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# Public health and quality of life in developing economies: A conceptual review

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**Abstract**
The study examined public health and quality of life in developing economies. Public health improves the quality of life of people through prevention and treatment of diseases. The paper examined the health aids in developing countries; and ascertained the sustainable development goals on public health. The study also examined public health programmes in a developing country; and assessed public health code of ethics. A previous work on public health for a developing economy was reviewed and thereby obtained public health situation for developing economies. The study relied on secondary source of information and therefore focused on conceptual exploration, and critical analyses of a previous study. This study affirmed that public health practitioners and organisations have an ethical responsibility to promote public health and wellbeing. And therefore, proposed that public health organisations should strive to conduct and disseminate health assessment focused on population health status and issues facing the community.

**Keywords:** Disease control, Health aids, Health assessment, Health ethics public health, Quality of life

## Introduction
Public health is seen as the art of sustaining life by preventing diseases and improving the quality of life through informed choices of society, organisations: Public and private, individuals and communities by organized efforts. Public health is the science that protects and improves the health of people and their communities. Thus, public health is achieved through research on diseases, promoting healthy lifestyles, injury prevention, and preventing, detecting, and responding to infectious diseases. Thus, public health focused on protecting the health of an entire population which could be a neighbourhood, a country or a particular region of the world. Professionals in public health try to prevent problems from happening or recurring through conducting research, administering services, recommending policies and implementing educational programmes (www.cdcfoundation.org) [16]. The aim of public health is to assess the determinants of health of a population and its threat. The concept of health covers the physical, psychological and social well – being of a population or society. Public health is an interdisciplinary field which involves epidemiology, social sciences, biostatistics and management of health services. The following are the subfields of public health: community health, health economics, environmental health, public policy, health education, occupational safety, gender issues in health, sexual and reproductive health, and disability (Perdiguero, 2001) [9]. The aim of public health is to improve the quality of life of people in a community through prevention and treatment of diseases. This is conducted through surveillance of cases and promotion of healthy behaviours. The public health approaches include promotion of breastfeeding, hand washing, suicide prevention, obesity education, smoking cessation, delivery of vaccinations, increasing healthcare accessibility, distribution of condoms to control the spread of sexually transmitted disease (WHO). In developing countries access to health care and public health initiatives are difficult challenges. The infrastructures for public health are not available. Consequently, public health helps in disease prevention in the developing and developed countries through local health facilities and non-governmental organisations. The government of most countries set up their own public health agency known as the ministry of health and it is responsible for domestic health issues. The World Health Organization (WHO) is the international agency that responds on global public health issues.

## Conceptual review
### Health care in developing countries
A great disparity in access to health care and public health initiatives exists between developed countries and developing countries, as well as within developing countries. Public health infrastructures are yet to be established in developing countries: They lack trained health workers, monetary resources, sufficient knowledge to provide even a basic level of medical care and disease prevention (Chem, *et al*, 2006; Jamison & Mosley, 1991) [2, 5]. Consequently, diseases and mortality rate increase in developing countries which results to extreme poverty.

Some developing nations are plagued by largely preventable or treatable infectious diseases. Similarly, many developing countries are experiencing more of the effects of chronic diseases; with, the poorer communities being heavily affected by both chronic and infectious diseases (Jamison & Mosley, 1991) [5]. Thus, the public health problems in developing countries include poor maternal and child health, malnutrition and poverty. A lack of exclusive breastfeeding during the first six months of life of a child contributes largely to avoidable child deaths each year. Irregular preventive therapy for treating and preventing malaria episodes among young children and pregnant women is one public health measure in endemic countries.

Addressing determinants of health across a population is the concern of modern public health. It has been recognised that health is affected by factors which is knew as social determinants of health: Environment, genetics, income, educational status and social relationships. The upstream drivers such as environment, education, employment, income, food security, housing, social inclusion etc, affect the distribution of health between and within populations and are often shaped by policy (WHO, 2010) [15]. Concerning the spread of diseases due to globalization and the HIV/AIDS epidemic in sub-Saharan Africa; there has been a significant increase in health aid to developing countries after World War II (Twumasi, 1981; Asim & Bruno, 2013) [11, 1]. From 1990 – 2010, total health aid from developed countries to developing countries increased from 5.5 billion to 26.87 billion. Some wealthy countries have continuously donating billions of dollars every year, with the goal of improving population health (Asim & Bruno, 2013) [1]. However, between 2000 and 2010, HIV received over $6 billion which was more than the increase that was seen in any other sector during those years (Eran & Jay, 2014) [3]. Health aid has increased through multiple channels including private philanthropy, bilateral donors, non-governmental organizations, private foundations such as the Bill & Melinda Gates Foundation, and multilateral donors such as the World Bank or UNICEF (Asim & Bruno, 2013) [1]. Recently, health aid was channeled towards initiatives such as financing antiretroviral medication, insecticide-treated mosquito nets, and new vaccines. The positive outcomes of these initiatives can be seen in the eradication of smallpox and polio.

**Public health programmes in developing countries**

Non-Communicable Diseases (NCDs) rises globally and have reached epidemic proportions according to World Health Organization, 2014. Overall mortality due to NCDs was 60%. The disease specific share was as follows: Cancers-7%, Diabetes-2%, Cardiovascular Diseases-26%, COPD-13%, Other NCDs-12%. With large number of diabetic patients in India, there is also a mounting problem of Impaired Glucose Tolerance (IGT). Around 35% of IGT sufferers go on to develop type-2 diabetes (Verma, Khanna & Bharti, 2014). Immunisation, being one of the cost effective interventions for disease prevention; however, the success of the Universal Immunisation Program is constrained by implementational issues like poor cold chain management and injection safety, non-uniform coverage, high dropouts, poor monitoring and surveillance. Health education focuses on only knowledge-based interventions, neglecting felt needs and ground reality and does not reach the remote corners and vulnerable sections in India. Quality of training is doubtful, training of health educators is not regularly done. The involvement of the NGO s as a public-private-partnership provides hands-on technical support to the field staff is a commendable strategy but if without the supervision -vision of medical college teachers, could result in poor training: performance mostly proving counter-productive (Mohapatra, Mohapatra & Mohapatra, 2016) [7].

Family planning programme in developing countries: some women lack access to contraceptives: thus, many women have unmet need of contraception due to inability to get contraceptives and family planning services or information. Few women in Sub-Saharan Africa and South Asia use modern contraceptives. (www.gatesfoundation.org) [17]. Social norms, illiteracy, traditional social attitudes, and patriarchal structure of society constitute main hindrance to the successful implementation of the family planning programme in the developing world, where women are not allowed to take decisions on family planning. Some governments who lack the initiative have failed to provide basic infrastructure to tackle the hindrances or to facilitate public-private partnership to run family planning programmes. The reasons for the unmet need for family planning are fear of side effects, opposition of family planning by family members, limited knowledge about methods, poor involvement of males, reliance on breast feeding and poor health system delivery (Mohapatra, Mohapatra & Mohapatra, 2016) [7].

**Public health code of ethics**

The following Factors should be considered in any Setting where Public Health Interventions and Policies are Planned Permissibility: Public health ethical practice should be set within the parameters of the law at any given time and within established procedures for changing the law over time. A professional in ethics should try to work within the law so as to serve the needs, rights, and well-being of individuals and society at large. Moreso, organizations and individual professionals can ethically strive to change the law through the democratic and judicial process.

Respect: This supports human dignity within transactions, exchanges, and relationships. Reciprocity: This refers to the notion that social life should reflect mutual exchanges and cooperation rather than unilateral imposition. Reciprocity ensures us to relieve as much as is reasonable, the burdens of adhering to public health policy. Whenever a public authority requires individuals and communities to participate in an important communal undertaking, it is required on that authority to provide the means necessary to see that such contributions are not unreasonably burdensome. The ethical ideal of reciprocity attests to the notion that social life should reflect mutual exchanges and cooperation. Effectiveness: If the goals of a proposed public health action are determined to be morally permissible, it is then necessary to assess how well those goals will be met. A proposed public health action or decision should be able to achieve its intended public health goals, if the best information is presently available,

Responsible use of Scarce Resources: Ethical decision making needs to consider whether a given action requires expenditure of resources in relation to other needs or health goals that need immediate attention or in the foreseeable future.

Proportionality refers to assessment of the relative positive or negative effect of an action or a decision. A proportionate action is the one in which the means used to attain a public health goal are considerable when the benefits and the costs are compared, provided that those benefits and costs are equitably distributed. However, a disproportionate action is the one that involves a little chance of significant benefit to a few and the cost of widespread deprivation that cause harm to many.

Accountability and Transparency: Public health practice

relies on the support and voluntary cooperation of individuals and communities, both of which require trust. Trust is built on ongoing transparency and accountability. This involves describing actions and motives even when no critical questions are being asked. By giving an account of the reasoning and evidence behind a programme, public health practitioners demonstrate respect for the affected communities and stakeholders. Accountability reveals the seriousness of purpose involved in public health decision making, when the stakeholders disagree with the specific decision or outcome in question.

Public participation show the meaningful involvement of members of the public in public health research, decision making, planning, policy, and practice. Thus, public participation shows that participants and decision makers are mutually informed and engaged in dialogue and exchange (Thomas, Sage, Dillenberg & Guillory, 2002) [10].

**Previous work**

Mohapatra & Sengupta (2016) [8] conducted a research on health programmes in developing country – why do we fail? The objective was to ascertain why the health programmes in india failed. The public health initiatives have contributed to the improvement of several indicators over the years but morbidity and mortality levels are still unacceptably high. The gaps in health outcomes continue to widen, notwithstanding that India possesses as never before, a sophisticated interventions, knowledge and technologies needed for providing health care to her people. Thus, the power of the existing interventions does not match the power of health systems, to deliver the needy, adequately and comprehensively. Access to public health services are inadequate; and benefits from the public health system have been inadequate between the rich and the poor.

The researchers made a line list of all the National Health Programmes in the country and carried out a SWOT (Strengths, Weakness, Opportunities and Threats) analysis to examine the reasons for the failure of National Health Programmes in India. They summarized the gaps in the implementation of the programmes and discussed the reasons of poor programme performance.

Findinds indicated that the coordination between policy makers and programme implementers is far from what is desired for effective rolling out of health programmes. Policy and programmes are formed with inadequate knowledge of existing bottlenecks at the field level. Thus, the history of health programmes dates back to 1951, when India became the first country to adopt National Family Welfare Scheme (Lenka & Kar, 2012) [6]. India invests very small amount of public fund in health care: the total expenditure for health is only 1.62% of the whole budget out of which the National Health Mission's share is less than one percent. The government deviates from the core strategies of the National Health Mission-the allocation for the health sector has not increased. Poor communication and inefficiencies disrupt the continuity of health care. Also, there are poor use of healthcare informatics, insufficient management training, a lack of an organisational structure and financial resources that limits collaboration with other healthcare organisations. In India, due to rural impoverishment, urbanization and rapid industrialisation, migration of rural communities to urban areas is on increase. The primary health care system is not structured and organised in urban areas. However, the manpower and infrastructure are not sufficient to meet the needs of the growing urban population, especially the migrant influx. There is less number of health facilities (clinics), their facilities, functioning, and attitude of staff definitely influence the utilisation by the people. Issues of affordability in terms of treatment costs and costs of drugs, etc. were also major obstacles. One fourth of the urban population of India, approximately, 80 million people live below poverty line. Poverty and insufficient health services leave a considerable percentage of this population with little or no access to basic healthcare facilities. The researchers affirmed that an understanding of migration and healthcare utilisation has the potential to influence health policy and provision of health services through an appreciation of differential needs of urban communities. Organisational capability that refers to management, strategies, and decision making are invaluable in helping researchers, clinicians, and programme directors in developing countries assemble teams, use resources effectively, network, and form partnerships.

**Conclusion**

The health of a population depends on poverty mitigation, healthcare financing, reduction of inequalities, health education and communication, and life style changes. Additionally, health of populations depends on efficient healthcare delivery systems in public and private sectors, and reducing mortality and morbidity. Health and safety are important aspect of human existence. Public health practitioners and organisations have an ethical responsibility to minimize, prevent, protect and promote public health and wellbeing.

**Recommendations**

Public health decision makers need to be transparent and honest about disclosing conflicting influences and interests.

Public health practitioners and organisations should strive to conduct and disseminate health assessments focused on population health status and issues facing the community.

Medical colleges should be actively involved in training of health practitioners and also perform operational research to evaluate health programmes and find solution to health programmes failure.

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**Biography**

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