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CURBING INDIVIDUALISM IN PUBLIC HEALTH

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‘Propagating individualism has always been a characteristic feature of a consumerist society’ | Photo Credit: Getty Images/iStockphoto

A failure to examine and interpret public health problems from a population perspective is leading to ineffective and unsustainable solutions as far as complex public health problems are concerned. This is obvious for problems such as undernutrition, for which individualist solutions such as micronutrient supplementation and food fortification have been proposed as solutions in lieu of sustainable approaches such as a strengthening of the Public Distribution System, supplementary nutrition programmes, and the health services. Similar is the case with chronic disease control, wherein early diagnosis and treatment is the most popular solution, with little scope for solutions that can modify health behaviours (through organised community action). There is a strong tendency in public health to prioritise individual-oriented interventions over societal oriented population-based approaches, also known as individualism in public health.

Two of the most recent public health programmes of the Government bear testimony to this: as a nationwide publicly-funded insurance scheme, the Pradhan Mantri Jan Arogya Yojana (PMJAY) falls under Ayushman Bharat. It is the largest health insurance scheme in the country covering hospitalisation expenses for a family for 5 lakh a year. The goal is to ensure ‘free’ curative care services for all kinds of hospitalisation services so that there is no financial burden to the beneficiary. What is not talked about in the entire scheme is the need for hospitalisation services per year for any population. Instead, every individual is given an assurance that if there is a need for hospitalisation expenses, the scheme will cover the expenses, highlighting the risk/probability of every individual facing hospitalisation in a year. This is an individualistic response to the problem of hospitalisation expenditure faced by populations. This becomes obvious when one examines the data on annual hospitalisation across populations.

Data from the National Sample Survey Organisation (75th round) show that on an average, only 3% of the total population in India had an episode of hospitalisation in a year (from 1% for Assam to 4% for Goa and 10% for Kerala — the need also a function of availability).

The proportion hovers around 3%-5% across most Indian States. Ideally, the Government needs to ensure health-care facilities to only 3%-5% of the population to cover all the hospitalisation needs of a population. This is population-based health-care planning. Instead, giving an

assurance to every individual without ensuring the necessary health-care services to the population is not really helping in a crisis. This was evident in an evaluation of publicly-funded insurance schemes, which points to the low proportion of population that benefited from the scheme annually. The assurance of a service remains an unfulfilled promise when more than 90% of those who were given the promise do not need hospitalisation in the near future. From an individualist perspective, any individual can be at risk for hospitalisation anytime but from a population perspective, one can confidently argue that each year, the maximum proportion of population in need of hospitalisation will be in the range of 5% of the total population.

The approach to vaccination for COVID-19 has been similar, wherein, unlike other vaccinations, it was evident that a COVID-19 vaccine cannot prevent people from getting the disease but only reduce hospitalisation and deaths in the event of contracting COVID-19. It was also evident that around 20% of the total COVID-19 positive cases needed medical attention, with around 5% needing hospitalisation and around 1%-2% needing intensive care (ICU) or ventilator support. To effectively manage COVID-19, what was needed was to have primary, secondary, and tertiary health-care facilities to manage the above proportion of cases.

This is what a population-based approach to epidemic would be focusing on. Instead, by focusing on a vaccination programme for the entire population, it is again an assurance and a promise to every individual that even if you get COVID-19, you will not need hospitalisation and not die. Even after the entire crisis, not much is talked about in terms of the grossly inadequate health-care infrastructure to ensure the necessary primary, secondary and tertiary care services for COVID-19 patients, in turn leading to many casualties.

Instead, the entire focus has been on the success story — that every individual is protected from hospitalisation and death achieved through vaccine coverage. Most of the deaths due to COVID-19 are a reflection of the failure to offer ventilator and ICU support services to the 1%-2% in desperate need of it. Curative care provisioning is never planned at an individual level as epidemiologically, every individual will not necessarily need curative care every time. The morbidity profile of a population across age groups is an important criterion used to plan the curative care needs of a population. There are large-scale data that points to this need and can be estimated across populations. What it means is that for population-level planning, the need of the population as a single unit needs to be considered.

There are at least three reasons for the dominance of individualism in public health. All these operate in combination and, hence, can be detrimental to public health practice. The first is the dominance of biomedical knowledge and philosophy in the field of public health with a misconception that what is done at an individual level, when done at a population level, becomes public health. This is despite the contrasting philosophy and approaches of clinical medicine and public health and the evidence that support the latter and must be based on population characteristics and economic resources. Related to this is the second aspect of ‘visibility’ of health impacts among the general public. Health effects are more visible and appear convincing at the individual level, wherein improvements at the population level will be clear only after population-level analysis; this needs a certain level of expertise and orientation about society — an important skill required for public health practitioners.

The public, and to a large extent, those public health experts who take individual experiences at face value, will make the same mistake of judging a population’s characteristics based on individual experiences; popularly known as atomistic fallacy in public health. Third, and the most important influence of all, is the market’s role and the effect of consumerism in public health practice. The beneficiaries for a programme become the maximum when 100% of the population is targeted. On the contrary, from a population perspective, the actual beneficiary will reduce to only 5%-10% in case of hospitalisation services and 20% of those affected with COVID-19 for

treatment needs. Instead of making efforts to supply evidence of the actual prevalence of public health problems, market forces would prefer to cast a wide net and cover 100% of beneficiaries. Propagating individualism has always been a characteristic feature of a consumerist society as every individual can then be a potential ‘customer’ in the face of risk and susceptibility. All forms of individualistic approaches in public health need to be resisted to safeguard its original principles of practice, viz. population, prevention, and social justice.

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