AMERICAN JOURNALS
Open Access, Peer Reviewed Journals

American Journal of Business Management, Economics and Banking
ISSN (E): 2832-8078 Volume 24, | May - 2024

ECONOMICS OF HEALTHCARE SYSTEMS AND POLICIES IN DEVELOPING COUNTRIES

Madina Norbutaeva Raxmatullo qizi
145-School Tashkent, Uzbekistan Yashnabad District
Istikbol Street,37 Economics
+998880080029

A B S T R A C T

Health economics is poorly developed in the francophone community. There is little published work addressing developing francophone countries, and it is largely limited to the sub-Saharan Africa. Few specialist research workers from developing countries contribute. Universities only propose global analyses, and other groups involved (expert consultants) only conduct narrow studies, targeted at immediate action or decision making. The article analyses some of the reasons from this underdevelopment, and overviews what has been produced over the last 15 years.

K E Y W O R D S

Countries, conduct, published, work, health economics

Introduction

A strong health policy is an essential platform for the formation of a comprehensive health system in developing countries. Three essential purposes of such a policy are (a) assuring adequate and accessible health services; (b) encouraging responsiveness by the country's population; and (c) protecting the population against health-related catastrophes (WHO 2000). Such a health policy, in turn, is dependent on responsible governance and adequate financial resources. International health policies focused primarily on communicable diseases (HIV, Tuberculosis and Malaria), non-communicable diseases (NCDs), and maternal and child health problems. In addition, attention is given to malnutrition, problems of drug resistance, mental illness, and chronic NCDs. Invariably, economic, social inequalities, and often cultural differences existing in developing countries result in poor health status among the disadvantaged, but also, increasingly, chronic NCDs including heart disease, hypertension, stroke, and diabetes along with a growing epidemic of obesity, these problems not limited to industrialized countries. An increasing number of countries have undertaken health sector reform involving an integrated stewardship process based on a decentralization of healthcare services and the inclusion of social insurance or protection. Accordingly, such stewardship and high standards of governance are essential to effective health policies. Such policies and the programmes emanating from them require rigorous monitoring and evaluation. China has been successful in decentralizing responsibility and services to local government entities, yet these local governments

have generally failed in their monitoring and evaluation responsibilities. By contrast, Mexico, which also has implemented health sector reform, has been successful in integrating monitoring and evaluation mechanisms into these systems. With decreasing infant and child mortality and improved disease control in many countries, the proportion of elderly persons in these countries has increased (UNFPA 2017). Changes also have been observed in the patterns and causes of death in many countries, with the burden of NCD increasing (WHO 2017). These have been accompanied by the 'nutrition transition' now taking place both in industrialized and developing countries, with countries as diverse as India, China, Brazil, and Russia facing both under- and overnutrition problems (Kapoor and Anand 2002; de Neuezer et al 2001). As a result, health policies and programmes are evolving to tackle these emerging health needs (Martens 2002). The health transition includes what have been called demographic and epidemiologic transitions (Omran 1998). (The ecological and economic transitions which often accompany health transitions are not included in this article.) The demographic transition describes changes over time in fertility and mortality rates (Notestein 1945; Demeny 1968; Borgerhoff 1998). The epidemiologic transition describes the changes in mortality and morbidity patterns (moving increasingly from infectious to chronic NCDs) relative to socio-demographic and economic changes (Omran 1971). Epidemiologic transition theory includes three models: (a) the 'western or classical model' (e.g. Western Europe and Northern America), (b) the 'accelerated model' (e.g. Japan and Eastern Europe), and (c) the 'delayed or contemporary model' (e.g. most developing countries) (Omran 1998). Overall, the health transition, internationally, has evolved through the following three stages: Stage I, 'The Age of Pestilence and Famine' was characterized by high and unstable mortality that impedes population growth. During this stage, average life expectancy at birth was low and inconstant, ranging from 20 to 40 years (Omran 1971). The stage was characterized by a high prevalence of infectious diseases and high rates of undernutrition. Women of childbearing age were prone to pregnancy-related illnesses and more vulnerable to tuberculosis. Epidemics such as plague, cholera, and smallpox were often managed by isolation and quarantine measures as experienced in the late seventeenth century in several European cities (Goudsblom 1986), and these measures also became common in addressing contagious diseases, with rules adopted for trade quarantine and isolation of the sick in US port cities in the eighteenth century. A law for isolation of smallpox patients and for ship quarantine was enforced beginning in 1701 in Massachusetts (Hanlon and Pickett 1984). The recording and reporting of deaths by the plague and other diseases were established in the late seventeenth century (Goudsblom 1986). With increased urbanization in the nineteenth century, infectious diseases like smallpox and tuberculosis spread easily. Under-five mortality rates were particularly high. During this stage of health transition, public health measures against infectious diseases were developed, and hospitals for physical and mental illnesses were established in the US in the eighteenth century (Turner 1977). Information on health issues facing developing countries during this stage was limited. In Stage II, 'The Age of Receding Pandemics', we see a significant reduction in mortality. Infectious disease epidemics were less common and sometimes eliminated. Life expectancy at birth increased to 30–50 years. As a result, population growth rates increased significantly. In the early phase of this stage, endemic, parasitic and nutrition deficiencyrelated diseases, and maternal and child health problems were the leading causes of death (Caldwell 2001). During the nineteenth century, sanitation and personal hygiene improved markedly as increasing numbers of people better understood the causality of infectious diseases and their modes of transmission (Winslow 1923). Although epidemics remained

a public health problem, infectious disease control measures evolved from quarantine and isolation to prevention, e.g. personal hygiene and environmental sanitation. Environmental sanitation including waste and sewage disposal and sanitation promotion was adopted in the UK by the Public Health Act of 1848 (Chave 1984). At the same time in the US, comprehensive public health systems evolved from initiatives such as Shattuck's Report of the Massachusetts Sanitary Commission (Winslow 1923; Rosenkrantz 1972), and boards of health and state health departments began to be established shortly thereafter (Hanlon and Pickett 1984; Fee 1987). Industrialization, however, became an increasingly prevalent mode of transmission for infectious diseases (Wohl 1983). Although sanitation improved, death from urbanization-related diseases, particularly tuberculosis, increased, as seen in the state of Massachusetts (Hanlon and Pickett 1984). By late in the nineteenth century, however, bacteriology, the germ theory, and laboratories to investigate the causes of infection were being developed in the United States (Winslow 1923). And mortality due to such infectious diseases as yellow fever and typhoid were significantly reduced by improved water sources and sanitation and through an understanding of the concept of vector-borne diseases (Winslow 1923; Blakes 1956).

References

1. Adjuik, M., et al. (2006). Cause-specific mortality in sub-Saharan Africa and Bangladesh. Bulletin of the World Health Organization, 84, 181–92.
2. Atkinson, S., et al. (2005). Prevention and promotion in decentralized rural health systems: a comparative study from northeast Brazil. Health Policy Planning, 20, 69–79.
3. AIDSMap. Task Shifting: Successes from Mozambique and Rwanda, 5 September 2008. [Online] Available at: https://www.aidsmap.com/news/ sep-2008/task-shifting-successes-mozambique-and-rwanda
4. Arya, N. and Santa Barbara, J. (2008). Peace Through Health: How Health Professionals Can Work for a Less Violent World. Sterling: Kumarian Press.