[64] Spears, R., & Postmes, T. (2015). Group identity, social influence, and collective action online. In S. S. Sundam (Ed.), The handbook of the psychology of communication technology (pp. 23–46). Oxford: John Wiley & Sons.

[65] Bae, M. (2016). The effects of anonymity on computer-mediated communication: The case of independent versus interdependent self-construal influence. Computers in Human Behavior, 55, Part A, 300–309. doi:10.1016/j.chb.2015.09.026

[66] Christie, C., & Dill, E. (2016). Evaluating peers in cyberspace: The impact of anonymity. Computers in Human Behavior, 55, 292–299.

[67] Suler, J. (2004). The online disinhibition effect. Cyberpsychology & Behavior, 7(3), 321–326.

[68] Joinson, A. N. (2007). Disinhibition and the internet. In J. Gackenbach (Ed.), Psychology and the internet: Intrapersonal, interpersonal, and transpersonal implications (pp. 75–92). Boston, MA: Elsevier Academic Press.

Health Care Sector in Kerala: An Overview

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Health is wealth because of its multifaceted benefits which have a far reaching effect on our lives. Healthy people compose a better society. Health is a productive asset that influences economic development significantly. Many factors influence health status and a country's ability to provide quality health services for its people. Democracy has historically played a little role in driving global health. But new research shows that democracy is becoming more important as the health needs of the low and middle income nations shift from infectious diseases to non -communicable diseases. Between 1980 and 2016 the democratic experience of a nation was more responsible for reduction in mortality from cardiovascular diseases, transportation injuries, cancers and most other non- communicable diseases. The opposite is true for HIV, diarrhoeal diseases and most other communicable diseases where democracy matters little.

Democracy improves health directly because democratic governments are more protective of media freedom and the sharing of health information, more open to feedback from constituents and interests groups and more willing to use feedback to improve the quality of government health care services.

In India health care is managed at the state level. Over the last six decades, the Indian states have had

varying levels of success in health outcomes. Notably Kerala has consistently been a prominent outlier with better health outcomes in a number of areas compared to most states in India. The tradition of government support for health development has been a catalyst for the advancement of health care in the state. The health care system is considered to be the principal factor for attaining the high level of health status in Kerala. In many respects Kerala's health status is almost on a par with that of other developed economies. Kerala's achievements in health have already been acclaimed all over the world and several international agencies has described Kerala model of health as 'good health at low cost based on social justice and equity'. There are many socio economic conditions unique to Kerala which have been postulated to make this health model possible.

In 2011, Kerala attained the highest Human Development Index of all Indian states based on its performance in key measures.

- Lower infant mortality rate of 12 per 1000 live births in Kerala vs. 40 per 1000 live births in India.
- Lower maternal mortality ratio of 66 per100,000 live births in Kerala vs.178 per100,000 live births in India,
- Higher literacy among both males at 96% in Kerala vs.82% in India and females with 92% in Kerala vs. 65% in India.

The health gains made in Kerala can be attributed to several factors including strong emphasis from the state government on public health and primary health care (PHC), health infrastructure, decentralised governance,

financial planning, girl's education community participation and a willingness to improve systems in response to identified gaps.

The spread of education exemplified by the high literacy rate and the health care system are believed to have contributed to the low infant mortality rate. Dr Thankappan of the AMCHHSS illustrates this by saying, "The spread of education has obviously heightened people's health consciousness which explains why 95% of pregnant women get antenatal care and 92% of deliveries are institutional. Similarly the immunisation coverage of children between 12 and 24 months (diphtheria/pertussis/tetanus89% oral polio vaccine 89%, measles77%,BCG 95%) is among the highest in the world". All over, the world indices such as infant mortality have shown an inverse relationship with female literacy.

The state still has the highest overall life expectancy at birth, at 74.9 years for men and 77.8 for women according to the Sample Registration System (SRS) Sep.3, 2019. The reason for the better statistics in life expectancy is the better investment that successive governments have made in public health and education. Moreover there is an increased awareness of the literate people of the state in matters of hygiene, vaccinations, nutritious food and the professional medical help undergone when required along with easy access to primary health. The effective implementation of the public distribution of food through fair priced ration shops played an important role in improving nutritional status.

The universally available public system in Kerala has also contributed to the high health status of the people. A three-tier system of self-governance was established, comprised of 900 villages (panchayats), 152 blocks, and 14 districts . The current Primary Health Care system consists of sub-centers, primary health centers (PHC) that support five to six sub-centers and serve a village, and community health centers(CHC). The sub-centers serve the smallest population and do not have inpatient capacity, while PHC facilities serve about 26,000 citizens and provide maternity services and limited inpatient services, and CHCs provide care to approximately 230,000 individuals. In 2012, there were 23,940 PHC centers in Kerala

Under the new system, the PHC centers and their referring sub-centers were brought under the jurisdiction of villages in order to engage more closely with the community to identify and implement effective changes to respond to local health needs and encourage the use of PHC centers and sub-centers as the first point of care . Communities were brought together to determine which health topics were important and needed attention, with selected topics ranging from strengthening PHC facilities to improving water and sanitation safety . This decentralization resulted in physicians and community members working together and many facilities undergoing significant renovations to address community priorities. As another component of the new system, individuals, especially in lower socioeconomic groups, were encouraged to utilize public health centers. Particularly in villages with strong panchayat governance, there have been

improvements in access to medications and health outcomes, as well as increased patient utilization of care at PHC centres. Kerala has also continued to innovate to meet the needs of more vulnerable populations including establishing a Weekly Iron and Folic acid Supplementation (WIFS) Program and Adolescent Friendly Health Clinics (AFHCs) to benefit adolescent health .

Kerala had long ago recognised the importance of palliative care as can be seen from the growth of community-based care units. . Kerala has also extended the definition of palliative care to include the long term chronically ill and even the mentally incapacitated. Health professionals having expertise in palliative care extend their services by offering specialised out patient service and domestic care to the needy chronic patients. . The volunteers in these units after training provide psychological, social and spiritual support.

Kerala's formal palliative care policy, is the only state with such a policy, the community-based Neighbourhood Network in Palliative Care (NNPC) project that employs an army of volunteers and the government funding for these local community based care units Kerala's palliative care network contains over 100 units. Palliative care initiatives in Kerala can broadly be categorised into five sections. The first segment functions under the monitoring of government agencies as well as local self government institutions, and this official initiative makes use of ASHA (Accredited Social Health Activist) workers. National Rural Health Mission

(NRHM) serves as the co-ordinator for this. Another major stream is run by registered charitable trusts, and this is the forerunner in the state with grass-root level initiatives in North Malabar regions through 'neighbourhood network groups'. These community based organisations (CBOs) are purely volunteer driven.

In recent times, political and religious organisations also play a dominant role in this initiative. The third category is in association with hospitals and under the supervision of health care professionals. The chronic and incurable patients are provided with separate facilities and adequate emotional as well as mental support is offered to them. The service of counsellors and psychologists are also provided to equip them to face the inevitable. Institute of Palliative Medicine located in Kozhikode is the beginner in this stream. Specialised home care initiative for supporting the bedridden patients is the fourth segment of the palliative initiative. Here besides a staff nurse, volunteers and field staff will also be included. Student volunteers also extend their service to this team. The fifth section is the patient- outpatient (IP-OP) care by utilising the existing facilities in hospitals. The care system is also funded largely through local micro-donations of as little as Rs 10 per month.

The inherent vibrancy and resilience of the Kerala health system was evident during the major challenges the state faced during the Ockhi cyclone in 2017 and the unexpected floods in 2018. There were very few incidents of waterborne and vector borne disease during Ockhi cyclone and the floods. A few deaths took place owing to rat fever. Two episodes of Nipah virus epidemics hit the state during 2018 and 2019. Within no time the health

department tackled it with commendable courage. The efficiency with which Kerala managed to control Nipah epidemic that affected the state within the shot span of six months had been widely acclaimed all over the world.

Given in this context, Kerala's response to Covid-19 has been remarkable. Kerala has been publishing daily updates about quarantine tests and hospitalisation. With strict travel restrictions and other measures in place, daily hospitalisation of suspected cases have shrunk considerably in Kerala and the number of patients daily discharged after a negative report and subsided symptoms outnumber the former consistently. Timely dissemination of surveillance data was an effective way in which the government of Kerala managed to keep panic under check and gain the confidence of the community.

Despite these health improvements, Kerala's PHC system is facing a number of challenges. The epidemiological transition towards chronic disease , erosion of public health funding, and the continued presence of private health care at much higher cost have pushed the health system to its limits. The rise of non-communicable diseases like obesity, cancer and CVD in the state has also challenged the healthcare system. Overall, Kerala has made significant strides through investing in infrastructure, decentralized governance, and community engagement. . Kerala's collaborative work across public and private sectors, interdisciplinary coordination and cooperation across all levels of government has set the bench mark for all stakeholders to adhere to in the future as well.

Conclusion

Democratic institutions and practices can affect human development in multiple ways including population health and wellbeing. The democratic decentralized health care system in the state thus helps to increase the levels of equality in health. Though many challenges remain, the rectification of short comings can make the health services function more effectively delivering better health system performance and outcomes.

Bibliography

Chacko Anooja," Palliative Care Movement in Kerala: A Historic Overview (2017) ,6-7.

Deepesh Vendoti, "Lessons from Kerala's Bold Fight with Nipah", Health Express (2018).

Dr.B. Ekbal, " Kerala Marches Forward in Health" People Democracy,2019; (XLIII):28.

Dr.B. Ekbal, "Kerala Model of Health": From Success to Crisis. 2020; The New Indian Express.

Elamon J, Franke RW, Ekbal B. Decentralization of health services: the Kerala People's Campaign. Int J Health Serv. 2004;34(4):681-708.

Government of India Planning Commission. Twelfth Five Year Plan 2012-17. Available from: http://www.planningcommission.nic.in/plans/planrel/fiveyr/welcome.html

Government of India. Rural Health Statistics in Rural India 2012. Statistics Division Ministry of Health and Family Welfare, 2012.

Government of Kerala, Department of Economics And Statistics, Gender Statistics 2017-2018.

Government of Kerala. Health Policy Kerala. 2013.

Khosla D, Patel FD, Sharma SC. Palliative care in India: current progress and future needs. Indian J Palliat Care. 2012;18(3):149-54.

Kutty VR. Historical analysis of the development of health care facilities in Kerala State, India. Health Policy Plan. 2000;15(1):103-9.

Levesque JF, Haddad S, Narayana D, Fournier P. Outpatient care utilization in urban Kerala, India. Health Policy Plan. 2006;21(4):289-301.

Nabae K. The Health Care System in Kerala-Its Past Accomplishments and New Challenges Journal of the National Institute of Public Health. 2003;52(2).

Nair VM, Thankappan KR, Vasan RS, Sarma PS. Community utilisation of subcentres in primary

health care--an analysis of determinants in Kerala. Indian J Public Health. 2004;48(1):17-20.

Oommen CK,"How an Indian State Successfully Fought And Contained the Deadly Coronavirus.

Thomas J Bollyky, "Demoracy matters in Global Health " Council on Foreign Relations.2019.

Varatharajan D, Thankappan R, Jayapalan S. Assessing the performance of primary health centres under decentralized government in Kerala, India. Health Policy Plan. 2004;19(1):41-51.