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Civilization based health Care

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Abstract

Public health has been described as the art of preventing diseases and also comes under the society based and health medicine. Now a day in modern civilization people is having their own interest towards their health which is important to every fellow human being to overcome the health issues occurred in our day by day daily life. The civilization is common for every gender, some of the countries were failed to test the civilization with respect to ferocious behaviour towards the public. Mainly this failure occurs because of the age limitations and the gender variations. In most of the civilized countries boxing is banned because if the prevention of the injuries and other health issues like Concussion, Facial injuries: cuts, broken bones in the nose, Wrist sprain, etc. for their people. Not only boxing some games were also been as injured games but compared to them boxing is most effected game. As we discussed before about age limitations it is because of the immune power of the particular ages and not only the particular genders it varies depends on their diet, for example in ancient times the injuries were treated in natural process with medicinal leaves and roots which improves the immune power and also there diet is so good but now a days we treat ourselves with antibiotics injections etc. which where contract pneumonia added natural flavours for the particular antibiotics and body become resistant and improves immune power not as much as the original therapy because of the now days diet and all.

Keywords: Health care; Civilization

Introduction

The health based civilization is not only for the particular diseases or particular health issues; it comes under the every health issue and every health problems and diseases [**1**]. Now a days population is becoming more the government should also take the preventions accordingly because if the world is suffering with the deadly diseases the number of patients were more and the hospital beds were less it is purely showing the civilization in health centre is not working properly so we should also concentrate with the particular issues and take the safety measures and precautions accordingly. To promote the health civilization we should conduct the health programs though the people were more interested towards their health but also we should conduct the programs because the non-educated and some small villages can't reach the exact precautions were taken to prevent the health diseases and prevention methods because of 34% of the illiterate population in the world. There are some advantages of the health civilization it increases the access to the health centres and improved quality in treatment and focus on prevention and also reduced need of primary care. The disadvantages of health care civilization is universal health care may lead to the economic costs to the financially unhealthy nation so to overcome this we can provide good health care for all particular citizens and also it is good for nation economy. Thus we are about say that the health civilization is important for every citizen in the world and also there are advantages and disadvantages in this health civilization [**2-5**].

Discussion

Developing countries such as Mexico are undergoing an epidemiological transition, during which the burden of disease is high because of non communicable diseases (NCDs). Today, type 2 diabetes mellitus (T2DM) is the leading cause of healthy life years lost and the second leading cause of death in Mexico, preceded only by heart diseases. Moreover, it has been reported that the prevalence of high blood pressure is greater among obese adults and people with T2DM. Currently, according to the International Diabetes Federation, the prevalence of T2DM in Mexico is 14.8%, and the National Health and Nutrition Survey (ENSANUT, by its initials in Spanish) indicates a prevalence of 9.2% in the rural population in 2016. Furthermore, is well known that hypertension is the most important risk factor for cardiovascular disease and its prevalence is 31% among Mexican adults and 24.9% in the rural population. The ENSANUT has shown that the proportion of people unaware of having T2DM or hypertension is 5% and 47.3%, respectively.

NCDs are generally of long duration and slow progression. Worldwide, these are an important source of inequalities in mortality and life expectancy. These inequalities can be present in screening, diagnosis, and treatment of NCDs. Furthermore, financial and physical access, health-care use and quality, individual and community characteristics are among the factors that may lead to them.10 However, within the country, disparities can be found depending on the region [**6**].

A leading cause to inequalities in detection, diagnosis, and treatment of NCDs is having a fragmented health-care system; a common feature in many countries in the Americas. In Mexico, the health-care system is tripartite, divided into public, social insurance, and private health services. Social security and public health care are segmented; public health-care services comprise a complex net of diverse institutions disintegrated to social insurance. In contrast, the private health-care sector consists of private insurance providers, private practices, and hospitals.

The main social security institution is the Instituto Mexicano del

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Seguro Social (IMSS; Mexican Institute of Social Security), offering services to 80% of the population entitled to social security. The second-largest provider is Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE; Institute for Security and Social Services for State Workers)13,15 On the other hand, the Ministry of Health (SSa by its initials in Spanish) provides health-care services to the population without social security; health-care service was provided on a public assistance basis. However, in 2003, a health-care reform established a new system of health protection: Seguro Popular (popular health insurance), which focused on covering around 50 million people without any public insurance scheme.15 This scheme started in 2004, although it was not until 2005 that it came into action as a countrywide program, providing health care to workers in the informal sector, the unemployed, and their families.13,15 In 2006, a considerable proportion of people with T2DM were most likely not receiving clinical supervision, as 41.8% were uninsured.

The number of people insured increased largely with Seguro Popular affiliation, and nowadays this scheme is positioned as the second principal health-care provider, only behind IMSS.The majority of the Mexican population is covered by some health-care scheme; 86% in 2016 according to the Mexican government report of 2017–2018.19 However, this does not imply that the services offered are effectively used, as it is essential to consider the quality, access, and information regarding health-care services among different populations. Moreover, disparities regarding the availability of health services have been reported in some states of Mexico **[7-9].**

The global urban–rural divide has disparities among settings, leading to uneven opportunities and social exclusion.Today, only a minority of the population lives in rural areas. However, in Mexico, most indigenous populations, handicraftsman workers, one-third of adults aged 60 or older, and other vulnerable groups live in rural communities, which include almost 20% of the total population **[10].**

Conclusion

In general, the health services were undersupplied and suffered from a lack of effective and adequate human resources. Lack of medicine was a significant barrier to treatment adherence; short supply caused people to purchase their medicines, which posed an economic burden to many people through out-of-pocket expenditures. Moreover, among indigenous populations, the main barrier to health-care access was language, in that health-care personnel often cannot speak indigenous languages and the health-care users often cannot speak Spanish. Conversely, family and community support was a positive aspect that facilitated access to health care and treatment adherence.

This study provided important information in that it demonstrated that disparities do not only exist among urban and rural populations; indigenous populations are also regularly subject to inequalities in health care. As noted, while access to health-care coverage has improved, the number of skilled health professionals who practice in rural areas must be increased. Moreover, these professionals require further training to prepare them to serve indigenous populations better. In particular, the language barrier deserves special attention to reduce inequalities in health and to guarantee effective care for all; actions toward increasing the number of health professionals coming from the indigenous populations and incentives for them to remain in local areas should be prioritized.

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Conflict of Interest

Author declares there is no conflict of interest.

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