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## Individual Healthy Behaviors as Our Public Health System Resource

Romeo B. Lee

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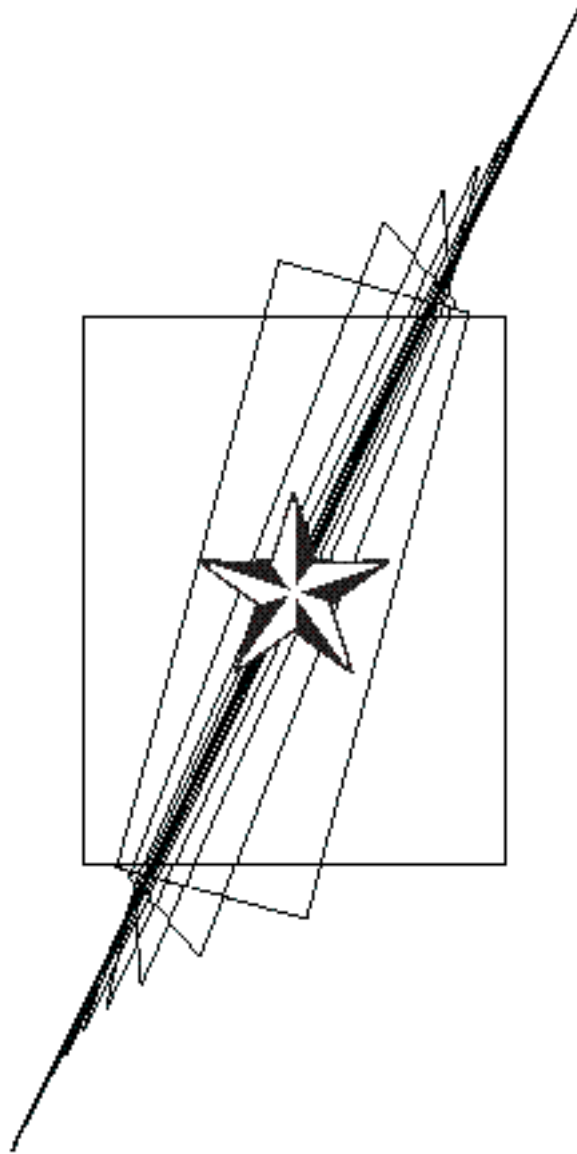
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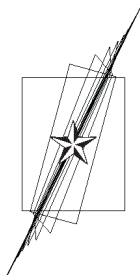
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# From the Editor

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## Individual Healthy Behaviors as Our Public Health System Resource

In emerging economies, our public health system, which comprises—according to the U.S. Centers for Disease Control and Prevention—all government, private, and voluntary groups delivering essential health services to a population within a given jurisdiction, has just recently added COVID-19 into its long list of communicable diseases (CD; e.g., influenza, tuberculosis). As of November 8, 2020, roughly 49.9 million people worldwide have contracted COVID-19, 2.5% of whom have died as a result. The coronavirus is, by no means, the last and the final in the CD list. Our deepening interactions with the rest of the living creatures in the ecosystem would be giving rise to more novel CD occurring in our midst in the future. According to the World Health Organization (WHO), we have had more than 20 of such diseases that affected us in varied ways in the past 30 years.

Along with the CD list, our public health system has an equally long registry of non-communicable diseases (NCD; e.g., diabetes, cancers, cardiovascular and respiratory diseases, hypertension, and mental ailments). CD and NCD alike are causing innumerable mortalities, particularly to those whose access to the advanced system of disease diagnosis, treatment, and care is limited. WHO reported that 40 million people die from NCD annually, about half of whom before the age of 70.

Both CD and NCD have been exacting a very heavy toll on our public health system; in particular, on the government that has to continuously earmark resources for health; the facilities and providers that have to deliver the products and services daily; and the patients, including their families and other social groups (e.g., employers), that have to expend money, time, and energy to regain their precious health and well-being. The systemic strategies utilized to address these tolls have thus included, among others, earmarking more funding to the public health system; providing more and diversified facilities, products, and services; hiring additional medical and para-medical professionals or raising their remuneration; and giving the public greater or universal access to health services. For some time that these strategies were religiously pursued, the economic system was still robust, and the relevant morbidities and mortalities were under control, our public health system was able to meet the facility-based health requirements of patients.

Over time, though, with developments turning worse, our public health system began having shortfalls in its delivery of facility-based services. Patient numbers increased, public sector funding stalled, operational costs of health facilities and services skyrocketed, mismanagement of and corruption within the public health system persisted, demands for salary increases among providers and staff intensified but remained unmet, patients' purchasing power due to rising inflation stagnated, income-generating opportunities shrank, and lifestyles both broadened and worsened.

Because the contributing factors are structural—and there is nary any clear solution in the foreseeable future—our public health system has been heavily overwhelmed by the burdens brought about by CD and NCD. When our public health system struggles, as demonstrated in the case of some patients with severe COVID-19 infections, hard decisions have to be made, such as placing them under the do-not-resuscitate (DNR) order. For the public health system to invoke the DNR order—and even for patients to wait for several days or hours before a

medical provider or a hospital bed becomes available, or to be turned away because one cannot present a hospital deposit or advance payment—are indicative of a system that has gone awry. Health has turned into a lottery, an uncertainty, and a social precarity where the odds are heavily stacked against the patient. The patients are bereft of any control over their health, utterly unempowered, and helpless as if they are totally subjugated by the very system mandated to attend to their health needs.

To be true to its mandate, our public health system must explore better ways of delivering facility-based services, but it also has to strengthen its health promotion responsibility to enable the public to adopt individual healthy behaviors (IHB). This health promotion responsibility, which is intended for the general and the non-patient population, is overly neglected in favor of the facility-based services. Yet, health promotion, as a proactive approach, enables the broader population to take control and become agents of their own health status and outcome; and helps lessen the population's chances of becoming ill and patients. Many of the CD and NCD are preventable and controllable provided the population observes IHB. For example, against COVID-19 infection, all the public has to do, as their protective behaviors, are to wash their hands properly, wear a mask, and observe social distancing. Against HIV, abstinence, having one monogamous partner, and using a condom for sexual intercourse are the recommended behaviors. Against diabetes, a multi-pronged healthy lifestyle is suggested, of which cutting sugar intake, working out regularly, drinking water, and not smoking are necessary behaviors. Against depression, regular physical exercise as well as sufficient sleep, among others, are central. Against obesity, proper food intake, a higher level of physical activities, and reduction of a sedentary lifestyle are effective preventive behaviors. These IHB are every person's insurance against potential illness, thus an invaluable and a highly-sustainable resource for the public health system. Instead of occurring by chance, IHB are systematically designed, sustained, and nurtured.

Let me summarize the following key points on IHB:

1. IHB are a set of specific, enduring, and interrelated personal behaviors.
2. In effect, IHB are life-long norms, lifestyle, and culture.
3. IHB are founded on key personal behaviors, such as personal hygiene (e.g., regular body and hand washing), nutrition (i.e., balanced diet), exercise, sufficient sleep, and a clean home environment.
4. IHB are recommended even if medicines and vaccines are available.
5. IHB is learned at an early age.
6. Families—particularly household heads—are key IHB learning partners, along with the school system and the media. All these sectors must have a harmonized framework and action on IHB.
7. Our national government has to exercise effective management over the public's learning of IHB. Our public health goal must reign supreme over the vested interests of the capitalist sector.
8. Our government has to find ways within the general and the everyday lives of the public on how to integrate IHB. For instance, it can mainstream nutrition by requiring food outlets to provide a free sample of key vegetables (e.g., tomatoes) on every dining table. Additionally, it can require producers and providers to calibrate a non-problematic level of sugar and salt into the contents of their commercial food products.
9. Reliable societal-wide structures and conditions have to be improved in support of the public's learning and practice of IHB. For example, latrine facilities, water services, and affordable and nutritious food supplies must be made universal. Poverty alleviation must be prioritized.
10. Movements in terms of the public's learning and practice of IHB have to be systematically measured, documented, and analyzed to determine current trends and future direction.

Because IHB are a social goal whose benefits—albeit lifelong—are far from sudden and immediate at both the social and individual levels, the extent of the public's learning and practice of the said behaviors may be limited during the first few years of promotion. If the extent is modest, the promotion has to be recalibrated and strengthened rather than stopped (as is usually done to many public health interventions that are underperforming at the early phase). The social sciences, in tandem with the health sciences, including public health, can help in determining the pathways for mainstreaming IHB. Usually, there are natural and social events in the larger society

or even in small communities that can be tapped as pathways for mainstreaming IHB. The sciences should be all eyes and ears to all of these events and work extra hard towards gaining milestones, momentum, and tipping points to make the rightful impact. IHB would be a highly-portable and adaptable resource for preventing and controlling any future epidemic and pandemic.

I thank the many authors who published with us in the past 12 months—the period during which COVID-19, being the newest disease in our midst, had wreaked havoc on our countries, economies, health systems, and collective and individual lives. We had fought back against the disease, and up to this day, we are still continuing our fight. COVID-19 is a truly lived experience for all of us. Hopefully, we would have our IHB as part of our large-scale armors against new diseases in the future.

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