A project financed by the European Union

A project implemented by Medici con l'Africa Cuamm

MEDICI CON L'AFRICA CUAMM

EQUAL OPPORTUNITIES FOR HEALTH ACTION FOR DEVELOPMENT

I DETERMINANTI DELLA SALUTE

In partnership with:

Department of Medicine and Public Health, University of Bologna (Italy)

Italian Global Health Watch - OISG (Italy)

Italian Secretariat of Medicine Students (Italy)

Region of Veneto (Italy)

Transilvania University of Brasov (Romania)

Medicine Students Scientific Association of Brasov (Romania)

Humanitarian Aid Foundation "Redemptoris Missio" - Medicus Mundi (Poland)

Poznan University of Medical Sciences (Poland)

International Federation of Medical Students' Association (Poland)

Latvian Association for Family Planning and Sexual Health " Papardes zieds" (Latvia)

University of Medicine – Pleven (Bulgaria)

In association with:

Bulgarian Medical Students' Association (Bulgaria); Association "Development of Personality and Human Communities" (Bulgaria); Latvian Medical Students' Association (Latvia); University of Latvia (Latvia); Malta Medical Students' Association (Malta); Central European University Budapest (Hungary); Italian Federation of Medical Association - FNOMCeO (Italy).

Che cos'è la salute?

L' Organizzazione Mondiale della Sanità definisce la salute come:

"stato di completo benessere fisico, mentale, sociale e spirituale e non la mera assenza di malattia o di infermità"

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ETA'

Maggior rischio di:

- malattia/mortalità
- ospedalizzazioni

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Il ruolo del contesto sociale

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SESSO/GENERE

Patologie più frequenti nel sesso femminile:

- Malattie autoimmuni
- Cancro della mammella
- Osteoporosi

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Ma anche in questo caso non dimentichiamo il ruolo dei processi sociali...
Il 'gomito della lavandaia': patologia del *sesso* o del *genere* femminile?

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FATTORI COSTITUZIONALI

Anemia Falciforme

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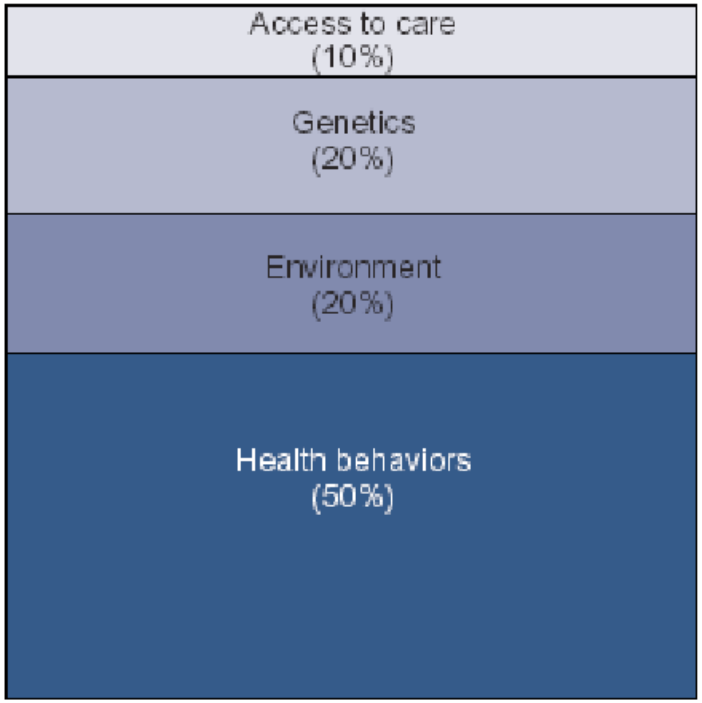
Qual è il “peso” degli stili di vita?

Determinants of health



Source: IFTF; Centers for Disease Control and Prevention.

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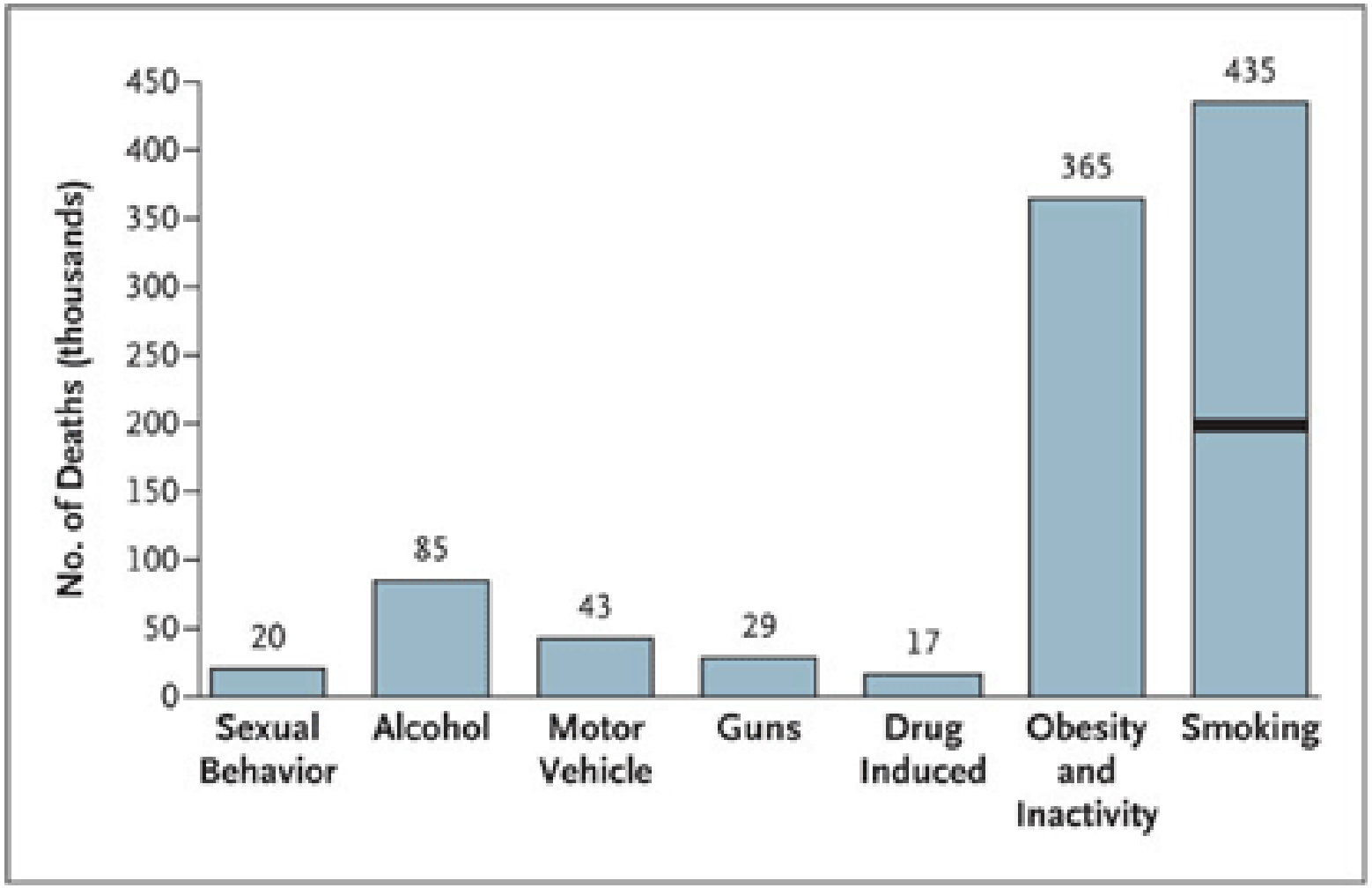

Numbers of U.S. Deaths from Behavioral Causes, 2000.

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“Scelte” di vita?

- Abitudini alimentari
- Fumo, alcol
- Attività fisica/sedentarietà
- Sessualità
- Consumo di sostanze
- ...

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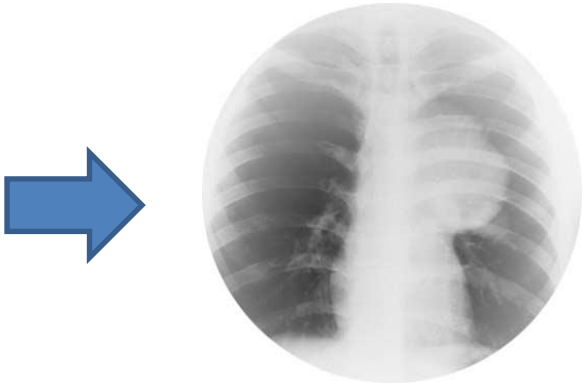
Cause distali



Lung cancer Rates per 1000,000			
Social class	*Year*		
	1970-72	1979-83	1991-93
I – Professional	41	26	17
II – Managerial & Technical	52	39	24
III(N) – Skilled (non-manual)	63	47	34
III(M) – Skilled (manual)	90	72	54
IV – Partly Skilled	93	76	52
V – Unskilled	109	108	82
England and Wales	73	60	39

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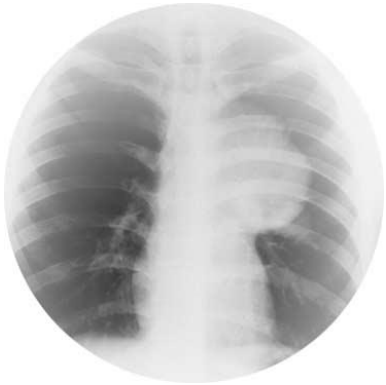
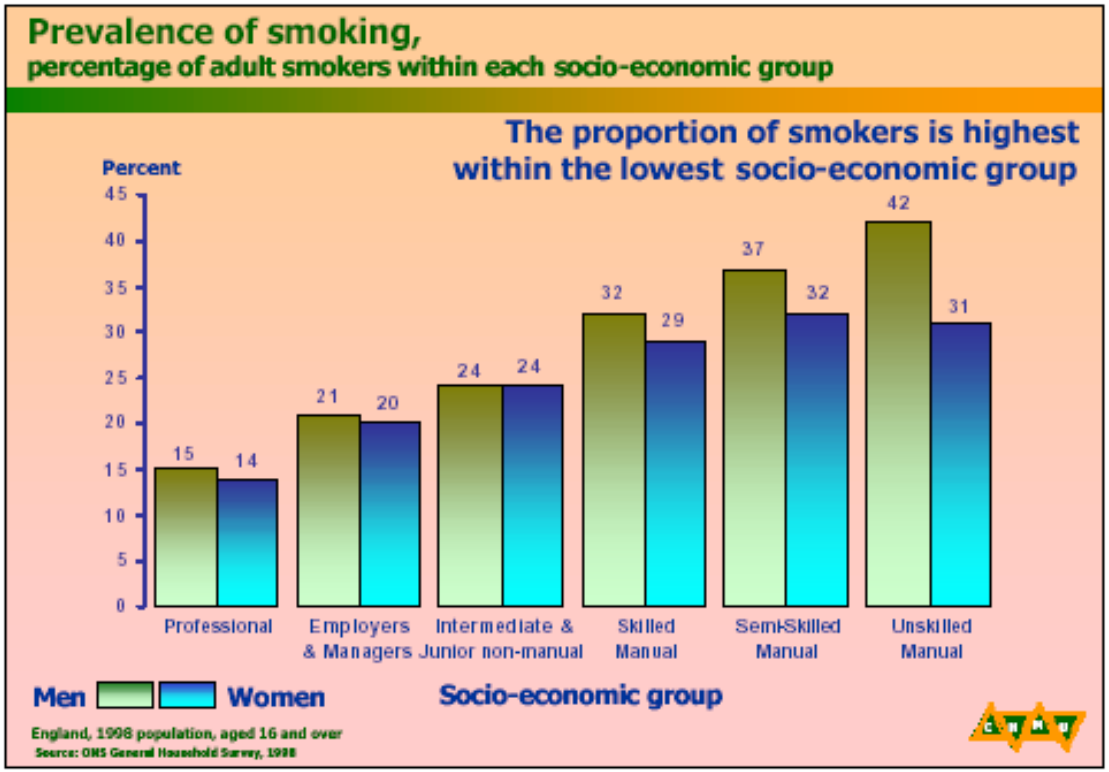
Cause distali





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Il disagio sociale (sia esso valutato in base alla situazione abitativa carente, al basso reddito, alla mancanza di un genitore, alla disoccupazione o alla condizione di senzatetto) è associato a elevati tassi di tabagismo e a bassissimi tassi di abbandono del vizio.

(“The solid facts”, Wilkinson, Marmot)

Stili di vita: scelte individuali e/o correlate al contesto in cui si vive?

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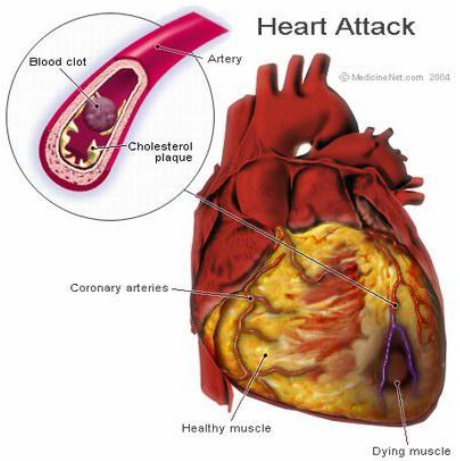
Cause distali



Coronary heart disease	Rates per 1000,000		
Social class	*Year*		
	1970-72	1979-83	1991-93
I – Professional	195	144	81
II – Managerial & Technical	197	168	92
III(N) – Skilled (non-manual)	245	208	136
III(M) – Skilled (manual)	232	218	159
IV – Partly Skilled	232	227	156
V – Unskilled	243	287	235
England and Wales	209	202	127

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ALIMENTAZIONE

Risorse di tempo, possibilità economiche, accesso alle informazioni, presenza di una rete sociale…

Stili di vita:
scelte individuali e/o correlate
al contesto
in cui si vive?

L'effetto Roseto: un confronto della mortalità su 50 anni

B Egolf, J Lasker, S Wolf, and L Potvin

Gli abitanti di Roseto avevano una mortalità per infarto miocardico inferiore nel corso dei primi 30 anni di osservazione, che poi è risalita ai livelli di Bangor in seguito a un periodo di erosione delle relazioni familiari e comunitarie, tradizionalmente coese. I dati hanno confermato l'esistenza di una differenza di mortalità significativa tra Roseto e Bangor in un periodo in cui vi erano molti indicatori di maggiore solidarietà sociale e omogeneità a Roseto.

Roseto (Abruzzo, Italia)

Roseto (Pennsylvania, USA)

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OPEN ACCESS Freely available online

PLOS MEDICINE

Editorial

Social Relationships Are Key to Health, and to Health Policy

The *PLoS Medicine* Editors*

OPEN ACCESS Freely available online

PLOS MEDICINE

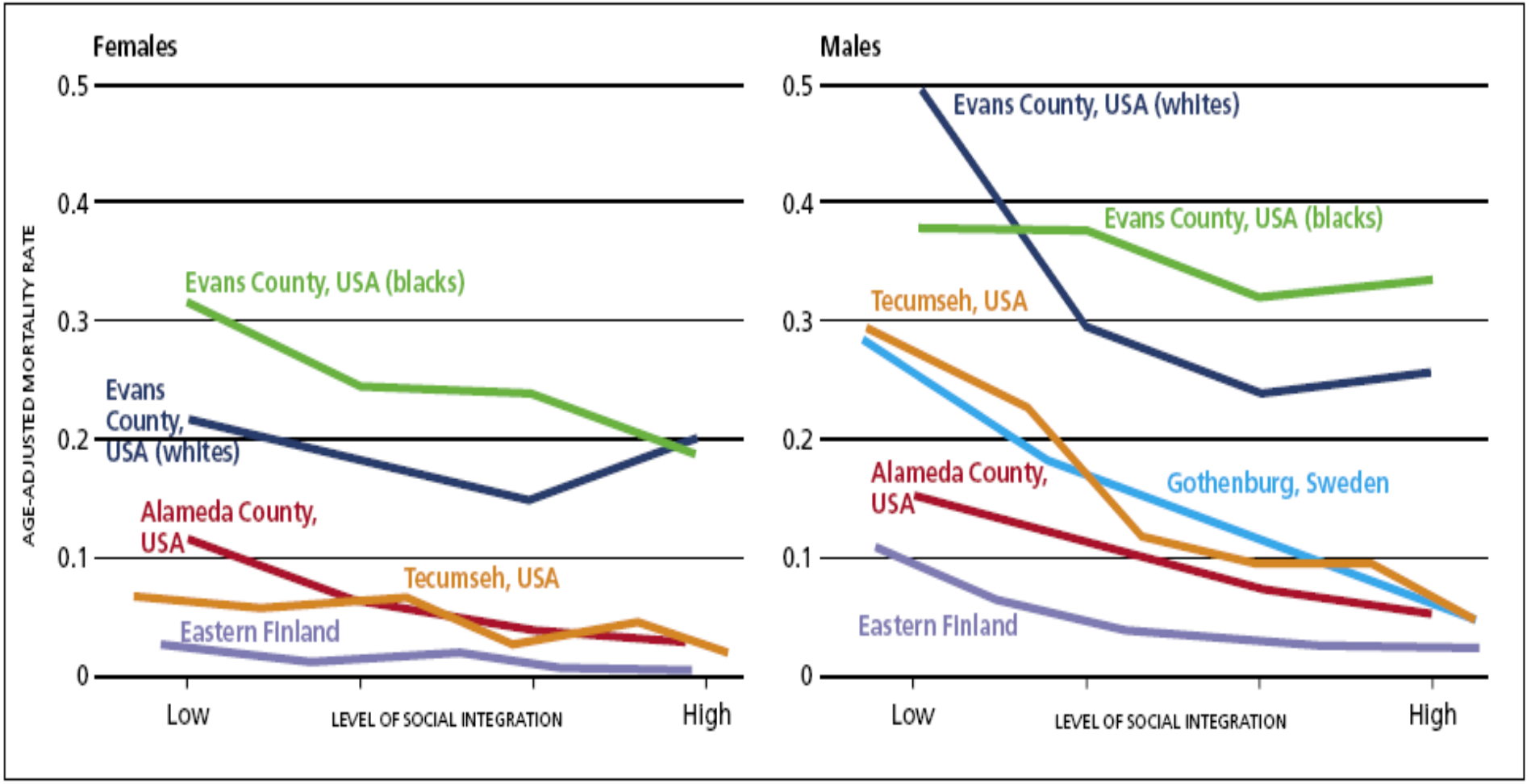
Social Relationships and Mortality Risk: A Meta-analytic Review

Julianne Holt-Lunstad[1,2]*, Timothy B. Smith[2,3], J. Bradley Layton[3]

1 Department of Psychology, Brigham Young University, Provo, Utah, United States of America, 2 Department of Counseling Psychology, Brigham Young University, Provo, Utah, United States of America, 3 Department of Epidemiology, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina, United States of America

tality was reported). The researchers reported that stronger social relationships were associated with a 50% increased chance of survival over the course of the studies, on average. The effect was similar for both "functional" (e.g., the receipt or perception of receipt of support within a social relationship) and "structural" measures of relationships (e.g., being married, living alone, size of social networks).

COESIONE SOCIALE



The Solid Facts, 2003

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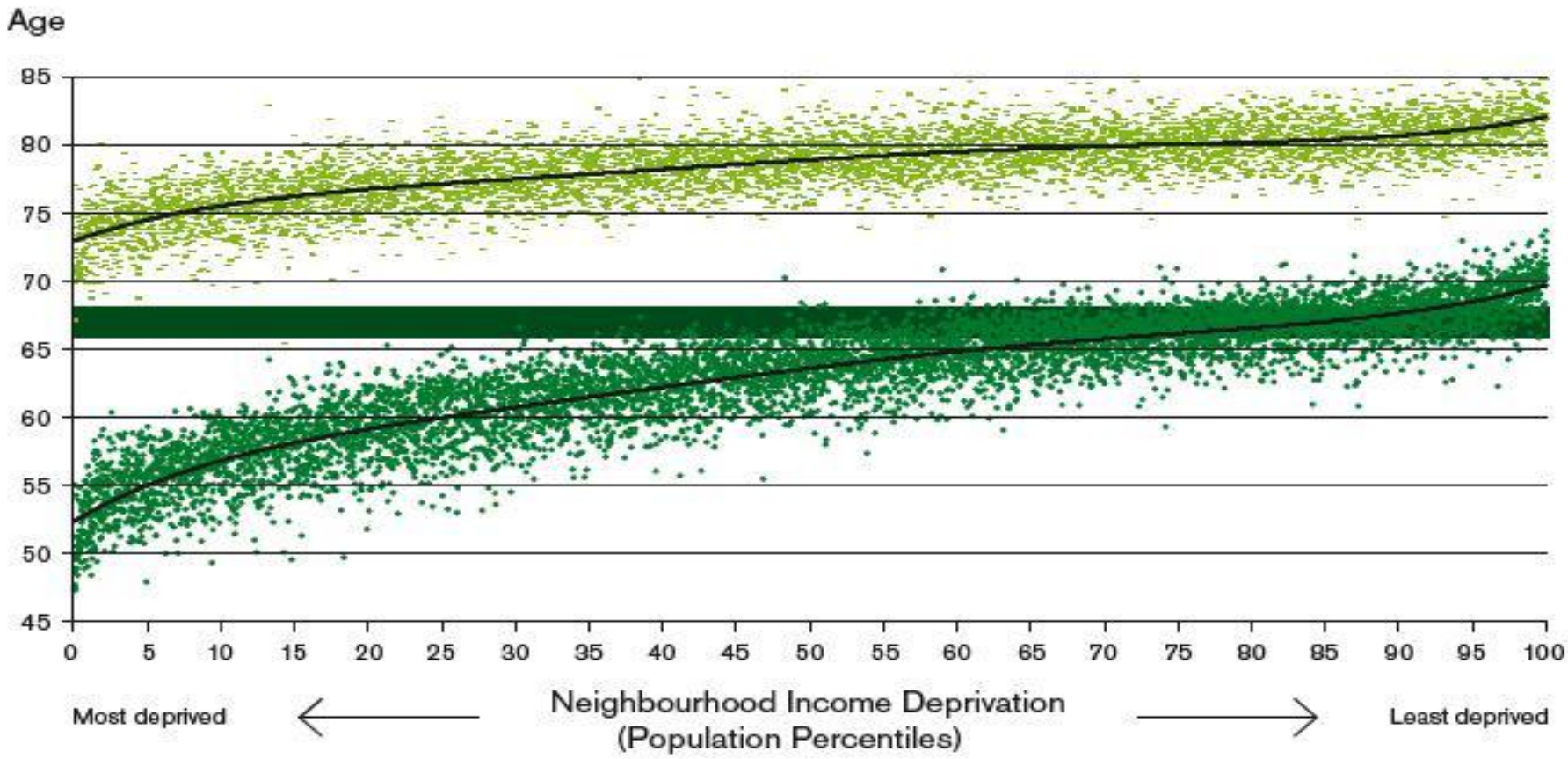
REDDITO (il gradiente sociale)

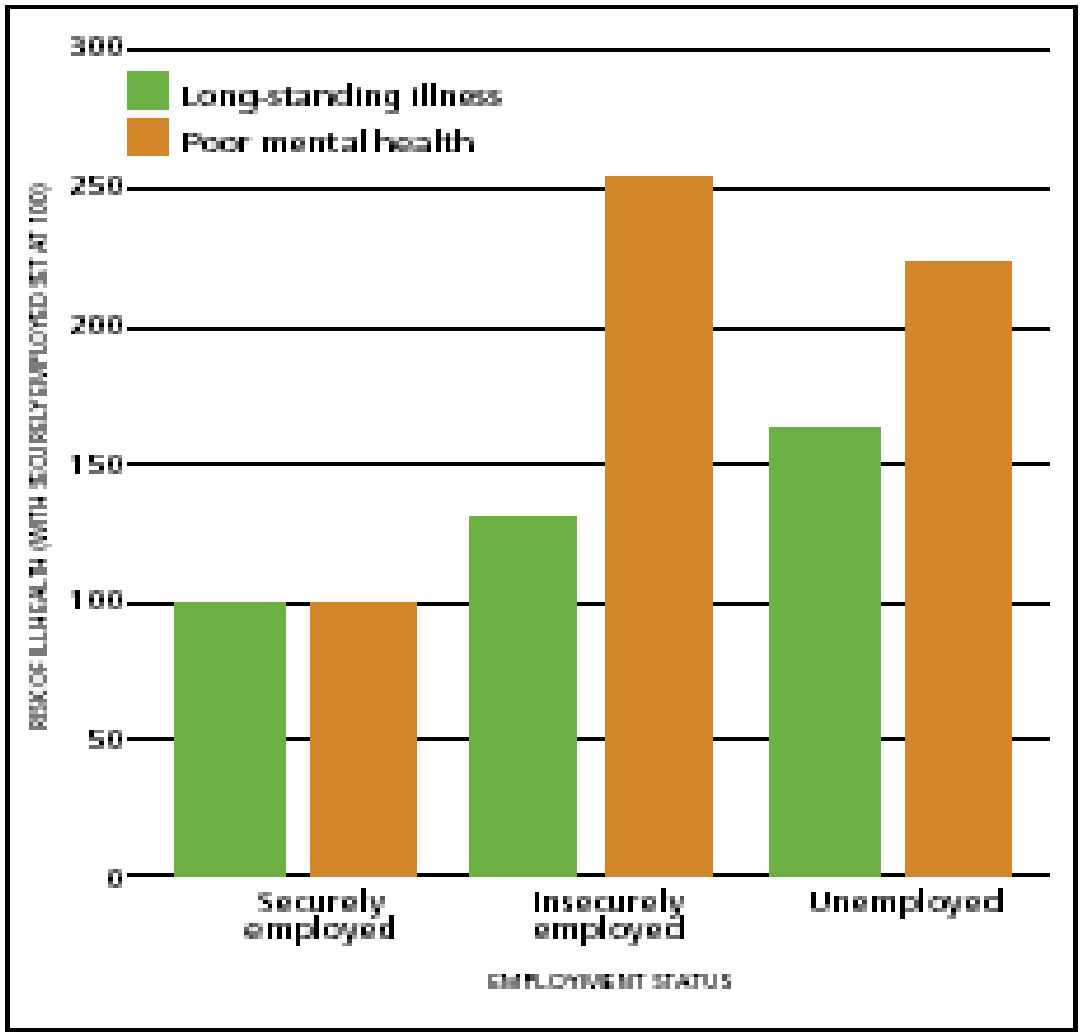
Figure 1 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003



Source: Office for National Statistics[5]

CONDIZIONI LAVORATIVE

Fig. 5. Effect of job insecurity and unemployment on health



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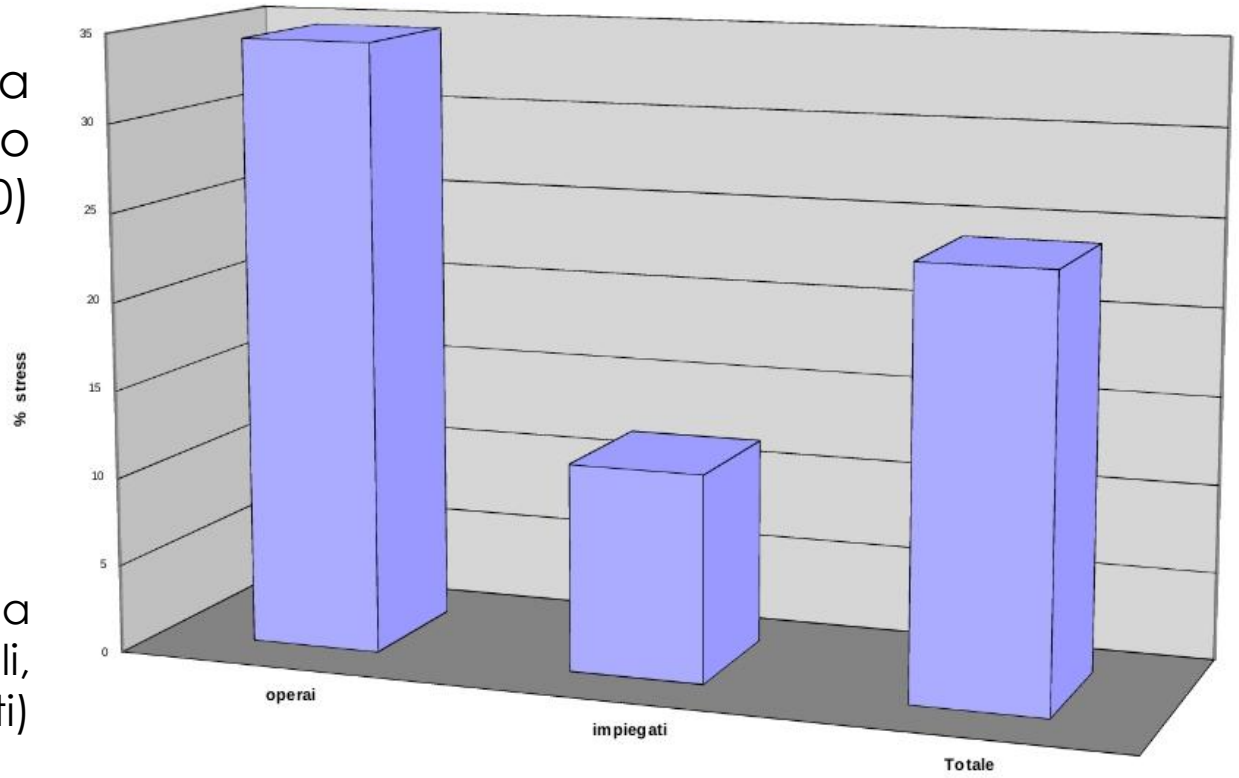
AMBIENTE LAVORATIVO

% di persone esposte a elevato stress lavorativo (Torino, Italia, 2000)



Campione di 1479 individui a Torino (797 lavoratori manuali, 682 impiegati)

	operai	impiegati	Totale
n. soggetti esposti ad elevato stress sul lavoro (%)	34,5	11,7	24
totale	797 (100)	682 (100)	1479 (100)

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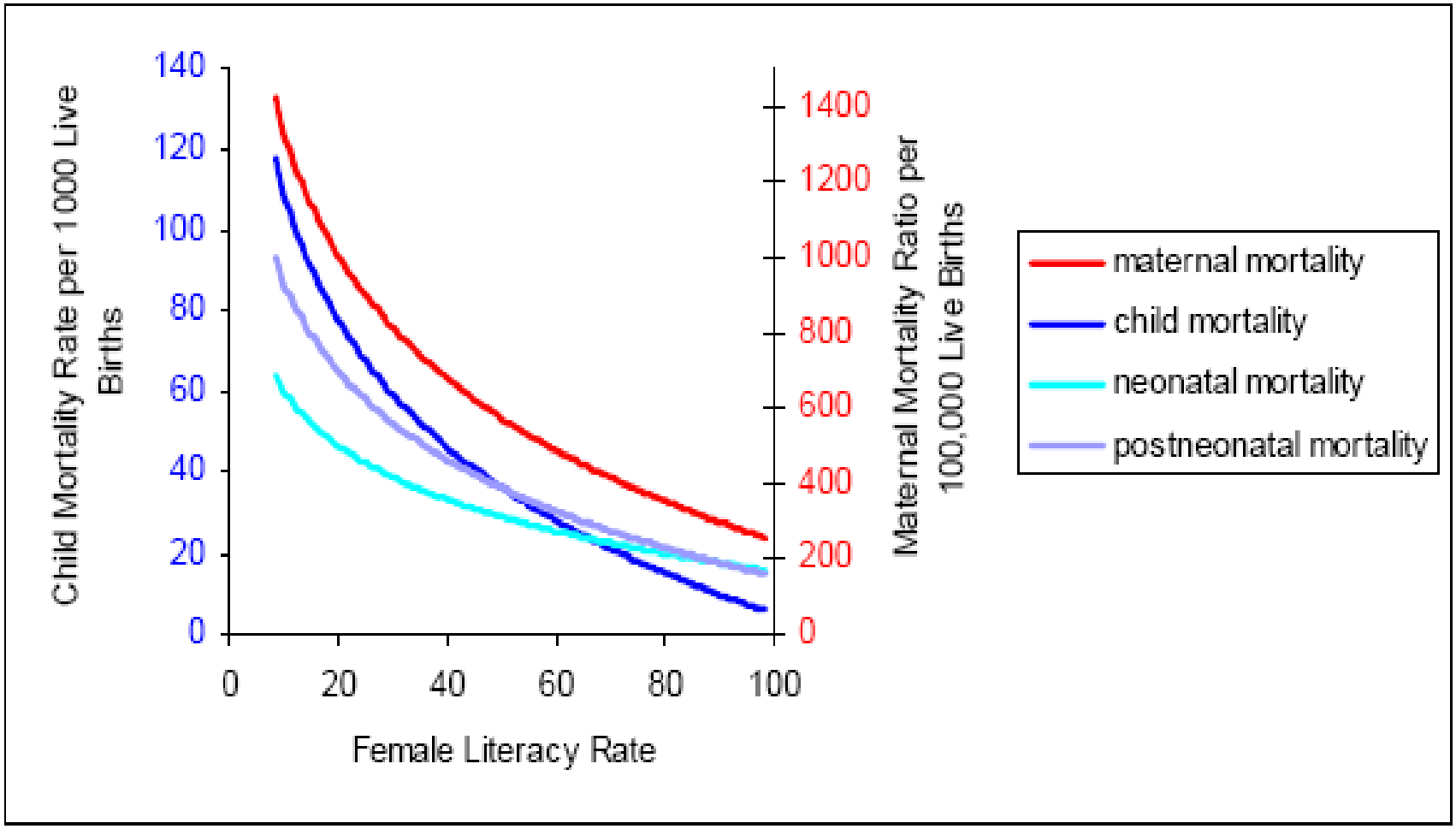
EDUCAZIONE



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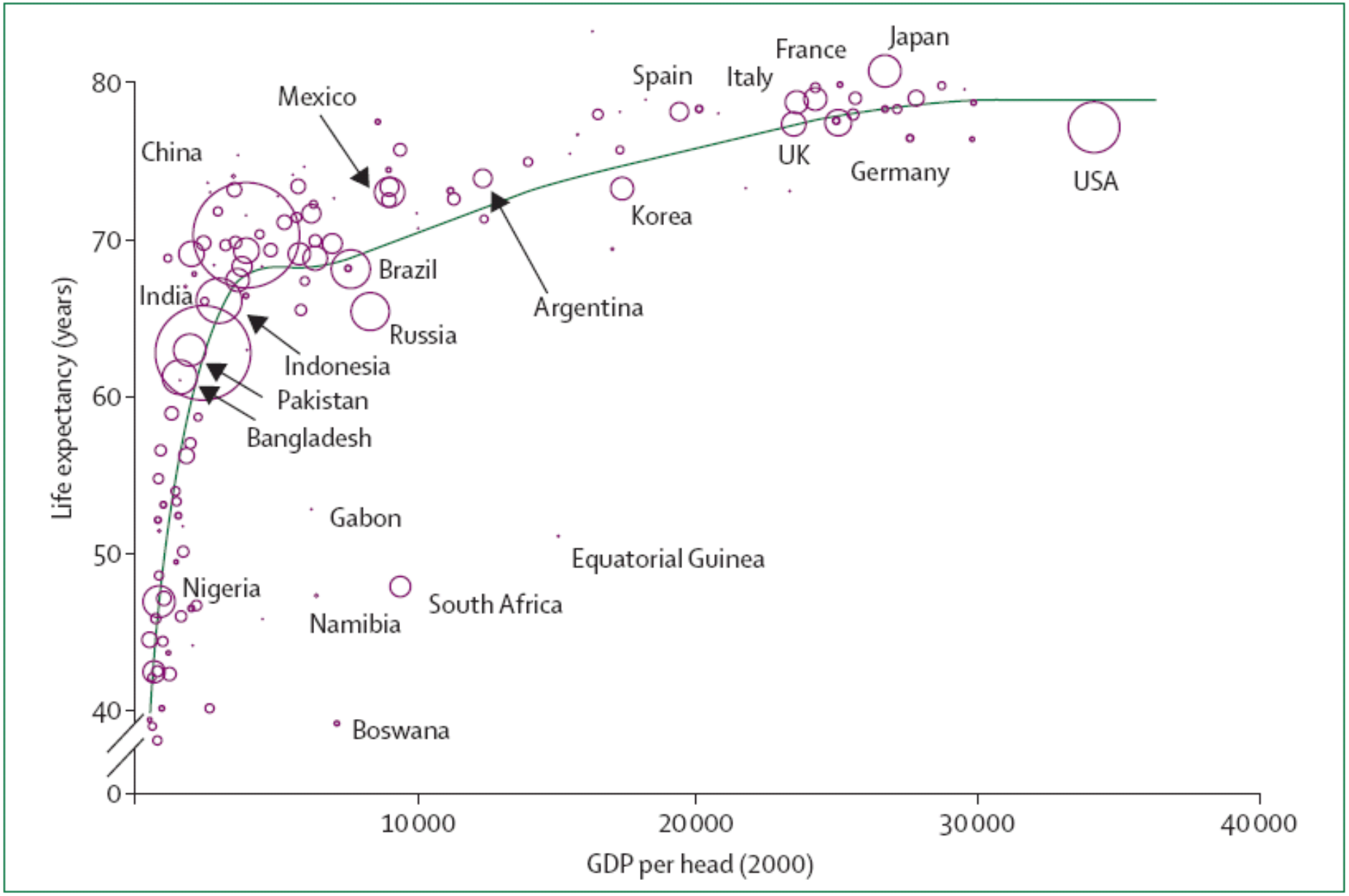

Marmot, *Lancet* 2006

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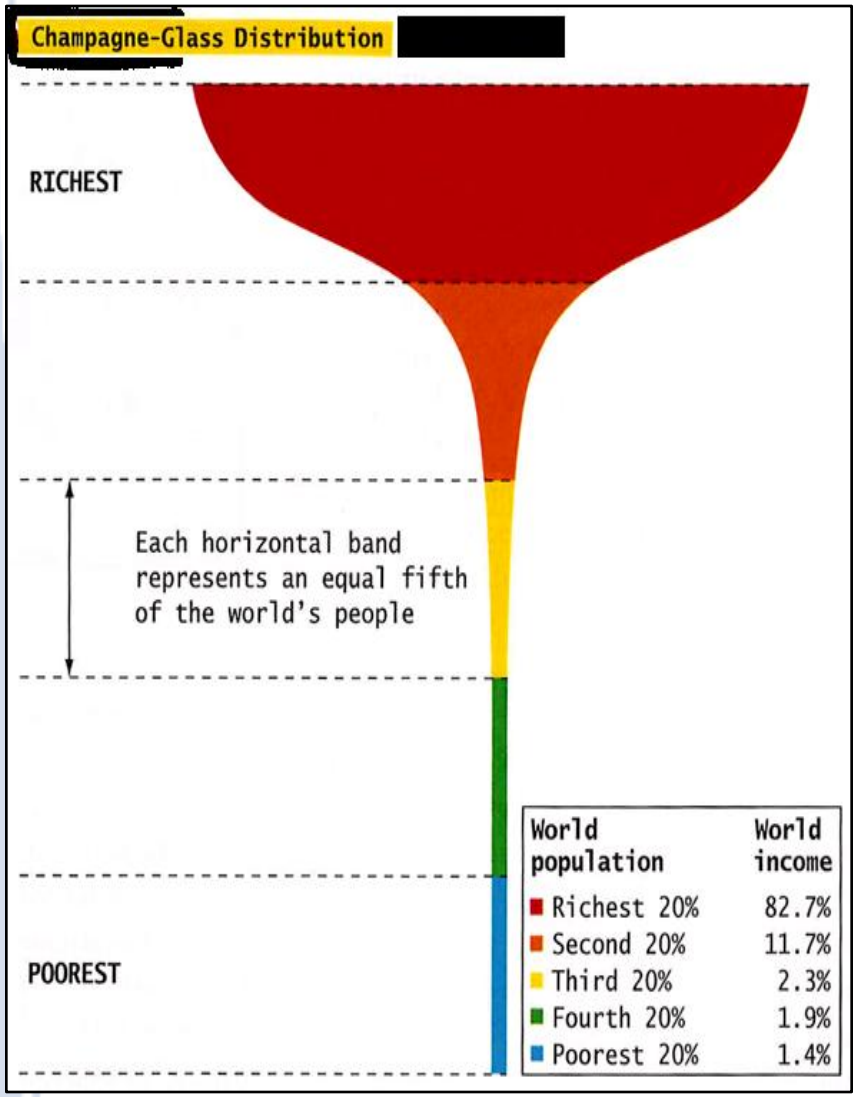
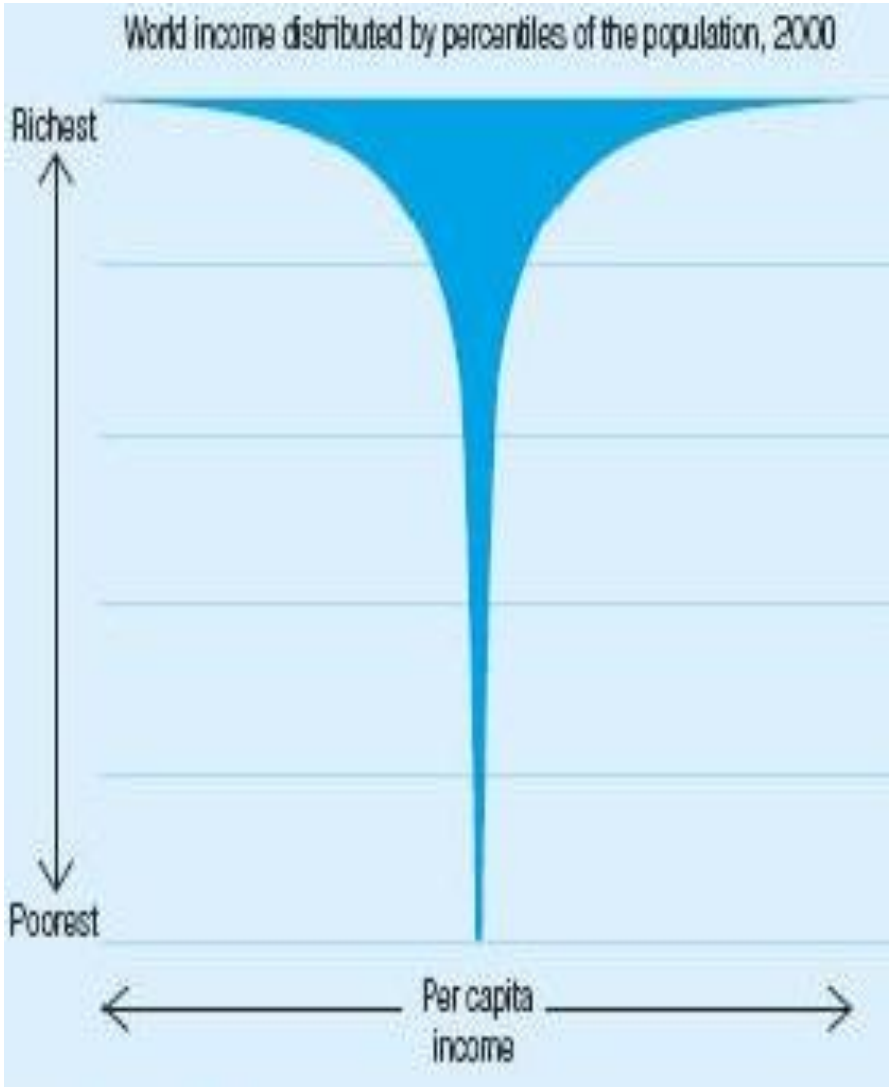
Viviamo in un mondo ineguale



1992



2000

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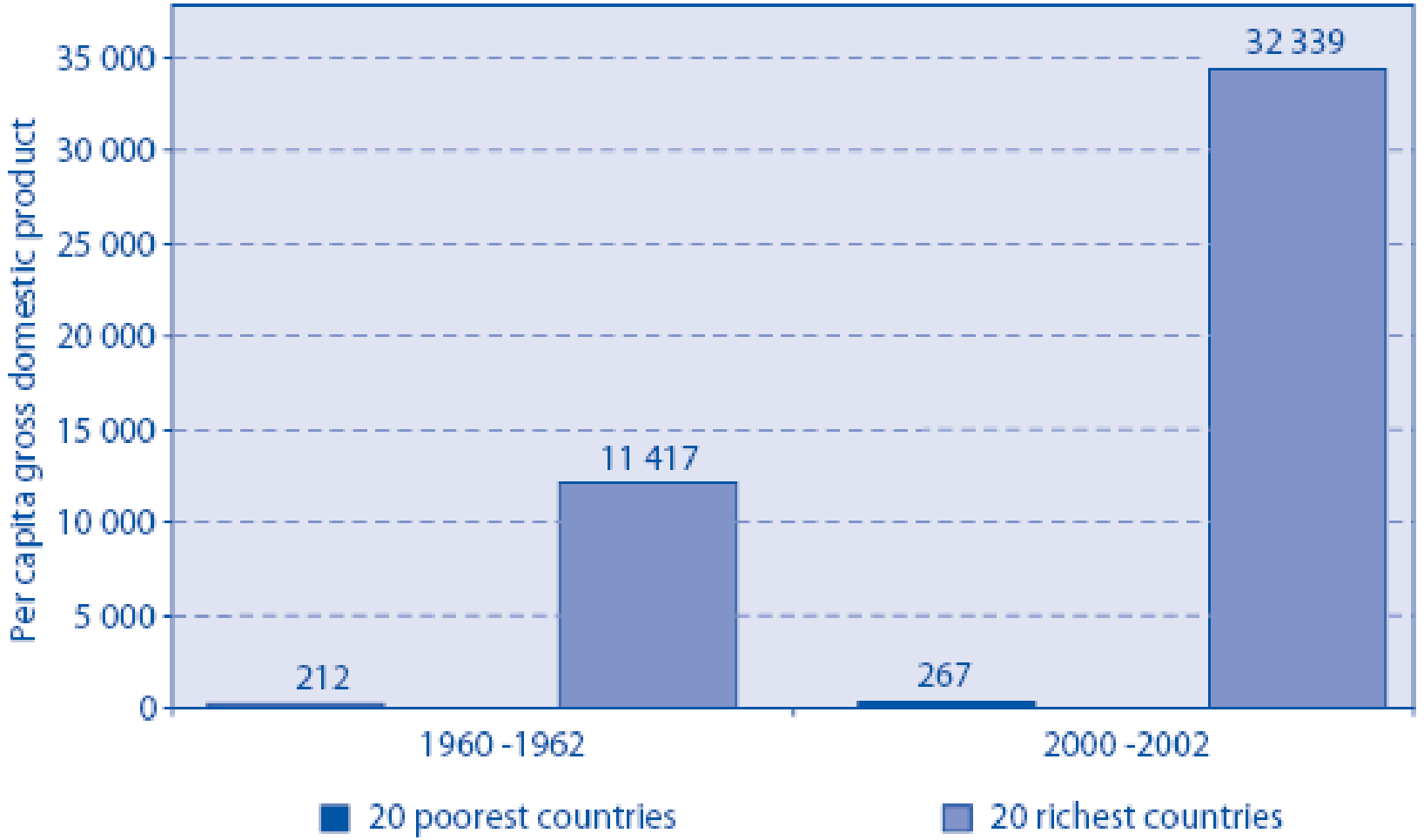
Figure III.2. Per capita gross domestic product in the poorest and richest countries, 1960-1962 and 2000-2002 (*in constant 1995 US$, simple average*)



Source: World Commission on the Social Dimension of Globalization, *A Fair Globalization: Creating Opportunities for All* (Geneva, International Labour Organization, February 2004).

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"The poor are getting poorer, but with the rich getting richer it all averages out in the long run."

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"The primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social. Medicine and politics cannot and should not be kept apart".

Geoffrey Rose
"The strategy of preventive medicine", 1992.

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WHO Commission on the Social Determinants of Health (CSDH)

World Health Organization

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Social determinants of health

WHO > Programmes and projects > Social determinants of health > Commission on Social Determinants of Health, 2005-2008

Commission on Social Determinants of Health, 2005-2008

The Commission on Social Determinants of Health (CSDH) was established to support countries and global health partners to address the social factors leading to ill health and inequities. It drew the attention of society to the social determinants of health that are known to be among the worst causes of poor health and inequalities between and within countries.

:: More about the Commission

ESSENTIAL INFORMATION

Key concepts

THE FINAL REPORT OF THE COMMISSION

The Report, Executive Summaries and backgrounders

Interview with Sir Michael Marmott, Chair CSDH
Video [streaming wmv, 00:06:22]

Dr Margaret Chan WHO Director-General

MEETINGS

Closing the Gap in a Generation (London, November 2008)

Wellcome Centre History of Medicine (London, November 2008)

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World Health Organization

Commission on Social Determinants of Health

Closing the gap in a generation

Health equity through action on the social determinants of health

EQUAL OPPORTUNITIES FOR HEALTH ACTION FOR DEVELOPMENT

The Commission's overarching recommendations

1 Improve Daily Living Conditions

Improve the well-being of girls and women and the circumstances in which their children are born, put major emphasis on early child development and education for girls and boys, improve living and working conditions and create social protection policy supportive of all, and create conditions for a flourishing older life. Policies to achieve these goals will involve civil society, governments, and global institutions.

2 Tackle the Inequitable Distribution of Power, Money, and Resources

In order to address health inequities, and inequitable conditions of daily living, it is necessary to address inequities – such as those between men and women – in the way society is organized. This requires a strong public sector that is committed, capable, and adequately financed. To achieve that requires more than strengthened government – it requires strengthened governance: legitimacy, space, and support for civil society, for an accountable private sector, and for people across society to agree public interests and reinvest in the value of collective action. In a globalized world, the need for governance dedicated to equity applies equally from the community level to global institutions.

3 Measure and Understand the Problem and Assess the Impact of Action

Acknowledging that there is a problem, and ensuring that health inequity is measured – within countries and globally – is a vital platform for action. National governments and international organizations, supported by WHO, should set up national and global health equity surveillance systems for routine monitoring of health inequity and the social determinants of health and should evaluate the health equity impact of policy and action. Creating the organizational space and capacity to act effectively on health inequity requires investment in training of policy-makers and health practitioners and public understanding of social determinants of health. It also requires a stronger focus on social determinants in public health research.

Conferenza Mondiale sui Determinanti Sociali di Salute - Rio de Janeiro Ottobre 2011

Protecting the Right to Health through action on the Social Determinants of Health

A Declaration by Public Interest Civil Society Organisations and Social Movements

Rio de Janeiro, Brazil (18th October 2011)

URGENTLY REQUIRED ACTIONS BY MEMBER STATES AND WHO ON THE KEY AREAS

1. Implement **equity-based social protection** systems and maintain and develop effective **publicly provided and publicly financed health systems** that address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities.
2. Use **progressive taxation**, wealth taxes and the elimination of tax evasion to finance action on the social determinants of health.
3. Recognise explicitly **the clout of finance capital**, its dominance of the global economy, and the origins and consequences of its periodic collapses.
4. Implement appropriate international **tax mechanisms** to control **global speculation** and eliminate tax havens.
5. Use health impact assessments to document the ways in which **unregulated and unaccountable transnational corporations** and financial institutions constitute barriers to Health for All.
6. Recognise explicitly the ways in which the current structures of **global trade regulation shape health inequalities** and deny the right to health.
7. Reconceptualise **aid for health** from high income countries as an **international obligation** and reparation legitimately owed to developing countries under basic human rights principles.
8. Enhance **democratic and transparent decision-making** and accountability at all levels of governance.
9. Develop and adopt **a code of conduct** in relation to the management of **institutional conflicts of interest** in global health decision making.
10. Establish, promote and resource participatory and action oriented monitoring systems that provide **disaggregated data on a range of social stratifiers** as they relate to health outcomes.

ENT

Rudolf VIRCHOW
(1821-1902)
La medicina è
una scienza
sociale e
la politica non è
altro che medicina
su larga scala.

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Discorso di un lavoratore a un medico
Bertolt Brecht, 1938

“Noi lo sappiamo che cos'è che ci ammala!
Quando veniamo da te
ci strappiamo di dosso i nostri cenci
e tu ascolti qua e là sul nostro corpo nudo.
Sulla causa della nostra malattia
un solo sguardo ai nostri cenci ti
direbbe di più.
Una stessa causa fa a pezzi
i nostri corpi e i nostri abiti,
non dice nulla di diverso.”

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The Need for a New Medical Model: A Challenge for Biomedicine

George L. Engel

Science, Vol. 196, No. 4286 (Apr. 8, 1977), pp129-136

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- “La crisi della medicina sta nel fatto che la malattia è interamente spiegata dalla deviazione dalla norma di variabili biologiche (somatiche) misurabili e che i medici considerano i problemi psicosociali al di fuori della responsabilità e dell’autorità della medicina. All’interno di questa cornice concettuale non c’è spazio per le dimensioni sociali, psicologiche e comportamentali delle malattie”.

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RCP policy statement 2010

How doctors can close the gap

Tackling the social determinants of health through culture change, advocacy and education

EQUAL OPPORTUNITIES FOR HEALTH ACTION FOR DEVELOPMENT

RCP policy statement 2010

How doctors can close the gap

Tackling the social determinants of health through culture change, advocacy and education

4 Changing education

We must give medical students and trainees the encouragement and support to act on social determinants of health and to promote health throughout the population, rather than exclusively concentrating on treating individual patients. It is important to impress on students early in their medical careers that learning about the social determinants of health really will help them to make a difference to the health of society. As well as being taught

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“Clinicians can **discuss with patiens** the impact of wider social determinants on their health, identifying areas that may have a significant health impact and signposting towards appropriate support and services, inside and outside the health sector. This could be through **helping them to access health information, screening, health promotion and prevention services and treatment.**”

Royal College of Physicians Policy Statement 2010. *How doctors can close the gap. Tackling the social determinants of health through culture change, advocacy and education.*

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The role of advocacy

Recommendations

- Learning on health promotion, health inequalities, disease prevention and the social determinants of health should be made more engaging, be embedded as a vertical strand throughout medical education and be considered a key outcome of the process.
  Key actors: Deans of medical schools, course directors, postgraduate deans, medical royal colleges

- Senior medical figures and medical educators should legitimise, encourage and harness the power of student advocacy and action on the social determinants of health.
  Key actors: Deans, course directors, undergraduate and postgraduate deans, royal medical colleges

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