditures.

5. Conclusion and future scope

The topic of the current study is global health management, namely addressing health inequities and disparities. The entire structure of our society is changing profoundly and intricately as a result of globalisation, which also brings new risks and opportunities. Furthermore, the consequences of globalisation are making us more concerned about our health, and sustainable development's emphasis on intergenerational justice compels us to consider future generations' rights to a healthy environment and a good existence. Systematic disparities in the health status of various demographic groups are

known as health inequalities. Both people and societies bear heavy social and financial consequences as a result of these disparities. There is a wealth of research indicating that a person's health is significantly influenced by social factors, such as education, employment status, income level, gender, and ethnicity. Every nation, regardless of income level, has significant differences in the health of various social groups. An individual's risk of bad health increases with decreasing socioeconomic status

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