

Evaluating the health paradigm in terms of the Prevention-focused
Approach and community-based health services

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Assessment 2

Introduction

The health paradigm is changing day by day, especially after COVID19, and this is likely to have changed significantly. The health care required there is also changing, and we will critically evaluate the adequacy of recent policies on health care. In particular, it will assess current health care policies and consider the health paradigm in terms of how to introduce health care to rural and regional communities and the problems that arise in introducing health care. Also, among others, the Prevention-focused Approach and community-based health services appear to be necessary to provide health care services to all. These perspectives will therefore be the focus of a critical assessment of the current health paradigm.

The Prevention-focused Approach and community-based health services

One perspective of the health paradigm is the Prevention-focused Approach. In

particular, vaccinations are considered necessary to prevent the transmission and spread of diseases. Given the need for vaccinations to be carried out by the masses, it is considered necessary to consider the health awareness and health literacy of each and every individual. According to Benn, C. S. *et al* (2020, p. 2), in the current vaccine paradigm, it is usually assumed that vaccines only protect against targeted infections, that effective vaccines reduce mortality, and that vaccine efficacy is similar in boys and girls. Also, a vaccine paradigm has developed in which vaccines are 'biological agents that improve immunity to a specific disease'. However, vaccines are usually only assessed for their preventive effect against the target disease, not for their effect on susceptibility to infection or mortality (Benn, C. S., 2020). In addition, exposure to vaccine misinformation is thought to increase perceptions of vaccine risks, resulting in more negative attitudes towards vaccination (Jolley, & Douglas, 2014; Nan & Madden, 2012). Also, there is uncertainty and disagreement about safety and efficacy, such as vaccines causing disease or vaccine components causing side effects (Guidry, Carlyle, Messner, & Jin, 2015). These make it difficult to assert that vaccines are necessarily safe, and even if vaccines are proven to be safe, it is difficult to provide correct information to all. While these are the current status of vaccines, the following vaccine policies can be found around the world. In 2000, the Vaccine Alliance Gavi (previously the Global Alliance for Vaccines and Immunisation) was established in response to the stagnant immunisation coverage seen in developing countries in the 1990s (Jaupart, P. *et al*, 2019). This is a global public-private partnership aimed at improving access to vaccines for children living in the world's poorest countries (Jaupart, P. *et al*, 2019). According to Albrecht, D. (2022), people living in poverty often live in crowded and unsanitary conditions that are conducive to the spread of disease, and they are more likely to have underlying medical

conditions and often have inadequate medical care. Therefore, increasing immunisation coverage in developing and poor countries can be considered necessary to prevent disease and provide adequate health care. However, in high poverty areas, language barriers and lack of trust in health experts are thought to be among the reasons for low immunisation coverage (Albrecht, D., 2022). Also, in Ghana, an association between parental education levels and vaccine and polio vaccination schedules has also been found (Ali, H. A. *et al.*, 2022). Elsewhere, in India, it has been found that improving the education of mothers and fathers leads to predominantly higher child immunisation coverage (Ali, H. A. *et al.*, 2022). Accordingly, language barriers and lack of trust in health experts may be reasons for low immunisation coverage in developing countries and poor areas. Therefore, we can argue that these can be rooted in a low level of education.

In terms of community-based health services, an example of community health is district nursing. According to Midlov, E. M. *et al* (2020), as more people need palliative care at home in recent years, more advanced medical activities need to be carried out at home. In some countries, the possibilities of receiving palliative care at home have increased (Midlov, E. M. *et al*, 2020). However, district nurses have significant responsibilities in home care, including activities for all types of patients, from preventive to palliative care, and require both medical knowledge and psychosocial competence to meet the needs of patients and their relatives (Midlov, E. M. *et al*, 2020). According to Scott, K. *et al.* (2018), community-based health worker (CHW) programmes are undergoing a resurgence to enable universal health care. The programme has been introduced in many low- and middle-income countries over the last decade, with paid or volunteer health workers with less than two years' training providing community-based health services (Scott, K. *et al.*, 2018). However, language barriers and lack of trust in health experts are

common in low- and middle-income countries. Therefore, it is possible that services may be provided against the will of people in poor and developing countries. Furthermore, although health services can be provided to a larger number of people by using volunteers instead of medical professionals, their medical knowledge cannot be sufficient. Consequently, we can argue that it is not always possible to provide health services that are tailored to each and every person.

In order to enable more patients to access health services, telehealth is being recognized as a way. Telehealth has the potential to both reduce health inequalities and increase health inequalities due to digital exclusion within certain groups (Eddison, N. *et al.*, 2022). According to Snoswell *et al.* (2021, p. 659), ‘telehealth is recognised as an effective tool to increase access for individuals with transport difficulties or those living in rural and remote areas’. However, according to Mackert, M. *et al.* (2016), people with low health literacy were also less likely to use digital health tools or to find them easy to use. Therefore, we can argue that it is considered necessary not only to introduce telehealth in the community, but also to inform and educate about health literacy at the same time. In addition, approximately 50% of clinicians state that patients' physical symptoms, such as gait disturbance, cannot be seen over the phone (Bera, R. *et al.*, 2022). Even though telehealth is recognized as a consultation method for individuals with transport difficulties or those living in rural and remote areas, patients with physical symptoms who would need to be seen through telehealth cannot receive appropriate treatment. Also, according to Chen, J. *et al.* (2021), the likelihood of adopting telemedicine and the number of telemedicine services adopted were significantly lower in rural and micro-regional hospitals than in metropolitan hospitals. As a result, patients with physical symptoms are not able to go to hospital or receive medical attention via telehealth, which is considered

to be a lack of consideration. According to Bera, R. *et al.* (2022), further training and developing a skilled workforce of clinicians with the skills required for telehealth services is important for the long-term sustainability of telemedicine services. However, based on what has been done so far, it seems that a quality workforce alone is not sufficient to deliver health services to rural and local communities and provide health services to all. We can argue that public transport and the search for other methods of telehealth as well as video calls should be given higher priority.

In terms of mental health, according to Moroz, N. *et al.* (2020), community-based mental health delivery can reduce wait times and increase access to mental health services by coordinating care. Also, Zhu, Y. *et al.* (2020) states that the reform and development of community-based health services has established a model of hospital-community integration. By the end of 2016, more than 5 million people with severe mental disorders were registered with community-based mental health services (Zhu, Y. *et al.* 2020). In addition, inclusion of health professional services in the health insurance system would enable community care providers to provide early intervention and facilitate access to care for the majority of people with mild to moderate mental illness (Moroz, N. *et al.* 2020). However, only 23% of family doctors say they are adequately prepared for serious mental health problems even though 80% of Canadians already entrust their mental health needs to their family doctor (Moroz, N. *et al.* 2020). This may place a heavy burden on family doctors, making it difficult for them to see each patient. Also, despite the rapid development of mental health services in recent years, resources remain concentrated in affluent areas and are mostly allocated to patients with severe mental health disorders (Zhu, Y. *et al.* 2020). Studies also show that utilization of community-based mental health services is not high enough. These factors suggest that community-based mental health

services in the local community are not widespread and are problematic as they only increase the burden on family doctors. Other reasons for the lack of uptake of community-based mental health systems include the following. According to Zhu, Y. *et al.* (2020), lack of knowledge and stigma surrounding mental illness is believed to make people reluctant to seek mental health service resources. Therefore, it is considered necessary not only to improve community-based mental health services but also to reduce stigma and provide education on mental illness, and which can be assumed that this may improve the uptake of community-based mental health services. In terms of education, recent federal (United States Congress, 2015) and state legislation (Legislature, 2019) has focused on the promise of schools as a locus of mental health support for youth. Duong, M. T. *et al.* (2020) also cites claims that schools are ‘de facto’ mental health service systems for children and adolescents. According to Ojio, Y. *et al.* (2015), The School Health Act of the Japanese Government requires all primary and secondary schools to employ one or two full-time health teachers, depending on the number of students. It is considered a positive aspect that the trend towards the importance of health education in schools provides educational opportunities for all. On the other hand, we can argue that it is difficult to provide education that is tailored to each individual.

Conclusion

One health paradigm is the Prevention-focused Approach. In particular, programmes to promote immunization in developing countries are taking place due to the lack of health services in developing countries and poor areas. It is believed that not only the lack of health services in developing countries and poor areas, but also the low level of parental education is linked to low immunization coverage. Therefore, it is considered necessary

not only to improve health services but also to improve the educational environment, including health literacy. Also, in recent years, the demand for district nurses has increased due to the growing number of palliative care services provided at home. To supplement district nurses, paid or volunteer health workers are therefore providing community-based health services. However, they often lack sufficient medical knowledge and psychosocial competence and do not always seem to complete their responsibilities in providing home-based care. Furthermore, telehealth is also becoming established as one way to support community healthcare. However, it can be difficult to see patients with physical symptoms on video calls, and patients with physical injuries that make it difficult for them to travel to the local hospital. Therefore, it is considered necessary to develop not only a quality workforce but also a local public transport system and to explore other telehealth consultation methods other than videophone. In terms of mental health, possible problems include the high burden on family doctors compared to the number of patients and the fact that mental health services are less prevalent in local communities than in urban areas. Many people also do not have positive attitudes towards mental health service resources due to lack of knowledge and stigma. Regarding health education, although schools are considered as a locus of mental health support for youth, the inability to provide health education that is individualized for each student is a problem.

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