



**DOCTORS
WITH AFRICA**
CUAMM



HEALTH AND DEVELOPMENT

quarterly magazine
of international cooperation
and health politic
Jun 2013 — No. **67**

June 2013 / n° 67

TAKING CARE OF EUROPE





NEWS

Global violence against women

Violence against women is a global phenomenon and a tragedy of enormous dimensions. Roughly one third of the world's women has personally experienced episodes of violence, committed in the majority of cases by a partner. The World Health Organization (WHO) has for the first time dedicated a specific report on this issue, describing the scope of the problem and its consequences on women's health¹. The report considers two different types of violence against women: a) physical or sexual violence committed by partners and b) sexual violence committed by non- partners.

An overall total of 35% of women throughout the world have been exposed to this type of violence.

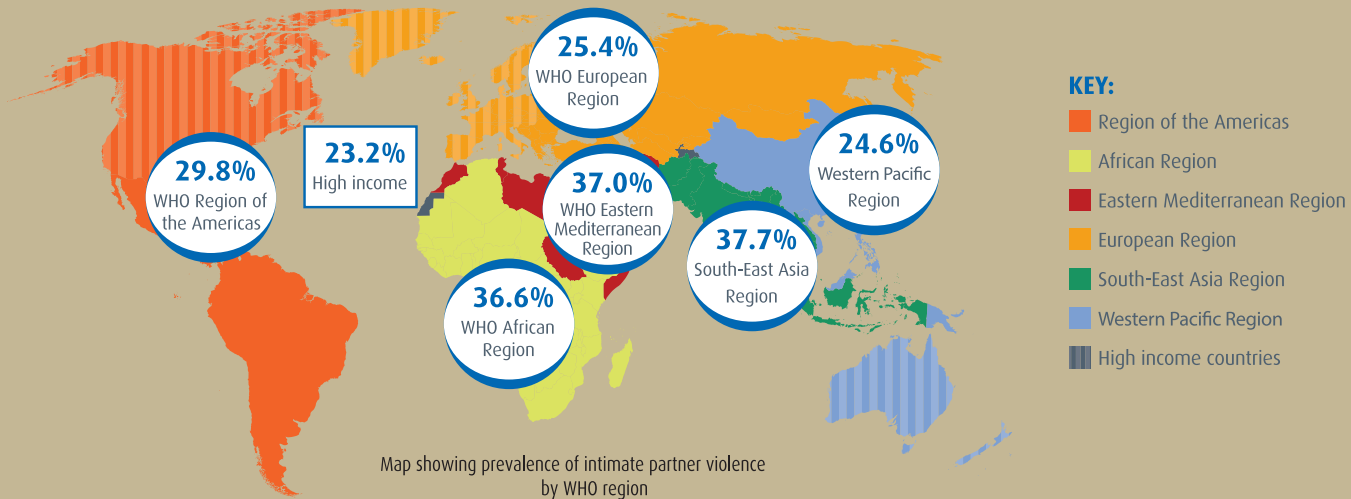
¹ <http://www.who.int/reproductivehealth/publications/violence/9789241564625/en/index.html>

FIGURE / VIOLENCE AGAINST WOMEN: 1 IN 3 WOMEN WORLDWIDE IS A VICTIM OF PHYSICAL AND SEXUAL VIOLENCE BY A PARTNER OR ANOTHER PERSON.



1 in 3 women

throughout the world will experience physical and/or sexual violence by a partner or sexual violence by a non-partner



All statistics can be found in the report entitled Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence, by the World Health Organization, the London School of Hygiene & Tropical Medicine, and the South African Medical Research Council, found here: <http://www.who.int/reproductivehealth/publications/violence/en/index.html>

INDEX

EDITOR

Gavino Maciocco

EDITORIAL STAFF

Maria Rosaria Acquaro, Andrea Atzori, Dante Carraro, Adriano Cattaneo, Donata Dalla Riva, Silvio Donà, Serena Foresi, Fabio Manenti, Luigi Mazzucato, Giovanni Putoto, Angelo Stefanini, Anna Talami

EDITOR-IN-CHIEF

Anna Talami

OWNERSHIP

Medici con l'Africa Cuamm

ADMINISTRATION

Via S. Francesco, 126 - 35121 Padova
t 049 8751279-8751649
f 049 8754738
e-mail cuamm@cuamm.org

EDITORIAL COORDINATION

Chiara Di Benedetto

EDITORIAL SECRETARIES

Elisa Bissacco

CREATIVE IDEA AND COVER ILLUSTRATION

Ramon Pezzarini

LAYOUT AND PRINTING

Publistampa, Via Dolomiti, 36 - 38057 Pergine Valsugana (Trento)

COPYRIGHT

Doctors with Africa CUAMM, Via S. Francesco, 126 - 35121 Padova.
Articles and materials contained in this publication can be reproduced in whole or in part provided that the source is cited

REGISTRATION AND AUTHORIZATION

c.o. the Law Courts of Padova n. 1129
on 5.6.1989 and on 11.9.1999

DISPATCH

in abb. post. D.L. 353/2003 (conv. in L. 27/02/2004 n° 46) art. 1
comma 2 - DCB Padova

TRANSLATION

Joanne Fleming

Cover illustration by Ramon Pezzarini.

Taking care of Europe, especially in health. And especially in this moment, when the "lights" of many healthcare system seem turning off, leaving citizens - particularly the poorest and the ones at risk of marginalization - in the position of not being able to cure themselves. *Health and Development* presents the reforms and changes that have affected many European countries in recent years, as a result of the economic crisis.



DIALOGUE

PAGE 2

HEALTH: A UNIVERSAL VALUE, EVEN DURING RECESSION

Text by / don Dante Carraro

PAGE 3

HEALTH IN EUROPE

Text by / Gavino Maciocco



FORUM

PAGE 6

CAUGHT FROM INSIDE - THE OTHER SIDE OF LIFE

Text by / Guido Maria Lattanzi, Egidio Candela

PAGE 7

EDUC-ACTION AND AWARENESS

Text by / Mario Staccioni

PAGE 8

THE HEALTHCARE SYSTEM IN HUNGARY

Text by / Eniko Demeny

PAGE 9

CEU OF BUDAPEST

Text by / Eniko Demeny



EXPERIENCES FROM THE FIELD

PAGE 12

A BIG BANG FOR THE ENGLISH HEALTH SERVICE

Text by / Gavino Maciocco, Chiara Di Benedetto

PAGE 15

THE TUBERCULOLOSIS EMERGENCY IN THE EX U.S.S.R COUNTRIES

Text by / Mario Raviglione, Giovanni Sotgiu



A CLOSER LOOK

PAGE 17

AUSTERITY AND ITS IMPACTS ON HEALTH: THE GREEK CASE

Text by / Renia Vagkopoulou



REVIEW

PAGE 18

THE HAVES AND HAVE-NOTS. STORIES OF INEQUALITY

Text by / Giovanni Putoto

PAGE 19

THE LANCET GLOBAL HEALTH

Text by / Gavino Maciocco



DIALOGUE

HEALTH: A UNIVERSAL VALUE, EVEN DURING RECESSION

Italy's economic and financial credibility and reliability continue to decline. The country's healthcare system does, however, work well and at a relatively low cost, but the threat of cutbacks loom on the horizon. Even during recession Doctors with Africa CUAMM endorses its commitment to combat social injustice, because health is the responsibility of all of us for all of us.

TEXT BY / DON DANTE CARRARO / DIRECTOR OF DOCTORS WITH AFRICA CUAMM

Triple B: this is the ranking recently assigned to Italy by the international rating agencies, whose job it is to assess a company's or a country's stability in the financial market. It is a sign that Italy's economic and financial credibility and reliability are continuing to decline. The rating would probably fall to triple C if we considered other indicators as unemployment, the prospects of young people and families, or the number of people below the poverty line.

Italy does, however, lead the table with a triple A in one area: the country has the world's lowest maternal mortality rate. In no other nation do women give birth with such high levels of skilled care and safety. While there is undoubtedly room for improvement, this result suggests that our healthcare system works well, providing citizens with a good service at a lower average cost compared not only to the United States, but also to other European countries.

Rather than prompting the need to strengthen social protection networks, such as healthcare systems, the current economic and social crisis is instead forcing the governments of many neighbouring countries to cut public health spending to the detriment of universality of national health service coverage. This has already happened in Sweden, Spain, Greece and even the United Kingdom, which was the first nation to start universal health coverage and a source of inspiration to other countries. This more restrictive approach is now threatening Italy.

At the end of 2012, Mr. Mario Monti, the then Italian Prime Minister stated that, "Unless new ways of funding services and programmes are identified, the future sustainability of national health services may no longer be guaranteed. This also applies to the Italian system, of which we are very proud," suggesting the need to find more or less extensive forms of privatized funding for the health system. Should this happen, the poorer sectors of the population, the chronically ill and the elderly would be the ones most affected, just as they are bearing the brunt of the economic crisis.

The question of the sustainability of a health service in a low-resource country needs to be addressed and the most appropriate solutions found. What we cannot do is tie the right to health to fluctuations in the fall or rise of GDP.

I was very moved by the exceptional example of the choreographer and dancer, Erdem Gunduz, who stood motionless for eight hours in front of the Ataturk Cultural Centre in Taksim Square, named after the father of secular Turkey. In the space of a few hours, a non-partisan crowd of young and elderly, students and workers, had gathered around him. They too stood in silence with their heads held high and a proud look on their faces, in a show of resistance to any attempt to circumvent democracy.

We too should make a stand in defence of everyone's right to access a dignified health service: motionless and in silence, alert and on guard, like sentries. A right without restrictions, reaching the most fragile members of our society.

Pope Francis is moving in the same direction: only a few days have elapsed since his first pastoral visit, taking him to the island of Lampedusa. On the subject of the victims of the sea and more generally the inequities between the world's northern and southern hemispheres, he maintained that, "The culture of wellbeing teaches us to think only of ourselves, making us insensitive to others and surrounding us in beautiful but worthless soap bubbles that offer a fleeting, futile but empty illusion, leading to indifference towards others, or worse still towards the globalization of indifference. We have grown accustomed to the suffering of others, it does not affect nor concern us; it is none of our business!"

Pope Francis calls on us to embody the value of solidarity and exchange among people, aspiring to the concept of globality in its noblest, most positive and ethical form. Indifference needs to be replaced by the value of sharing and the awareness that our apparently distant worlds do instead depend on each other.

We thus endorse our commitment to fight against indifference and social injustice on behalf of the weakest, most ailing peoples, because health and access to care is not for the privileged few but the responsibility of all of us for all of us.



DIALOGUE

HEALTH IN EUROPE

The aim is basically ideological: to oust the State from the social field, replacing the public with the private sector in the delivery of services and insurance cover. England, Spain and Sweden have already taken important steps in this direction.

TEXT BY / GAVINO MACIOCCO / DEPARTMENT OF PUBLIC HEALTH, UNIVERSITY OF FLORENCE

Authoritative medical journals are becoming increasingly concerned with the economic crisis that is sweeping Europe and the effects it is having on healthcare systems and population health. *The Lancet* has recently published a paper entitled, "Financial crisis, austerity and health in Europe"¹. Below are the salient points raised.

- Unemployment is the most worrying aspect of the economic turndown and is believed to have a highly detrimental effect on health. It is associated with a marked increase in mental and psychosomatic disorders, unhealthy behaviours (as alcoholism) and increased mortality, due in part to the rise in the number of suicides.
- Social protection networks should be scaled up during economic crises to mitigate the negative effects on health. According to an OECD study, an increase in social spending of 100 dollars per capita is associated with a 1.19% reduction in mortality.
- Austerity policies have instead led to cuts in social spending and made access to healthcare services more difficult, together with a reduction in public healthcare service delivery and an increase in user fees.

The *Lancet* paper concludes on a bitter note. European heads of health, from the ministers of the various governments to European Union commissioners, have responded to the tragedy with silence, despite their obligation to assess how EU austerity policies and the troika's prescriptions are affecting health. Their intervention has largely been limited to advising how the various health ministers should go about cutting their health budgets.

Moreover, the crisis has not only led to ill-advised austerity-related cuts, it has also paved the way for radical health-system changes, as in England. On the subject of Cameron government reforms, Martin McKee wrote in *BMJ*, "The economic crisis has given the government a once-in-a-lifetime opportunity. As Naomi Klein has described in many different situations, those who oppose the welfare state never waste a good crisis"². It is clearly no coincidence that in Europe the target of "those who oppose the welfare state" has been the "Beveridge model" of healthcare, found in countries as the United Kingdom, Spain, Sweden and Italy. Even though this general taxation-funded, state-run system of universal coverage is – amongst other things – less expensive than social insurance-funded "Bismarck models" adopted in countries like Germany, France, Switzerland and the Netherlands and, less still than private insurance-based systems, as in the USA.

The aim is basically ideological: to oust the State from the social field, replacing the public with the private sector in the delivery of services and insurance cover.

Accordingly, Cameron's reform, which came into force in **England** last April, has abolished the entire public infrastructure of the National Health Service – NHS, privatizing healthcare service delivery and introducing competitive and market mechanisms at all systems levels³.

In **Spain**, a royal decree passed in April 2012, accompanied by drastic public health expenditure cuts and increases in user fees, has established that users of the national health service shall henceforth be referred to as "the insured" rather than as "citizens". This variation in lexis heralds a change in the system in the direction of an insurance-based model⁴.

In **Sweden**, the *Free Choice Act Law* of 2009 formally endorsed the introduction of competition between private for-profit and public facilities in primary care delivery, enabling new facilities to share in available public fund allocation. To boost this reorganization programme, newly established private centres have been given priority access to funding while investment in purely public Primary Care Centres is permitted solely in the absence of new private facilities⁵.

NOTES

¹ Karanikolos M. et al., *Financial crisis, austerity, and health in Europe*, *Lancet*, published Online March 27, 2013.

² McKee M., Stuckler D., *The assault on universalism*. *BMJ* 2011; 343:1314-17.

³ Maciocco G., *Il Big Bang del NHS*, <http://www.saluteinternazionale.info/2013/04/il-big-bang-del-nhs/>

⁴ Garsia Rada A., *New legislation transform Spain's health system from universal access to one based on employment*, *Bmj* 2012, 344:3196.

⁵ Grillo Ruggieri T., *Sindrome di Stoccolma. La crisi sul sistema sanitario svedese*, <http://www.saluteinternazionale.info/2013/06/sindrome-di-stoccolma-la-crisi-sul-sistema-sanitario-svedese/>



POPE FRANCIS AMONG THE IMMIGRANTS ON LAMPEDUSA

"The globalization of indifference makes us all 'unnamed', responsible yet nameless and faceless". These were the powerful words spoken by Pope Francis last 9th July, during a mass celebrated on Lampedusa. The aim of the first official visit was to meet the last and the least, namely the immigrants, to remember the many victims of the sea, forgotten by the world's powerful, and to seek forgiveness because the "culture of comfort teaches us to think only of ourselves, making us insensitive to the cries of others and surrounding us in beautiful but worthless soap bubbles that offer a fleeting but empty illusion, which makes us indifferent to others, or worse still leads to the globalization of indifference."





CAUGHT FROM INSIDE - THE OTHER SIDE OF LIFE

Italian, Croatian and Macedonian medical and law students have joined forces to defend the rights of prisoners in Europe. The project *Caught from Inside* stems from the need to give visibility and voice to otherwise hidden issues, neglected in university programmes and in the media debate.

The project is divided into three steps: research, experience in the field and a final workshop.

TEXT BY / GUIDO MARIA LATTANZI, EGIDIO CANDELA / SISM - ITALIAN SECRETARIAT OF MEDICAL STUDENTS

THE INTERNATIONAL PROJECT

"The degree of civilization in a society can be judged by entering its prisons." If we based our analysis on this affirmation by Dostoyevsky in "Crime and Punishment," Italy would definitely not be considered a good model of civilization.

Recent figures reported by the European Council put Italy in third to last place in inmate-to-capacity ratio. Its prisons hold 66,897 detainees but are built for 45,700, meaning that capacity is exceeded by almost thirty percent. Among the many issues afflicting penal institutions, overcrowding is the one that draws most attention.

To begin to unravel this highly delicate problem, SISM (Italian Secretariat of Medical Students) and ELSA (the European Law Students' Association) have set up *Caught From Inside - The Other Side of Life*, an international project on the protection of the rights of inmates in Europe, in which SISM specifically focuses on the right to health and access to medical care.

THE THREE STAGES

The project involves ten SISM, ten ELSA Italy and ten ELSA Croatia and Macedonia students and is divided into three parts. The first is based on research into health in prison and will be carried out by the students with the support of four academic supervisors. The participants will have access to two penal facilities, one in Italy and one in Croatia. The third stage is for drawing conclusions and presenting the results of the study at a workshop based on non-teacher-led instruction, to be held in the autumn of 2013. The aim of this methodology is to involve as many students as possible, by giving them an active role in the development and understanding of these issues, and bringing them into contact with associations and professionals working in social care, specifically inmate reintegration.

The project covers the four areas that form the basis of all European care-related studies and projects and focus on key health issues in penal facilities: mother and child health, infectious disease control, psychiatric care and dedicated analysis of migrants' living and health conditions.

HEALTH PROBLEMS IN PRISON

As regards mother and child health, maternity statistics for Italian prisons are in line with European trends², with 50 inmates with children and 13¹ pregnant women at 31 December, 2011. Focus group attention will not, however, be limited to this aspect. Specific importance will also be laid on the spread of gynaecological pathologies and therefore on screening and prevention programmes, with a view to improving standards and the quality of peri- and neonatal care. In Italy, as in the rest of Europe, infectious diseases are the second most widespread pathologies in the prison setting. Four out of ten inmates suffer from infectious diseases. Of them, 35% have hepatitis C, the pathology affecting the highest number of detainees in Italy. Between 6-7% have hepatitis B and 2-3% have HIV. Factors related to overcrowding, poor hygiene, poor cleanliness of premises, and endemic sexual promiscuity mean that inmates are among the highest risk categories (and unfortunately least monitored) for this type of pathology. Some penal facilities are even the main breeding grounds for re-emerging diseases, as tetanus and TB³.

During 2011 there were 63 recorded cases of suicide, 1,003 of attempted suicide, and 5,639 of self-harm among Italian inmates. Suicide causes the biggest stir within the psychiatric sphere, but historically is just one of the disordered behaviours with the highest prevalence in the world's prison population (substance abuse and psychoses being the most frequent). Some clinical case series and treaties even include certain diseases considered exclusive to these populations and belong to the sphere of dementia and psychosis, as Ganser syndrome and prisonization⁴.

NON-EU CITIZENS

According to recent EU statistics, the average non-EU inmate is male, thirty years of age and comes from Western Africa or the Middle East. These data fully coincide with these findings for Italy, where over one third of detainees are foreign and mostly originate from Africa (50.4%), specifically Morocco and Tunisia⁵. Besides the problems of overcrowding and health and hygiene conditions that affect the lives of all inmates, these people have

the added disadvantage of having no-one to listen to them, uncertain detention conditions, continuous transfers, and no future prospects. What emerges is a dramatically insecure picture permeating every aspect of prison life and making it extremely difficult to really achieve (and often maintain) a status of physical and mental wellbeing⁶.

UNOFFICIAL ISSUES

Life inside damages otherwise healthy people. While some people have pre-existing conditions, as asthma, chronic pain or medical conditions, the majority of detainees report to have been in good physical health on entering prison. The 1975 prison reform and Gozzini's law of 1986 are no more than a mirage in today's prisons.

Caught From Inside therefore stems from the need to give visibility and voice to otherwise hidden issues, neglected in university programmes and in the media debate. The main tool for achieving this will be a workshop, planned for next autumn, followed by publication of an essay designed to raise public awareness, partly in view of the imminent closure of psychiatric hospitals for criminals (scheduled for April 2014). Our long-term aim is nonetheless to give the project continuity with a view to training a group of young doctors and jurists to gain the knowledge and skills to address these complex problems.

REFERENCES

- 1 Møller L., Stöver H., Jürgens R., Gatherer A., Nikogosian H., 2007. *Health in prisons. A WHO guide to the essentials in prison health*. WHO Regional Office for Europe.
- 2 *The Madrid recommendation: health protection in prisons as an essential part of public health*, 2010. WHO Regional Office for Europe.
- 3 Muratore M.G., a cura di, 2012. *I detenuti nelle carceri italiane - Rapporto Istat 2012* [Online]. Disponibile su: <<http://www.istat.it/it/archivio/77789>> [Date of access: 08/06/2013].
- 4 Depascalis M., Martone M., 2005. *Regime penitenziario dei detenuti stranieri* [Online]. [leguideimmigrazione.it](http://www.caritasitaliana.it/caritasitaliana/pdf/immigrazione/9_Regime_penitenziario.pdf). Disponibile su: <http://www.caritasitaliana.it/caritasitaliana/pdf/immigrazione/9_Regime_penitenziario.pdf> [Date of access: 08/06/2013].
- 5 Møller L., Gatherer A., Dara M., 2009. *Barriers to implementation of effective tuberculosis control in prisons*. *Public Health*, 123 (2009), 419-421.
- 6 Fazel S., Seewald K., 2012. *Severe mental illness in 33,588 prisoners worldwide-systematic review and meta-regression analysis*. *Br J Psychiatry*, 2012 May, 200(5), 364-373.



EDUC-ACTION AND AWARENESS

Since 2007, *Labmond* has travelled to various parts of Italy, enabling over 600 students to train in global health issues previously neglected in university degree courses.

TEXT BY / MARIO STACCIONI / SISM - ITALIAN SECRETARIAT OF MEDICAL STUDENTS

Labmond, (*Global Awareness Workshop*), the first course in global health designed by students for students, was organized in 2007. Since then, *Labmond* has travelled to various parts of Italy, enabling over 600 students to train in global health issues previously neglected in university degree courses. From one edition to the next there has been a growing demand for novel, horizontal training where there is no clear distinction between teachers and students, rather each participant contributes in some way to a common pathway.

This year's *Labmond* sought to promote the idea through an experience-based journey, involving novices and students who had already encountered global health. The three-day workshop was divided up into four parallel sessions for 24 participants each, with a view to fostering dialogue. These sessions alternated with training in groups of 8 and with discussion and exchange on the findings of the various groups. Plenty of time was set aside each day to organize and discuss ongoing findings, which were reinterpreted in the light of the scientific literature and other sources of information.

Labmond's scientific committee, formed by 30 students and residents, managed each of the sessions and moderated the debates, continuously reviewing any "certainties" reached by the group in the light of new input, in accordance with a new "shared uncertainty building" model.

We hope that giving preference to an experience-based approach for bringing concepts of global health to the fore, as opposed to a teacher-led presentation of notions, has made participants more aware of their own impact on the world and motivated them to more closely investigate course content.



FORUM

THE HEALTHCARE SYSTEM IN HUNGARY

Doctors with Africa CUAMM continues its analysis of the health care systems of the partner countries involved in the *Equal Opportunities for Health* project. Here the focus is on Hungary, where the health situation and related findings are more alarming than might be expected, considering that only 7% of GDP is allocated to health.

TEXT BY / ENIKO DEMENY / CENTRAL EUROPEAN UNIVERSITY, CENTER FOR ETHICS AND LAW IN BIOMEDICINE, BUDAPEST, HUNGARY

THE COUNTRY

Hungary is located in Central Europe and has about 10 million inhabitants, some 1.7 million of whom live in Budapest, the country's capital. The population is ethnically relatively homogeneous. The largest ethnic minority is Roma, with more than 500 000 people. Hungary is a Member State of the EU since May 2004. Despite substantial increases since the mid-1990s, life expectancy at birth in Hungary (71.5 years in 2011, 71 years for man and 78.8 for woman) is still among the lowest in Europe. Infant mortality has decreased substantially in the last decades but is still above the EU27 average, it was 4.9 in 2011. Total health expenditure decreased from 8.3% of GDP in 2005 to around 7% of GDP in 2012. Public expenditure on health accounted for 69.7% of total health spending in 2009.

THE HEALTHCARE REFORM

Hungary, as other countries in Central and Eastern Europe chose the shift from the centralized Semashko model back to the Bismarck model in the early 1990's. The change of the financing method of the health care systems was achieved in order to overcome the common challenges of the health care system: lack of financial resources, poor infrastructure, low salaries for medical staff, general dissatisfaction with the system, poor health of the population, inefficient organization. In 2010 a new reform plan was developed, entitled *Revived Health Care, Recovering Hungary–Simmelweis Plan to Save Health Care*. The main elements of this middle-and long-term sectoral strategy are the following: organization of patient pathways, the restructuring of the health care delivery system, the promotion of the functional integration of provider institutions, the development of technical quality, and the moderation of territorial inequalities in the health care delivery system.

Health insurance benefits are financed by the National Health Care Fund (established in 1993). Its revenues come from compulsory health insurance contributions and taxation. In 2013 the healthcare contribution to be paid by the employee is 7% of the employee's salary. Based on the current legal framework, coverage should theoretically be 100%, but the health insurance status of approximately 4% of the population is unclear. Voluntary health

insurance amounts to only 7.4% of private and 2.7% of total health expenditure. Public expenditure on health has declined, falling to 5.2% of GDP in 2009.

HEALTH SERVICES

According to the law every patient has a right to proper, continually accessible and equitable health services according to health status, right to freely choose general practitioners, the right to health care provision, right to information, to autonomy, to free choice of physician, and to human dignity. Patients have to register with one general practitioner. Regarding access to specialists in general it happens through referral by the general practitioner, except in cases of emergency. The right to health services is unconditional only for emergency life-saving services, services that prevent serious or permanent health damage, and services that reduce pain and suffering.

The health status of the Hungarian population is among the poorest in the OECD, including countries with a similar level of income per capita. While the poor health outcome has been driven by the socioeconomic status of the population and lifestyle risks, it also reflects the relatively limited effectiveness of the health care system. According to the *Euro Health Consumer Index 2012* Hungary was ranked 28 out of the 34 countries. The Eurobarometer survey (2009) confirmed the dissatisfaction of Hungarian citizens with the health system in general. According to the survey, 22% of Hungarian respondents perceived the quality of care as very bad and an additional 50% as bad. Despite the fact that Hungary has a relatively low life expectancy at birth and a considerably high avoidable mortality rate, there are quality measures that paint a more positive picture. For example, the vaccination system is well organized and serves the public health needs of the population. Among children, measles immunization coverage was 99.8%, in 2009, which is an outstanding result among all OECD countries and also in the WHO European Region.

EQUITY OF ACCESS TO HEALTH CARE

Special concerns have been formulated related to equal and equitable access to health care. Access to health is compromised by

the consequences of the global financing crisis and the serious budget cuts in health care, coupled with a rapidly accelerating health workforce migration. There are great variations in the physical infrastructure quality of the health service delivery system. The territorial-regional differences as well as the urban-rural split create inequalities both in access and in quality of available services. In 2008 the gap between the regions with the highest and lowest health-adjusted life expectancies at birth stood at 8.1 years for man, and 7.7 year for women, reflecting large geographical and socio-economic inequalities. Large segments of the Roma population in Hungary live under disadvantageous conditions. This is reflected in their health status, which is worse than that of the non-Roma population, with life expectancy being 10 years shorter. The frequency of certain diseases is also considerably higher among the adult Roma population than in the general population. Compared to the general population, Roma are less likely to use health services, especially those offered by specialists and dentists. A more recent study also found that socioeconomic status is a strong determinant of health of people living in Roma settlements in Hungary and thus ethnicity per se may not be the only explanation. Although some efforts have been made to improve access to health services among marginalized sections of society, planned interventions to deal with health inequities within the wider framework of social determinants of health are still lacking.



CEU OF BUDAPEST

Central European University (CEU) of Hungary is a partner in the *Equal Opportunities for Health: action for development project*, coordinated by Doctors with Africa CUAMM.

TEXT BY / ENIKO DEMENY / CENTER FOR ETHICS AND LAW IN BIOMEDICINE, CENTRAL EUROPEAN UNIVERSITY, BUDAPEST, HUNGARY

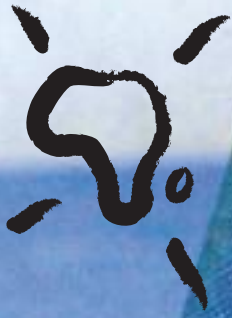
Central European University (CEU) is a graduate, English language university concentrating on the social sciences and the humanities as well as law and management. CEU was founded in 1991 and since that time it has become a new model for international education, a major convener on the international challenges of our time, a center for regional and global studies, and a source for intellectual support for building open and democratic societies that respect human rights. CEU closely engages with issues of public policy in order to support better governance in developing, developed and transition countries. CEU is a research-intensive university with more than 400 out of its 1,600 students pursuing doctoral degrees. CEU students are coming from 110 countries and its faculty from 40. Accredited both in the United States and in Hungary, CEU embraces the Bologna Process, actively partaking in the modernization of higher education across Europe, while also cultivating its ties to leading universities in the US.

The university's commitment to academic excellence and the social dimension of its mission are mutually reinforcing: being a regional thought-leader enables CEU to support and advise policy initiatives for social and economic reform. The university has been an active academic partner of local initiatives to strengthen good governance and address challenges as diverse as supporting independent media and promoting public health.

CEU acknowledged the need to explore the direct and indirect social, ethical, and legal implications of new technological advances and to understand them from a multidisciplinary perspective when it established the Center for Ethics and Law in Biomedicine (CELAB), in 2005. Since its foundation, one of the major activities of CELAB has been the participation in various European research and policy projects investigating the social, ethical and legal implications of contemporary biotechnologies and biomedicine. Among many other EU projects in which is involved CELAB participates as an Associate Partner in the *Equal Opportunities for Health: Action for Development* project that is an education and awareness-building project designed to highlight the importance of approaching health as a fundamental human right closely related to individual social development.

MAP / HUNGARY





**MALARIA AND MEASLES
AN INVISIBLE EPIDEMIC**

Few people are talking about it, fewer still show any concern, but in recent months a terrible combined epidemic of malaria and measles is raging at the hospital of Yirol in South Sudan and in the surrounding territory. The hospital with its 80 beds, is becoming a sort of "waiting room for hell," with peaks of almost 200 cases per week and only 2 CUAMM doctors to deal with the situation. The children come off worse, as always. Doctors with Africa CUAMM has started a local immunisation campaign against measles and at the same time is endeavouring to manage the many cases admitted to hospital. Info: www.mediciconlafrica.org.







EXPERIENCES FROM THE FIELD

A BIG BANG FOR THE ENGLISH HEALTH SERVICE

A new reform that will radically change the face of the English National Health Service came into force on 1st April of this year. It is rather a Big Bang for the oldest, most famous, most imitated universal healthcare system.

What will remain of the model? Very little, according to most.

TEXT BY / GAVINO MACIOCCO / DEPARTMENT OF PUBLIC HEALTH, UNIVERSITY OF FLORENCE
 CHIARA DI BENEDETTO / DOCTORS WITH AFRICA CUAMM

“Your new National Health Service begins on 5th July (1948). It will provide you with all the medical, dental and nursing care. Everyone – rich or poor, man, woman or child – can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a ‘charity’. You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness”. Less than a century ago, this declaration announced the establishment of the national health service to the British public, reassuring them that they would be safe should they fall ill, irrespective of income and social status¹.

Just a few months ago, on 1st April, 2013, a reform act (the *Health and Social Care Act, 2012*), approved last year and strongly supported by the conservative government led by Mr. David Cameron, officially came into force. The reform radically changes the face of the English National Health Service (NHS). It is rather a Big Bang for the oldest, most famous, most imitated universal healthcare system.

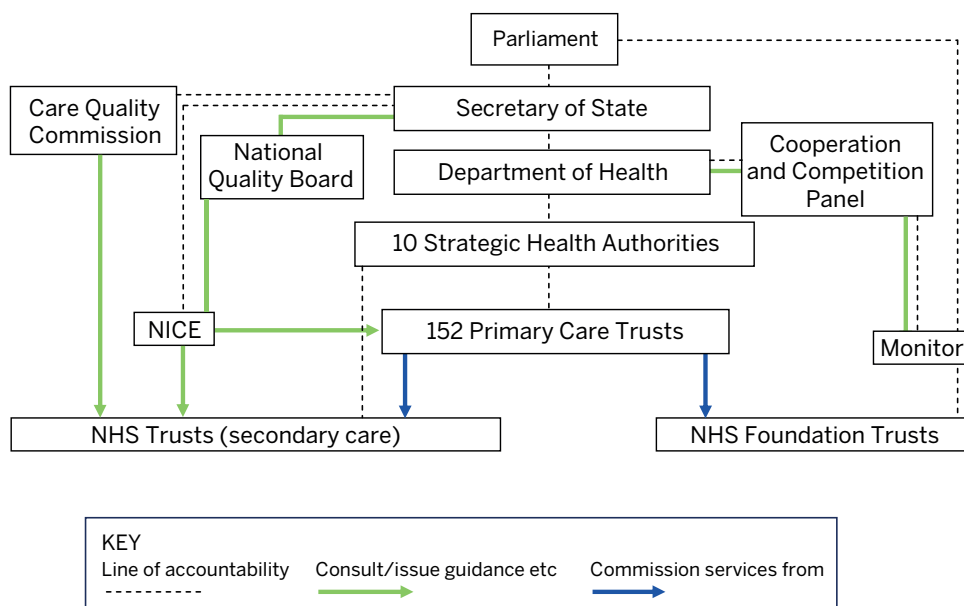
The main political content of the reform is as follows:

- the entire public health infrastructure, from the *Strategic Health Authorities to the Primary Care Trusts*, has been abolished as of April 1st;
- while health system funding remains the responsibility of the public sector and therefore of the taxpayer, service delivery (at the community and hospital levels) will move in the direction of widespread privatization of health services, driven by aggressive market logic, with the entry of large, powerful multinationals into the system;
- the few preventive services still run by the NHS (as infectious diseases control and screening schemes) have been completely transferred to the local town councils.

The *Primary Care Trusts* have been replaced by consortia of *General Practitioners* (GPs - family doctors), referred to as *Clinical Commissioning Groups* (CCGs). The CCGs, which are to all ef-

fects and purposes private organizations, form the cornerstone of the entire system. There will be 211 in the whole of England and will receive £65 billion of public funding (almost 70% of the £95 billion that constitute the entire national healthcare budget). “The switch to commissioning through GP Consortia,” reads an article in *The Lancet*, “undermines one of the key mechanisms

FIGURE 1 / MODEL OF THE PREVIOUS NHS



by which the NHS strives to ensure access to a full range of services wherever people live. PCTs are responsible for whole populations in defined geographical areas, not only for patients who are registered with specific health services. This population-based responsibility allows for long-term needs assessment, planning and commissioning of services to match those needs, and public accountability for resources for that population. The White Paper abandons this population-based principle; the basis for commissioning by the GP Consortia is for registered patients only, within amorphous and ill-defined boundaries. The ability to plan for the proper geographical dis-

tribution of services for communities and local populations will be lost”².

The CCGs will use the allocated funds to finance the work of GPs and the services offered to patients by the various public and private providers commissioned to deliver the necessary services: from home care to specialist and hospital treatment. This has immediately raised questions of potential conflict of interest: i.e., GPs will be prescribing services delivered by private providers with the potential for shared gain. As Matthew Limb wrote in *BMJ*³, “Half of GPs on clinical commissioning groups have financial links with private practices.”

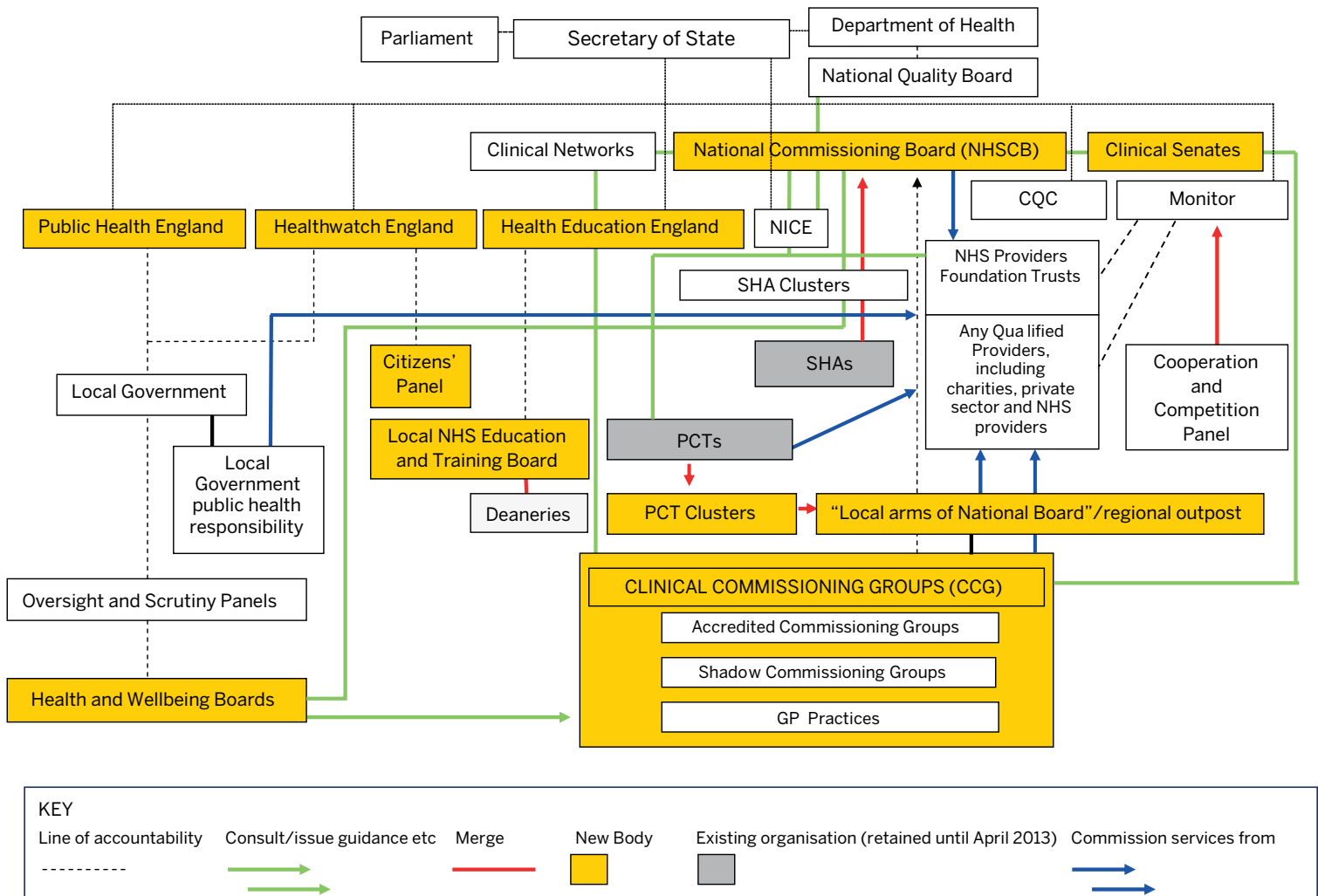
“The fact that GPs have these outside interests may influence their commissioning decisions, and may put at risk their relationship with their patients because the patient might mistrust where they are being sent to for treatment and the GP’s motives”, said Dr Clare Gerada, chair of the Royal College of GPs. “It may also damage the NHS because having many different

providers will increase costs and fragment care, which means patients will lose out.”⁴.

Things could be further complicated if – as provided for by the law – the CCGs were to outsource private agencies to perform their commissioning work, in which case the influence of financial gain in the choice of provider would be even more evident. Another critical element is the loss of nationally defined levels of essential care, set by the Ministry of Health prior to the reform. These established the services that public facilities were duty-bound to provide uniformly across the country and the contribution to be paid by patients for a limited number of services. Following the reform, each CCG will determine which services will be guaranteed and how much patients will contribute to costs.

The situation is further exacerbated by David Cameron’s government cuts to the health budget (leading to a £20 billion re-

FIGURE 2 / NEW MODEL OF THE NHS



duction by 2015) and other welfare sectors, which negatively influence health care. As General Practitioner, Simon Atkins, wrote in the *Guardian*, “An increasing number of people are attending our surgeries as a direct result of policies initiated by the government. The cuts are disproportionately affecting the poor, the old and the disabled and every day I see patients who are struggling because of them. This may be because their day centre, which used to provide support and company for them, has had to be closed down because funding has been withdrawn.”⁵

Lucy Reynolds of the London School of Hygiene and Tropical Medicine has likened the changes in the NHS to a genetic mutation, maintaining that the government is seeking to minimize the extent of change by asserting there will be no difference between services delivered by public and private providers. “In the public sector doctors attempt to arrange to have enough money to treat the medical needs of the people that come to them for help. The purpose is treatment, and the money is a means to an end. Once you move into the private sector,” con-

tinues Ms. Reynolds, “company law forces company staff to prioritise making money for the shareholders above everything else.” Reynolds predicts that the private sector will prevail in the fight for contracts between public and private providers, based entirely on cost, with irreversible consequences. “And every time one of those contracts is lost for the first time into the private sector, it means that that the public sector capacity to deliver that service disappears because there is nobody to pay the ongoing salaries”⁶.

Also convinced that the reform bill marks the beginning of the end of England’s NHS is David Hunter, Professor of Health Policy and Management at Durham University. His opinion can be summarized as follows: “From a market-oriented healthcare system we can expect: a) the quality of care to fall; b) the total cost of care to increase; c) public funds to become private profit; d) the freedom of choice to be reduced; e) public accountability and democratic control of healthcare to be undermined.”⁷

REFERENCES

1 Dossier NHS su SaluteInternazionale.info

2 Whitehead M., Hanratty B., Popay J., *NHS reform: untried remedies for misdiagnosed problems?* *Lancet* 2010; 376:1373-5.

3 Limb M., *Half of GPs on clinical commissioning groups have financial links with private providers*, *BMJ* 2012; 344 doi: <http://dx.doi.org/10.1136/bmj.e2431>

4 Campbell D., *The Guardian*, 27.03.2012.

5 Atkins S., *The Guardian*, 08.01.2013.

6 Reynolds L., *The future of NHS - Irreversible privatization?* *BMJ* 2013;346:f1848 doi: 10.1136/bmj.f1848.

7 Hunter D. Will, *1 April marks the beginning of the end of England’s NHS? Yes*, *BMJ* 2013;346:f1951 doi: 10.1136/bmj.f1951



EXPERIENCES FROM THE FIELD

THE TUBERCULOSIS EMERGENCY IN THE EX U.S.S.R COUNTRIES

In the countries of the former USSR, the populations' slide into poverty, unemployment, poorer living conditions and nutritional deficits, partly associated with alcohol and drug abuse, have facilitated the transmission and reactivation of the infection and its development into full-blown TB in infected subjects.

TEXT BY / MARIO RAVIGLIONE / DIRECTOR OF THE GLOBAL TUBERCULOSIS PROGRAMME (GTB), WORLD HEALTH ORGANIZATION
GIOVANNI SOTGIU / EPIDEMIOLOGY AND MEDICAL STATISTICS UNIT, DEPARTMENT OF BIOMEDICAL SCIENCES, UNIVERSITY OF SASSARI, AOU SASSARI, ITALY

Over the centuries and still today, tuberculosis - an infectious disease caused by *Mycobacterium tuberculosis* complex - remains a major clinical and world public health problem. The burden of the disease is enormous, particularly in geographical areas with low per capita incomes. From the 1970s onwards the incidence of the disease was demonstrated to be almost inversely proportional to a country's socioeconomic status. An estimated 8.7 million new cases of TB were recorded in 2011. Public health measures recommended by the World Health Organization (WHO) have led to a gradual fall in annual incidence since 2000. Nevertheless, the estimated prevalence in 2011 was 12 million with 1.4 million deaths, due to ineffective disease management and to the recent emergence of two novel epidemiological entities, particularly in the former Soviet Union, i.e., coinfection with HIV/AIDS, notably in Africa, and Multi-Drug-Resistant Tuberculosis (MDR-TB: caused by microbacterial strains resistant to at least two of the most powerful anti-TB drugs, isoniazid and rifampicin).

It should, however, be stressed that significant progress has been made since the mid-1990s. The public health strategies (i.e., DOTS and later the Stop TB Strategy) recommended by WHO have led to radical epidemiological improvements (see **Tables 1 and 2**) and it is estimated that approximately 51 million people have been treated and 20 million saved.

Although in recent years overall treatment success rates have exceeded 85% in subjects undergoing the six-month chemotherapy recommended by international guidelines, rates of below 70% have been recorded in some regional settings, including Europe, with the high frequency of MDR-TB being the main culprit, particularly in former Soviet Union countries. Political, economic and structural upheaval has led to poor tuberculosis management: deteriorating socioeconomic conditions followed by the collapse of the public health system, the populations' slide into poverty, unemployment, poorer living conditions and nutritional deficits, partly associated with alcohol and drug abuse, have fostered the transmission and reactivation of the infection and its development into full-blown TB in infected subjects. The rise in crime has been accompanied by an increase in the prison population, creating the perfect environment for disease transmission in detention facilities. In addition, the decline in primary care services, coupled with long waiting times for diagnoses, unsupported by adequate tools and approaches, the lack of some essential drugs, the use of inappropriate treatment regimens, and poor infection

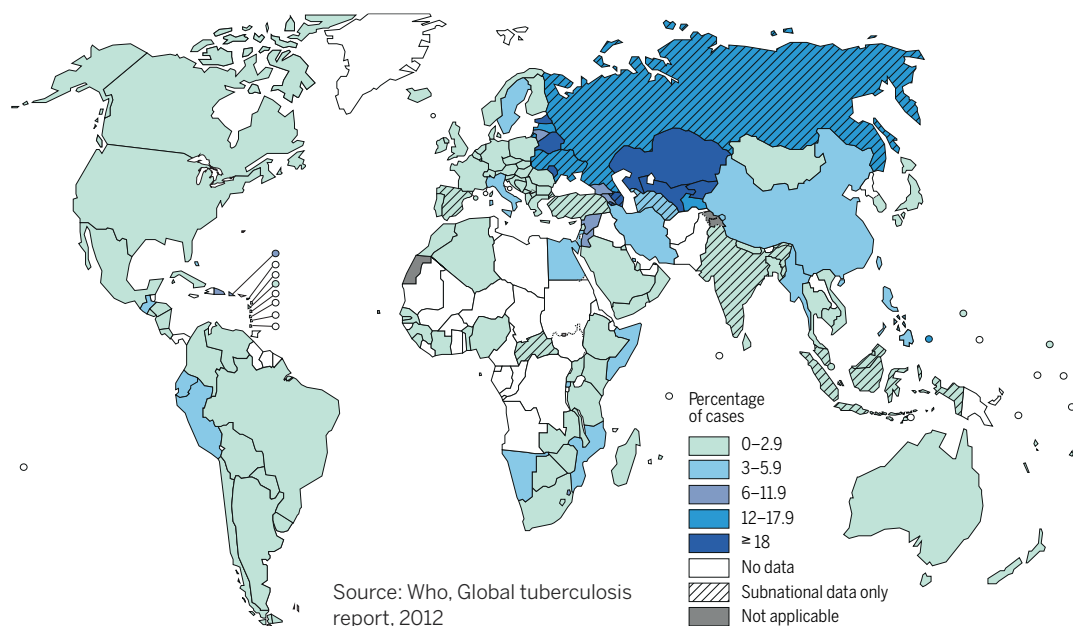
TABLE 1 / WORLD HEALTH ORGANIZATION DOTS STRATEGY, INTRODUCED IN THE MID 1990S

1. GUARANTEE CONSTANT POLITICAL COMMITMENT WITH ADEQUATE AND SUSTAINED FINANCING
2. GUARANTEE EARLY CASE DETECTION AND DIAGNOSIS THROUGH QUALITY-ASSURED BACTERIOLOGY
3. PROVIDE STANDARDIZED TREATMENT, WITH SUPERVISION AND PATIENT SUPPORT
4. GUARANTEE AN EFFECTIVE ANTI-TB DRUG SUPPLY AND MANAGEMENT SYSTEM
5. MONITOR AND EVALUATE PERFORMANCE AND IMPACT

TABLE 2 / THE WORLD HEALTH ORGANIZATION'S STOP TB STRATEGY, FOCUSED ON DOTS STRATEGY AND EXTENDED TO ADDRESS THE CHALLENGES OF THE NEW CENTURY

1. PURSUE HIGH-QUALITY DOTS EXPANSION AND ENHANCEMENT
2. ADDRESS TUBERCULOSIS/HIV COINFECTION, MULTIDRUG RESISTANT-TB, AND THE NEEDS OF POOR AND VULNERABLE POPULATION GROUPS
3. CONTRIBUTE TO STRENGTHENING THE HEALTH SYSTEM
4. ENGAGE ALL PUBLIC AND PRIVATE CARE PROVIDERS
5. EMPOWER PEOPLE WITH TUBERCULOSIS AND THEIR COMMUNITIES THROUGH PARTNERSHIP
6. ENABLE AND PROMOTE RESEARCH

control measures in hospital and non-hospital facilities have led both to treatment failures and to the onset and transmission of drug-resistance. Thanks to an international network of certified laboratories, the problem of MDR-TB can now be quantified. Surveys conducted by WHO in former Soviet Union countries have determined very high levels of MDR-TB: in Minsk (Belarus) MDR-TB rates stand at 35.3% in new and 76.5% in previously treated cases of tuberculosis. Similar levels have been recorded in the area of Arkhangelsk in Russia. The prevalence of MDR-TB is also very high in other regions of Russia, in Ukraine, Moldova, the Caucasus, the Baltic countries and in Central Asia. In 2011, had all the world's 5.8 million newly notified cases of tuberculosis been tested by antibiogram, 310,000 new cases of MDR-TB would have been detected. The greatest concentration is in 27 high-prevalence countries, of which as many as 15 are European and Central Asian. However, only 19% of the estimated number of cases (approximately 60,000) have been identified. Extensively Drug-Re-

FIGURE / PERCENTAGE OF NEW CASES OF TUBERCULOSIS WITH MDR-TB

sistant forms of tuberculosis (XDR-TB; caused by MDR strains also having resistance to fluoroquinolones and to at least one of the three second-line injectable drugs) are cause for great concern and have to date been notified in 84 countries, accounting for 9% of MDR-TB forms. Only about one third of the 107 countries affected by MDR-TB have managed to achieve a therapeutic success rate of $\geq 75\%$. Currently available, expensive treatment regimens are characterized by the use of less effective second-line drugs, which are more toxic and require prolonged administration of up to two years.

The financial crisis of the new republics born from the ashes of the communist regime has produced systems characterized by serious health and social problems (decline in hospitals, lack of pharmacological support for the sick, rise in HIV/AIDS cases, etc.), providing tuberculosis, particularly MDR-TB, with the perfect breeding ground. The example of the former USSR confirms what WHO has continued to maintain in its global strategy: the lack of political commitment and support is the starting point for the uncontrolled proliferation of tuberculosis in a specific national setting.

There are, however, promising signs on the horizon, particularly in the research and development field. At present, numerous laboratories in many geographical areas are performing new rapid molecular diagnostic tests, particularly to detect MDR-TB. WHO endorsement of Xpert MTB/Rif, for instance, has provided many countries with a technique for rapidly detecting cases of tuberculosis, including less contagious forms and those caused by bacteria resistant to rifampicin (indicating probable MDR-TB). This gives patients access to immediate treatment designed to improve the prognosis and reduce disease transmission. Moreover, two novel drugs (bedaquiline and delamanid), tested in MDR forms, could improve the present scenario characterized by expensive, prolon-

ged, highly toxic treatment regimens. Other novel antibiotics are still being tested and could radically change the approach to the patient. What is needed in primary prevention in public health is an effective vaccine to prevent pulmonary forms of tuberculosis. A clinically proven, safe, effective product could radically impact the disease and infection, as in the case of smallpox and polio, particularly in destitute settings as the ones where Doctors with Africa CUAMM provide important clinical and public health support. Currently, approximately twelve vaccines are in the advanced stages of development.

Further substantial funding, both from domestic government sources and international cooperation development agencies, is needed to control the disease, particularly in low- and middle-income countries. At the international agency level, above all the World Fund to Fight HIV/AIDS, Tuberculosis and Malaria and currently the leading external financier, financial aid should be concentrated in low-income countries not currently in a position to finance themselves. Conversely, domestic should rapidly replace external funding in countries experiencing rapid economic growth, in order to ensure sustainability and economic independence. Infrastructure, primary healthcare services, human resources, the drug information and procurement system and laboratories are some of the essential means of controlling tuberculosis that depend on the presence of an efficient health system. Preventing and controlling MDR-TB, for example, demands more extensive interventions than normally envisaged by national programmes. Some essential interventions, as the rational use of antibiotics, drug quality control or the installation of mechanisms for curbing hospital transmission, have to be implemented through ministerial policy makers, with a view to optimizing available resources and services.

In countries with a high incidence of tuberculosis, as those of the former USSR, it is paramount to strengthen primary care, adopt international diagnosis and treatment standards and improve treatment models, thereby avoiding long, costly, pointless hospital stays. New problems, as the rise in the incidence of non-communicable diseases that increase the risk of tuberculosis (e.g. diabetes mellitus and tobacco use) could undermine the already weak capacity of many health systems to manage tuberculosis. The evidence-based approach, recommended by WHO in several settings, may help downscale the tuberculosis epidemic through novel operational interventions, associated with a general improvement in socioeconomic setting, which has been a key determinant of this disease over the centuries.



A CLOSER LOOK

AUSTERITY AND ITS IMPACTS ON HEALTH: THE GREEK CASE

The deterioration of the socioeconomic determinants of health, combined with the limited public health provision and the inability to afford private expenditures due to economic shortage has led to a dramatic downturn in the population's well-being. 30% of the Greeks have no longer access to health care services.

TEXT BY / RENIA VAGKOPOULOU / INSTITUTE OF TROPICAL MEDICINE AND INTERNATIONAL HEALTH, CHARITE, BERLIN

Since 2009 Greece is hit by a severe debt crisis that has led the country to accept economical help from the International Monetary Fund and the Eurozone. The bailout loans received so far from the latter came with demands of implementation of strict austerity measures in the public sector and of liberalization of the Greek market.

The major labour reforms implemented include radical cuts of salaries, reductions of pensions and unemployment benefits and dismissal of public workers. Liberalization of the market takes place through mass privatization of the public infrastructure, deregulation and drastic tax increases affecting hardly the low and middle class.

The above implementations have resulted in rapid socioeconomic changes.

The unemployment rate has reached 27% and 60% among the young and the group living at risk of poverty and social exclusion is estimated to be 30% of the population. The amount of people pushed into homelessness has increased by 25%, while an accelerating number of persons who cannot afford the basics for living are forced to search support in newly formed community-based organizations. As a result of the reforms, free access to the National Health System is no longer guaranteed.

People who cannot afford paying the sickness funds or private health security schemes – mainly unemployed, low income workers, pensioners and migrants – remain with no access to health care services. The estimated number of the uninsured counts to 30% of the overall population and the number is rapidly growing.

Historical examples show that countries facing economic recessions must increase public spending on health in order to avoid deterioration of the health status of the population. Still the Greek government has proceeded to cut government expenditure on health extensively which has reached by now a 40% decline since 2009. This has mainly been achieved through reforms such as merging of public hospitals, decrease in the total number of hospital beds, reduction in human resources and constriction of street work programs. Moreover, consecutive reduction of social insurance health benefits come with an increase in co-payments for medication and diagnostic tests.

The deterioration of the socioeconomic determinants of health, combined with the limited public health provision and the inability to afford private expenditures due to economic shortage has led to a dramatic downturn in the population's well-being.

Suicide and homicide rates have increased by 16 and 26% respectively, facts that both can be associated with the rise in unemployment. Accordingly, self reported poor health and major depression has doubled during the last years. Trends in infectious diseases and especially HIV are particularly worrying.

Newly diagnosed HIV-1 infections have increased by 57%, whereas the increase reaches 1500% among the group of injection drug users. Moreover, within the last two years Greece has experienced outbreaks of infections of malaria and the West Nile virus, both attributed to the dismantling of preventive public health services. As a response to absence of the public security net, self-organized medical solidarity centres have appeared around the country to support the increase of people without medical insurance. However, only an abolition of the austerity policies and an orientation towards the strengthening of the public health sector could reassure the populations well-being.



REVIEW

THE HAVES AND HAVE-NOTS¹. STORIES OF INEQUALITY

What happens when you combine economics with history? An interesting, insightful analysis of inequalities of income and wealth in our world turns our thoughts to how the gaps between the richest and poorest can be closed.

TEXT BY / GIOVANNI PUTOTO / DOCTORS WITH AFRICA CUAMM

Branko Milanovic, a World Bank economist and one of the leading experts on global inequality, is also a history enthusiast. He has combined these two areas of expertise to compile an essay for a non-specialist audience that offers a very readable, but rigorously technical journey to acquire knowledge and to take a closer look at one of the most important yet “neglected” issues of our time: the inequalities of income and wealth.

The book is divided into three parts: the first addresses inequality within nations, the second focuses on inequalities between nations, and the third examines the problem of inequalities among the world’s citizens. Each part is illustrated by a series of stories that give structure to the book, whose aim is to highlight the importance that differences in birth, citizenship, income and wealth have on our lives, now as in the past. The tales of the three generations of Obamas and the tragedy of the young Harraga in the Mediterranean are particularly illuminating.

The key question remains as to how inequality should be measured. It used to be gauged by family incomes. Nowadays it is increasingly measured by consumption and the most commonly used indicator is the Gini Index² (where, on a scale of 0 to 100, 0 refers to the highest equality in income distribution and 100 the highest inequality). What is the current situation?

Considered separately, most European countries have a Gini coefficient of between 30 and 35. But things are changing. Italy, recently rising to 34, has become the second most unequal country in Europe³. The United States, like Russia, has recently risen from 35 to 40. Asia’s Gini coefficients range from 40 to 50, with little uniformity. There are bigger gaps in African and Latin American nations, with inequality reaching a Gini of over 60 in some.

The difference in absolute income between rich and poor countries has in turn risen significantly, except in China and India, where the gap is only marginally narrower. Although growth in China has led to a partial reduction in internal poverty, the country’s absolute income level continues to diverge significantly from that of the United States (37,000 USD PPP). To keep up with a 1%

US growth rate of per-capita GDP, India and China have to grow by 17% and 9%, respectively. This increase in the absolute income gap can be explained by massive flows of capital from rich countries to other rich countries and by access to technology. It is referred to as the “Lucas paradox” and undermines neoclassical theory of development, according to which globalization should cause countries’ incomes to converge. Hence the author’s assertion that, “globalization can no longer be said to offer benefits for poor versus rich countries”.

As concerns global inequality, the data published from 1988 to date are not surprising. The Gini coefficient reaches 70 and is stable. This index is, however, higher than in any individual country and is at its highest level since the industrial revolution. As things stand, the world’s 5% poorest people would have to work for two centuries to bridge the gap separating them from the world’s 5% richest.

Two above-mentioned dynamics have contributed to this situation: the growing inequality of incomes within many nations and the gap between the average incomes of different countries, with growth in China and India neutralizing this tendency.

By way of conclusion, the author asks whether it is important to address inequality. The affirmative answer is not motivated solely by social justice and ethics per se but also by structural reasons. Migratory flows and the social and political stability of countries cannot be governed by ignorance, ideology and greed. Findings are sound and the options on the table are clear. If there is to be integration of economies and populations, the incomes of the poor have to be increased in the countries where they live.

Why then does public opinion in western countries respond to this evidence with such apathy? Perhaps, regrettably, inequalities are perceived to be less serious and intolerable than they actually are. Perhaps the extremism of the dominant economic school of thought masks flaws in the system⁴. So what is the solution? “Old-style” awareness of the problem, public debate and a call to social activism⁵.

NOTES

¹ *Chi ha e chi non ha. Storie di disuguaglianze*. Branko Milanovic. Il Mulino, 2012.

² Developed in 1914 by Corrado Gini (1884-1965), Italian statistician and economist http://it.wikipedia.org/wiki/Corrado_Gini

³ See *Distribuzione dei redditi. Italia seconda in Europa per disparità*, Barbara Bisazzi, Sole24Ore, 24 June 2013.

⁴ See *Oltre la mano invisibile*, Kaushik Basu, Anticorpi Laterza, 2013.

⁵ There is a terminological overlap with *Health Activism in a globalising era: lessons past for efforts future*, Labontè R., Lancet, June 2013.

THE LANCET GLOBAL HEALTH

In June 2013 was born a monthly online, open access, freely accessible journal: to spread global readership geographically and in terms of users, in order to reach a larger number of students and readers in the poorest countries.

TEXT BY / GAVINO MACIOCCO / DEPARTMENT OF PUBLIC HEALTH, UNIVERSITY OF FLORENCE

Much ink has been spilled on the meaning of “Global Health”, particularly on the adjective “global”. *Global*, because over the last thirty years the globalization processes involving economics, finance and communications have also affected numerous aspects of health. Including the speed and intensity with which the risk factors of communicable and non-communicable diseases (e.g. the obesity epidemic) can spread throughout the planet; the consequences of natural resource exploitation and energy source usage, as climate change and food and water crises; market-oriented health policies and service privatization, driven by international institutions like the World Bank and World Trade Organization; pressure on population masses, including health providers, to migrate from one country to another and from one continent to another.

Besides its geographical connotations, the term *global* also refers to the complexity and scale of problems and issues that play a role in disease pathogenesis and health protection strategies. Likewise, global health encompasses the social determinants of health, the (economic, political, environmental etc) *causes* of diseases, and the intersectoral, multidisciplinary interventions required, as indicated in the almost prophetic Alma Ata Declaration of 1978.

The conceptual framework of Global Health – as observed in an article published in the *Lancet* in 2009¹ – draws on two different but complementary disciplines: *Public health* and *International health*.

Public health emerged in the 19th century thanks to the work of extraordinary figures as Farr, Chadwick, Virchow, Koch and Pasteur, who founded the new discipline on the basis of four elements:

- decision-making based on data and evidence (vital statistics, surveillance of epidemics, use of laboratories);
- a focus on populations rather than on individuals;
- the goal of social justice and equity;
- an emphasis on preventive rather than curative care.

International health has more recently developed along two different lines:

- a focus on the health problems of developing countries, as infectious and tropical diseases, protection of mother and child health, nutrition and the supply of water.
- comparative analysis of international health systems, their organization, costs and health outcomes.

Global health merges the two disciplines, which *The Lancet* defines as follows in the above-cited paper: “Global health is an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasises transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care”.

To demonstrate the importance of “Global Health”, *The Lancet* recently launched a specific online publication, *The Lancet Global Health*, the first issue of which came out on 26th June of this year². The *Lancet Global Health* is a monthly, online, open access, freely accessible journal, promoting the following important message: to spread global readership geographically and in terms of numbers, in order to reach students and readers in the poorest countries. Despite being an open access journal, the copyright policy interestingly states that, “All the articles remain the property of the authors, and reuse by others is permitted under a variety of Creative Commons licences, from the most restrictive to the most liberal, according to authors' own preferences”.

The first issue published in July 2013 contains four very engaging original papers on anaemia, intrauterine growth restriction, cataract surgery, and non-malarial causes of fever. Each article is accompanied by a comment. The one on fever was written by Zeno Bisoffi and Dora Buonfrate of the Tropical Disease Centre, Negar.

NOTES

¹ Koplan JP, et al., *Towards a common definition of global health*, *Lancet* 2009; 373: 1993-95.

² <http://www.thelancet.com/journals/langlo/issue/current>



DOCTORS WITH AFRICA CUAMM

Established in 1950, Doctors with Africa CUAMM was the first NGO in the healthcare field to receive recognition in Italy (pursuant to the Cooperation law of 1972) and is the largest Italian organization for the promotion and safeguard of the health of the African populations.

It implements long-term development projects, intervening with the same approach in emergency situations, with a view to ensuring quality services that are accessible to all.

HISTORY

In its **60** years' history:

- **1,330** people have departed to work on projects: 367 of these departed on more than one occasion. The total number of departures was therefore 1,908;
- **4,330** years of service have been carried out, with a mean of 3 years per expatriate person;
- **950** students have been accommodated at the college: 640 Italians and 280 from 34 different countries;
- **279** doctors have departed from the Veneto region in almost 60 years;
- **211** hospitals have been served;
- **40** countries have benefited from intervention;
- **150** key programmes have been carried out in cooperation with the Italian Foreign Ministry and various international agencies.

IN AFRICA

Today we are in Angola, Ethiopia, Mozambique, Sierra Leone, Southern Sudan, Tanzania, Uganda with:

- **80 providers:** 47 doctors, 4 paramedics, 29 administrative and logistics staff
- **37 key** cooperation projects and about a hundred minor support interventions, through which the organization assists:
 - 15 hospitals
 - 25 districts (for public healthcare activities, mother-child care, training and in the fight against AIDS, tuberculosis and malaria)
 - 3 motor rehabilitation centres
 - 4 nursing schools
 - 3 universities (in Uganda, Mozambique and Ethiopia).

IN EUROPE

Doctors with Africa CUAMM has for years been actively implementing projects and building networks at European level, with the aim of building public awareness on the subject of equality of access to treatment and healthcare systems. Specifically, from 2011 to 2014 the organization has been coordinator of the European project, "Equal opportunities for health: action for development", on which it has been working with 18 other partner organizations from 7 European countries. Universities, student associations, non governmental associations in Italy, Poland, Latvia, Bulgaria, Romania, Malta and Hungary are working together to give room and voice to training in Global health and to promote greater awareness about the relationships between health and development, both individually and collectively.

NOTICE TO READERS

Support and take part in our commitment to Africa, in one of the following ways:

- **Post office current account** no. 17101353 under the name of Doctors with Africa CUAMM
- **Bank transfer** IBAN IT 91 H 05018 12101 000000107890 at the Banca Popolare Etica Padua
- **Credit card** call 0039.049.8751279
- **Online** www.mediciconlafrica.org

Doctors with Africa CUAMM is a not-for-profit NGO. All donations are therefore tax deductible. They can be indicated for this purpose in the annual tax return statement, attaching the receipt for the donation made.

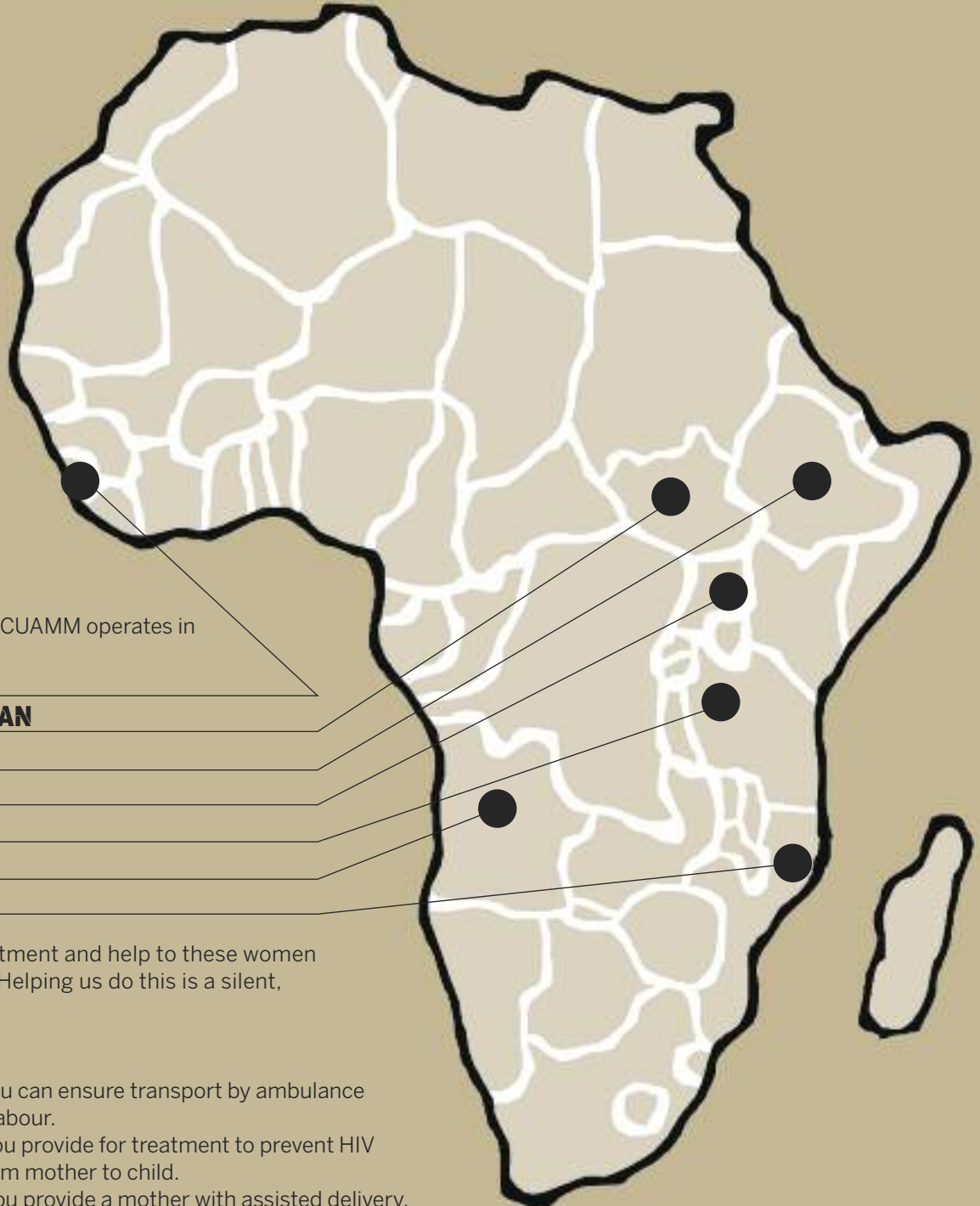
HEALTH AND DEVELOPMENT offers studies, research work and documentation which are unique to the Italian editorial world. Our publication needs the support of all readers and friends of Doctors with Africa CUAMM.



NEEDY AFRICA

EVERY YEAR IN SUB-SAHARAN AFRICA:

- 4.5 million children die before reaching five years of age, for preventable diseases that can be treated at low cost;
- 1.2 million newborn children die in the first month of life through lack of treatment;
- 265 thousand women die from pregnancy- and delivery-related problems.



Doctors with Africa CUAMM operates in

SIERRA LEONE
SOUTHERN SUDAN
ETHIOPIA
UGANDA
TANZANIA
ANGOLA
MOZAMBIQUE

where it offers treatment and help to these women and their children. Helping us do this is a silent, forgotten war.

- With 15 euros you can ensure transport by ambulance for a woman in labour.
- With 25 euros you provide for treatment to prevent HIV transmission from mother to child.
- With 40 euros you provide a mother with assisted delivery.
- With 80 euros you fund a week's training course for a midwife.



**DOCTORS
WITH AFRICA**
CUAMM



quarterly magazine
of international cooperation
and health politic
June 2013 — No **67**
www.doctorswithafrica.org



**EQUAL OPPORTUNITIES
FOR HEALTH**
ACTION FOR DEVELOPMENT



This publication has been produced with the assistance of the European Union. The contents of this publication are the sole responsibility of Doctors with Africa CUAMM and can in no way be taken to reflect the views of the European Union.