

Research Article

# Exploring Effective Approaches to Optimal Health

Shailla Cannie

Dean, Faculty of Nursing, Shri Mata Vaishno Devi University.

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## I N F O

**E-mail Id:**

shaillacannie@gmail.com

**Orcid Id:**

<https://orcid.org/0000-0002-3385-8252>

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## A B S T R A C T

India, today, faces the soi-disant “dual disease burden” as the quota of Non-Communicable Diseases (NCDs), better kenne as “lifestyle” disease; increases over the years along with a perpetuating ascend in communicable diseases. There is an impotent health-concrete regulatory environment guiding a moderate size and magnification of commercial health insurance with substantial potential causing a risk to the optimal health. The aim of the study is to outline the effective approaches to achieve optimal health. The reference is made from a selection of studies and reports that illustrated a variety of approaches to optimal health. The practical application sensitizes healthcare providers and others to identify each individual’s forward path towards improved health, even if it is not possible for them to procure a jeopardy-free status. In this way, the optimal health model aims to move each individual progressively in a more salubrious direction. If India wants to expedite its path to ecumenical healthcare and macrocosmic risk pooling coverage, it would require innovating in this regard as a matter of exigency.

**Keywords:** Optimal Health, Approach, Country, Models

## Introduction

Over the past few decenniums, there is an incrementing apperception that biomedical interventions alone cannot guarantee better health. Health is heavily influenced by factors outside the domain of the health sector, especially convivial, economic and political forces. These forces largely shape the circumstances in which people grow live, work and age as well. The systems have been put in place to deal with health needs of the people and ultimately lead to the inequities of health between and within countries.<sup>1</sup>

India, today, faces the soi-disant “dual disease burden” as the quota of Non-Communicable Diseases (NCDs), better kenne as “lifestyle” disease, increases over the years along with a perpetuating ascend in communicable diseases.<sup>2</sup> With the growing middle-class and working-age population,

there is incremented incidence of lifestyle diseases like diabetes and cardiac ailments. There is an impotent health-concrete regulatory environment guiding a moderate size and magnification of commercial health insurance with substantial potential causing a risk to the optimal health.

Around 200 countries of our planet have devised their own sets of provisions for meeting the three important fundamental goals of a health care system: keeping people salubrious, treating the sick, and assuring families against financial ruin from medical bills. Patient care perpetuates to be fragmented in India. A very little effort has been made to redesign the distribution of care or to promote patient-centred care. Likewise, health coverage models are fragmented, with patients given inhibited cull across packages.<sup>3</sup>

## Definition

Optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be facilitated through a combination of learning experiences that enhance awareness, increase motivation, and build skills and, most important, through the creation of opportunities that open access to environments that make positive health practices the easiest choice.<sup>4</sup>

Health, as the World Health Organization (WHO) defines, is the state of complete physical, social and mental well being and not just the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is considered as one of the fundamental rights of every human being.<sup>5</sup>

## Aim

The aim of the study is to outline the effective approaches to achieve optimal health.

## Method

The reference is made from a selection of studies and reports that illustrated a variety of approaches to optimal health.

## Five Approaches to Optimal Health

There are multiple challenges to this hyperbolicity of population which may not buy indemnification/prepayment products, poor products which return little value to beneficiaries, inconvenience to buy and use products, adverse cull, insurers risk cull, etc. The subsisting risk pooling platforms may accommodate as natural channels to magnetize out-of-pocket spending from the non-poor population.<sup>3</sup>

### Medical Approach

The medical approach aims to enable people to be liberated from medically defined disease and incapacitation, such as infectious diseases, cancer and heart disease. The approach involves medical interventions to obviate or ameliorate ill health. It is possible to utilize a persuasive paternalistic method, persuading for example of middle age people to be screened for high blood pressure. This approach values preventive medical procedures and the medical profession's responsibility to ascertain that patients comply with recommended procedures.

### Behavioural Change Approach

The behavioural change approach is predicated upon transmuting people's individual postures and deportments so that they adopt a healthy lifestyle. Examples include edifying people how to stop smoking, look after their teeth, virtual the "right food," and so on. In this approach it is argued that a salubrious lifestyle is in the best interest

of individuals and health professionals promoting this approach will optically discern it as their responsibility to embolden as many people as possible to adopt the salubrious lifestyle they advocate.

### Educational Approach

The aim of the edification approach is to provide individuals with knowledge, ascertain cognizance and understanding of health issues and to enable well-apprised decisions to be made. Information about health is presented, and people are availed to explore their values and postures and to make their own decisions. Avail in carrying out those decisions and adopting incipient health practices may withal be offered. The edifying approach emboldens individuals to make their own decisions and at the same time health professionals will visually perceive it as their responsibility to raise with clients the health issues which they cerebrate will be in the client's best fascinates.<sup>6</sup>

### Client Centred Approach

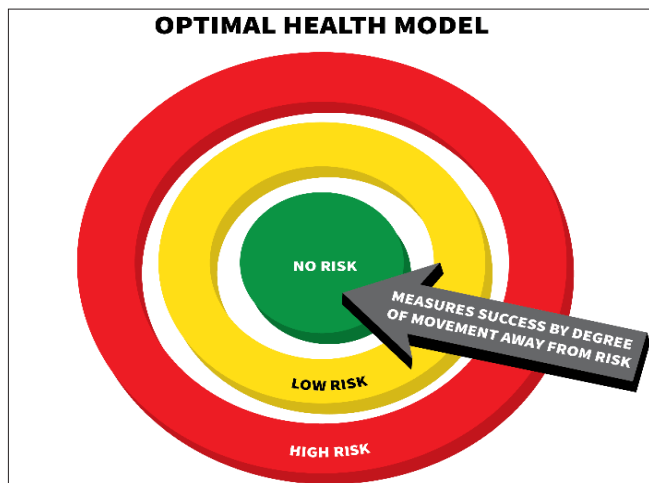
Within the client centred approach the health professional works with clients to avail them identify what they want to know about and take action on and make their own decisions and culls according to their own intrigues and values. The role of the health professional is to act as a facilitator. They avail people to identify their concerns and gain the cognizance and skills they require making changes transpire. The self-acknowledgement of the client is optically discerned as central. The clients are valued as equivalent. They have cognizance, skills and faculties to contribute, and they have an absolute right to control their own health destinies.<sup>6</sup>

### Societal Change Approach

Rather than transmuting the behaviour of individuals, the societal change approach modifies the physical and convivial environment in order to make it more conducive to good health. Those utilizing this avenue will value their democratic right to transmute society, and will be committed to putting health on the political agenda at all levels and to the consequentiality of shaping the health environment in lieu of shaping the individual lives of people who live in it.<sup>6</sup>

### Optimal Health Model

The optimal health model is a public health population approach, but it additionally provides a consequential lens for adaptation as a highly individualized element of individual-centred care. The practical application sensitizes healthcare providers and others to identify each individual's forward path towards improved health, even if it is not possible for them to procure a jeopardy-free status. In this way, the optimal health model aims to move each individual progressively in a more salubrious direction.<sup>7</sup>



The model is adaptable to a range of peril behaviour and diseases, and measures prosperity by the degree of mobility away from jeopardy. This aspirational public health model can avail transform the health conversation and promote optimal health for all. The optimal health framework acts as an intentional lens for individualized care. The model promotes the balance of physical, emotional, convivial, spiritual, and perspicacious health. In addition to that a fixate on inspiring individuals towards optimal health with changes that are concrete to their individual situation, but always quantifying prosperity by the degree of kineticism away from jeopardy.

## Distinct Models Used By Countries

### The Beveridge Model

This model is designated after William Beveridge, the daring gregarious reformer who designed Britain's National Health Services. This system of healthcare is financed by the governments through tax payments of its citizens just like the police force or the public library. Your taxes cover the cost of running the hospitals, so you don't have to worry about being billed for an injury, illness, or check-up. Besides all that, you don't have to worry about healthcare costs; you have to pay the same taxes as everyone else. The countries utilizing the Beveridge plan are Great Britain, Spain, most of Scandinavia and New Zealand include its birthplace. Hong Kong still follows its own Beveridge-style health care, because the populace simply relucted to give it up when the Chinese surmounted that former British colony in 1997. Cuba represents the extreme application of the Beveridge approach; it is probably the world's purest example of total regime control.

### The Bismarck Model

It is titled after the Prussian Chancellor Otto von Bismarck, who invented the welfare state as a component of the cumulation of Germany in the 19<sup>th</sup> century. The Bismarck model is found in Germany followed and practised by

France, Belgium, the Netherlands, Japan, Switzerland, and to a degree in Latin America as well. This system provides healthcare which would look fairly familiar to Americans in defiance of its European heritage. It utilizes an indemnification system the insurers are called sickness funds that customarily financed jointly by employers and employees through payroll deduction.

This model is more privatized and healthcare costs are customarily covered by yourself and your employer. Indemnification has to be offered to everyone and indemnification companies can't endeavour to make a profit. Hospitals are run by individuals in lieu of the regime, but since the regime still has a sizably voluminous verbally express in the industry, costs stay low. This model costs individuals more than the Beveridge model, but there's withal more liberation involved.

### The National Health Insurance Model

This system comprises both Beveridge and Bismarck elements. It utilizes private-sector providers, but payment emanates from a regime-run indemnification program that every denizen pays into. Since there's no desideratum for marketing, no financial motive to gainsay claims and no profit, these ecumenical indemnification programs incline to be more frugal and much simpler administratively than American-style for-profit indemnification.

The National Health Insurance model of healthcare has many privatized practices, like the Bismarck model, but it's paid for by the regime, like the Beveridge model. The good news is that the regime is conventionally able to keep costs low for patients, but the lamentable news is that they can prefer which medical procedures they would like to pay for. Additionally, individuals can culminate up waiting a long time to be treated. The classic National Health Insurance system was found in Canada, but some incipiently industrialized countries like Taiwan and South Korea have additionally adopted the National Health Insurance model.

### The Out-of-Pocket Model

An approximate of 40 developed industrialized countries of the world among 200 countries has established their own healthcare systems. Most of the nations on the planet are too impecunious and too disorganized to provide any kind of mass medical care. The rudimentary rule in such countries is that the affluent get medical care; the poor stay sick or die. Many countries follow this model. Fundamentally, everything is up to the individual. All healthcare practices are privatized and are sanctioned to charge however much they would relish, and the sick and injured are required to come up with enough funds to pay for the bill themselves. This system is good for people that are well-off and they can conventionally be optically discerned expeditiously. The poor, however, often have to go without medical care.<sup>8</sup>

In rural regions of Africa, India, China and South America, hundreds of millions of people go their whole lives without ever optically discerning a medico. High out-of-pocket spending (69% of total health expenditures) results in part from patient fees charged by private health care providers and, to some extent, public providers.<sup>9,10</sup> Under the National Health Mission, free care in public hospitals was elongated to certain accommodations: maternity, newborn, and infant care and disease control programmes.<sup>11</sup>

They may have access, though, to a village rejuvenator utilizing home-brewed remedies that may or not be efficacious against disease. In the poor world such as low- and middle-income countries or underdeveloped countries, the patients sometimes do not have enough money to pay their medico bill; it has been witnessed that in remote areas the people pay their medical bills in the form of potatoes or goat's milk in place of money or whatever else they may have they give for the treatment. If they retain nothing, they don't get medical care.

## Conclusion

The United States of America has settled numerous models for its citizens depending upon their economical status. This is much simpler, fairer and more frugal, additionally. It is the right time for India to explore further and plan new strategies for its citizens. If India wants to expedite its path to ecumenical healthcare and macrocosmic risk pooling coverage, it would require innovation in this regard as a matter of exigency.

**Conflicts of Interest:** None

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