I determinanti sociali e le disuguaglianze in salute

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What is global health?

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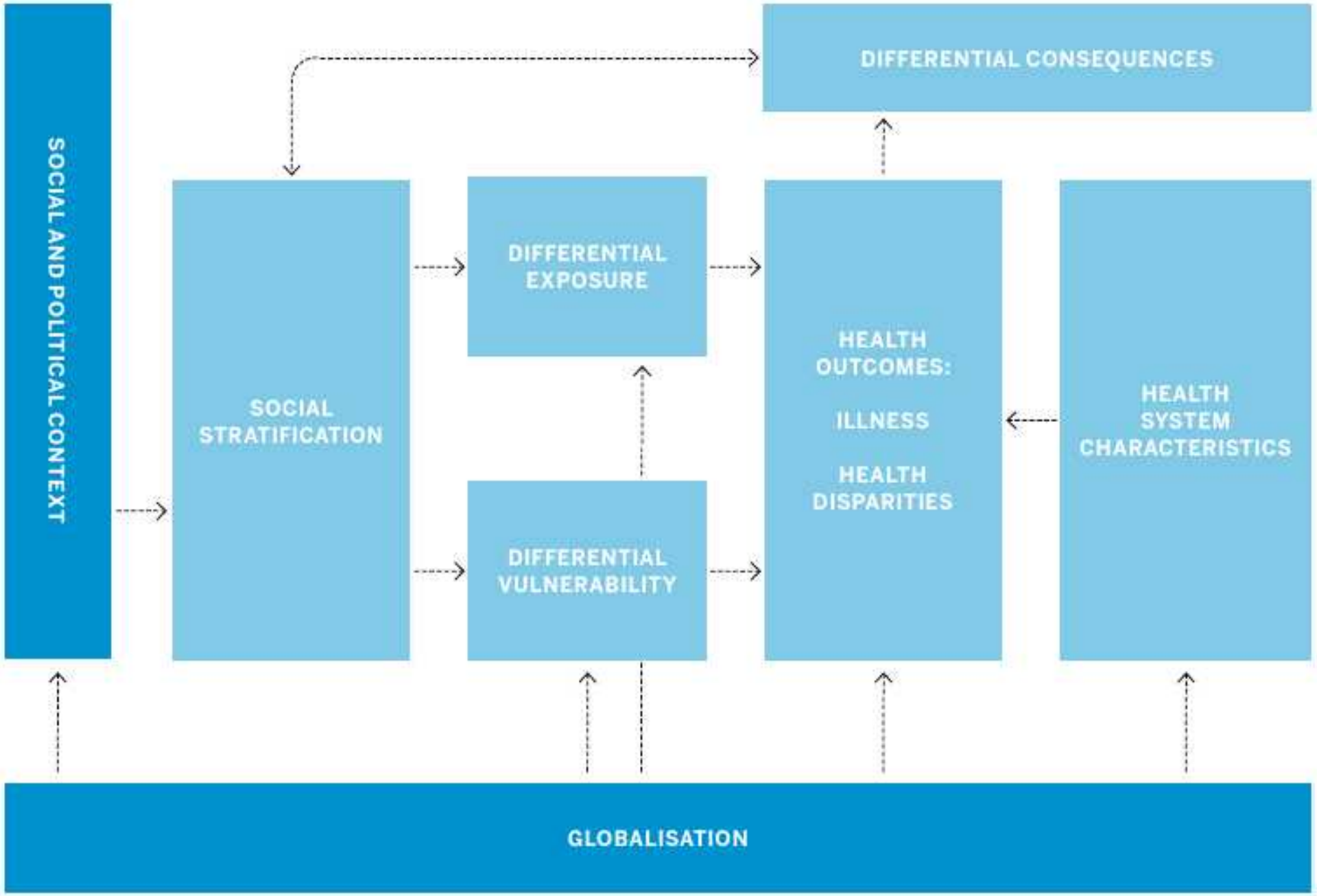

Source: Labonté and Schrecker, 2007

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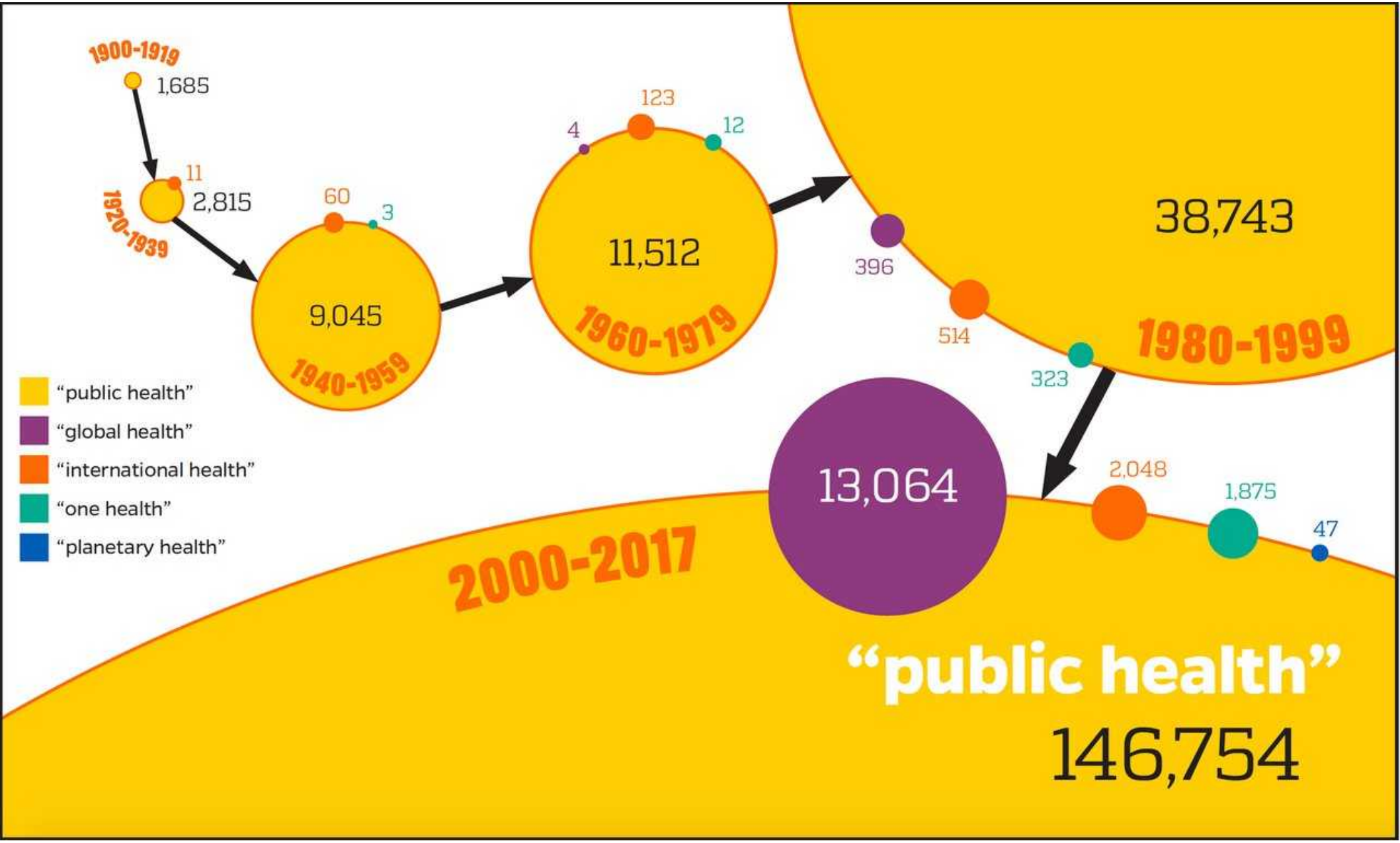
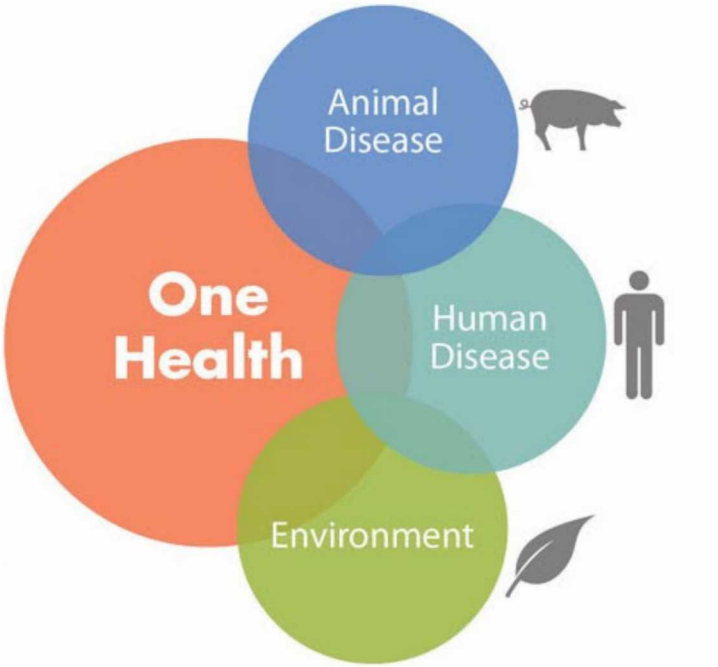
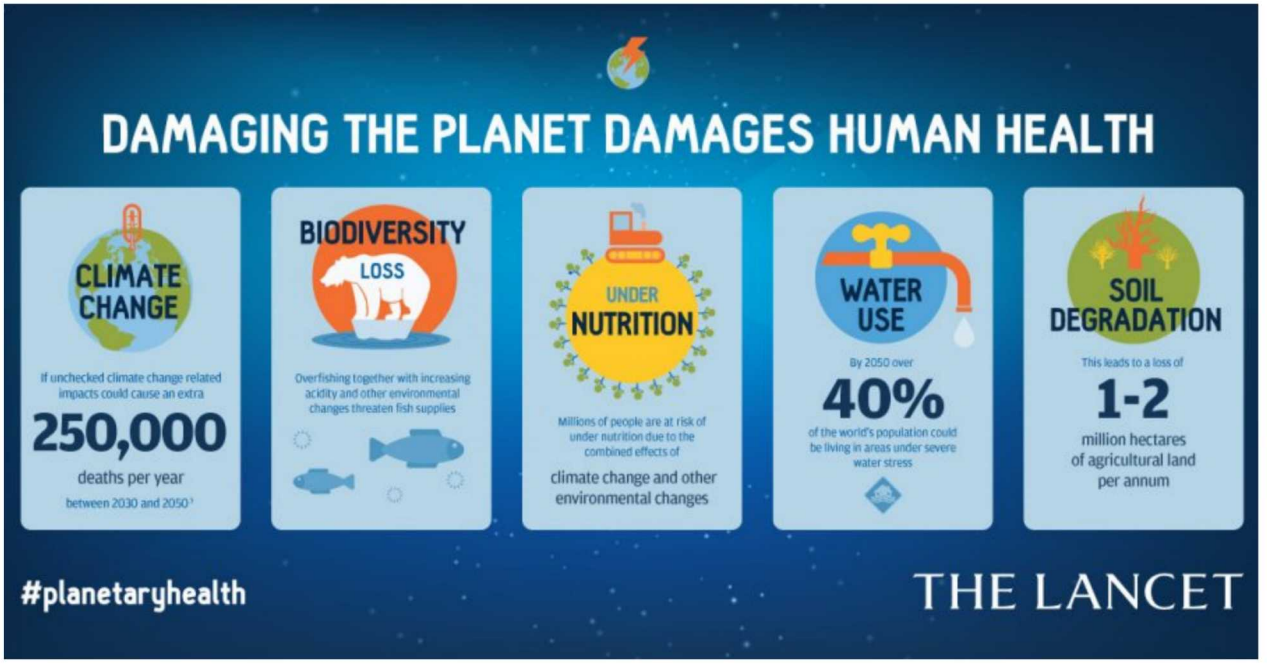


Source: [Global Health Now 2017]

New(er) approaches





Global health (RIISG)

- GH is meant to be a **new paradigm for health and health care**, grounded in the theory of the **social determinants of health**.
- Based on the principles of the **Alma Ata Declaration**, GH can be applied to health **promotion**, **prevention, diagnosis, treatment**, for **individuals and populations**.
- GH considers the relationship between **globalisation and health** in terms of equity, human rights, sustainability and international diplomacy. Adopting a transnational view, GH points out **health inequalities** both within and among countries, framing them also through the lens of **social justice**.
- GH adopt a **trans-disciplinary and multimethod** approach, built on the contribution of natural, biomedical and social sciences and the humanities.
- Fostering an ethics of **social accountability**, GH encompasses the fields of research, practice and education, **aiming at producing change in the community** and in the whole society, and bringing evidence into practice thus reducing the know-do gap.

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Source: www.educationglobalhealth.eu/en

Global health

	Global health	International health	Public health
Geographical reach	Focuses on issues that directly or indirectly affect health but that can transcend national boundaries	Focuses on health issues of countries other than one's own, especially those of low-income and middle-income	Focuses on issues that affect the health of the population of a particular community or country
Level of cooperation	Development and implementation of solutions often requires global cooperation	Development and implementation of solutions usually requires binational cooperation	Development and implementation of solutions does not usually require global cooperation
Individuals or populations	Embraces both prevention in populations and clinical care of individuals	Embraces both prevention in populations and clinical care of individuals	Mainly focused on prevention programmes for populations
Access to health	Health equity among nations and for all people is a major objective	Seeks to help people of other nations	Health equity within a nation or community is a major objective
Range of disciplines	Highly interdisciplinary and multidisciplinary within and beyond health sciences	Embraces a few disciplines but has not emphasised multidisciplinarity	Encourages multidisciplinary approaches, particularly within health sciences and with social sciences

Table: **Comparison of global, international, and public health**

Source: Koplan, 2009

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...meanwhile in Harvard

Proposed definitions of “global health” are generally depoliticized and include invocations of trans-national health issues and collaborations. Yet global health is only the newest iteration of what was formerly “international health”, “tropical medicine” and “colonial medicine”. **Its historical roots lie in European colonial endeavors and imperial interests. Just as those reflected the unequal power relations of that time, global health reflects the unequal relations of present.** North American and European universities, including Harvard, play a big role in this nebulous field. Syllabi, implicit theories, and agendas in these institutions posit the field as a technical one whose methods are universal, objective and value-neutral. **They portray the field as being devoid of its historical baggage, and do not critically challenge the underlying economic (e.g., neoliberalism) and political relations** (e.g., US imperialism) that constrain mainstream global health.

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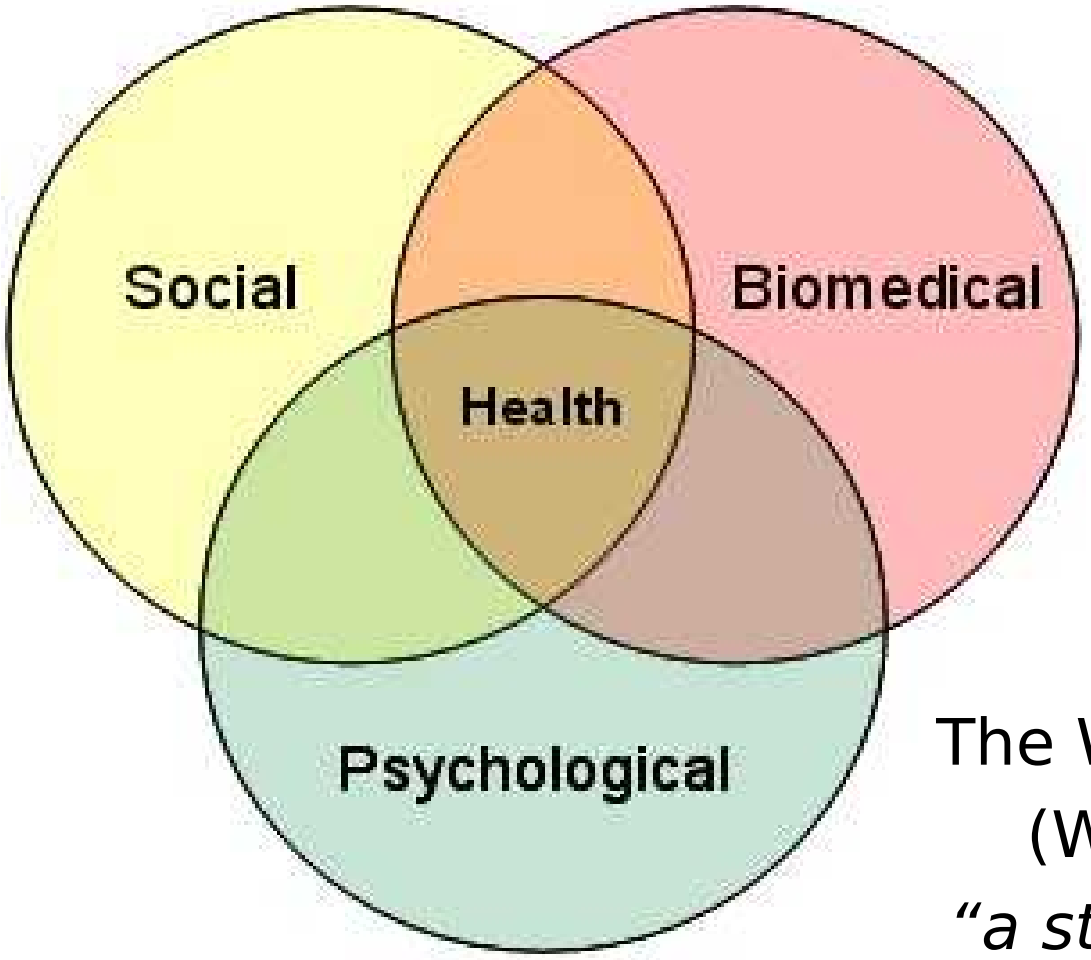

The World Health Organization (WHO) defines health as:

“a state of complete physical, mental, [spiritural] and social well-being and not merely the absence of disease or infirmity”

(bio-psycho-social model)

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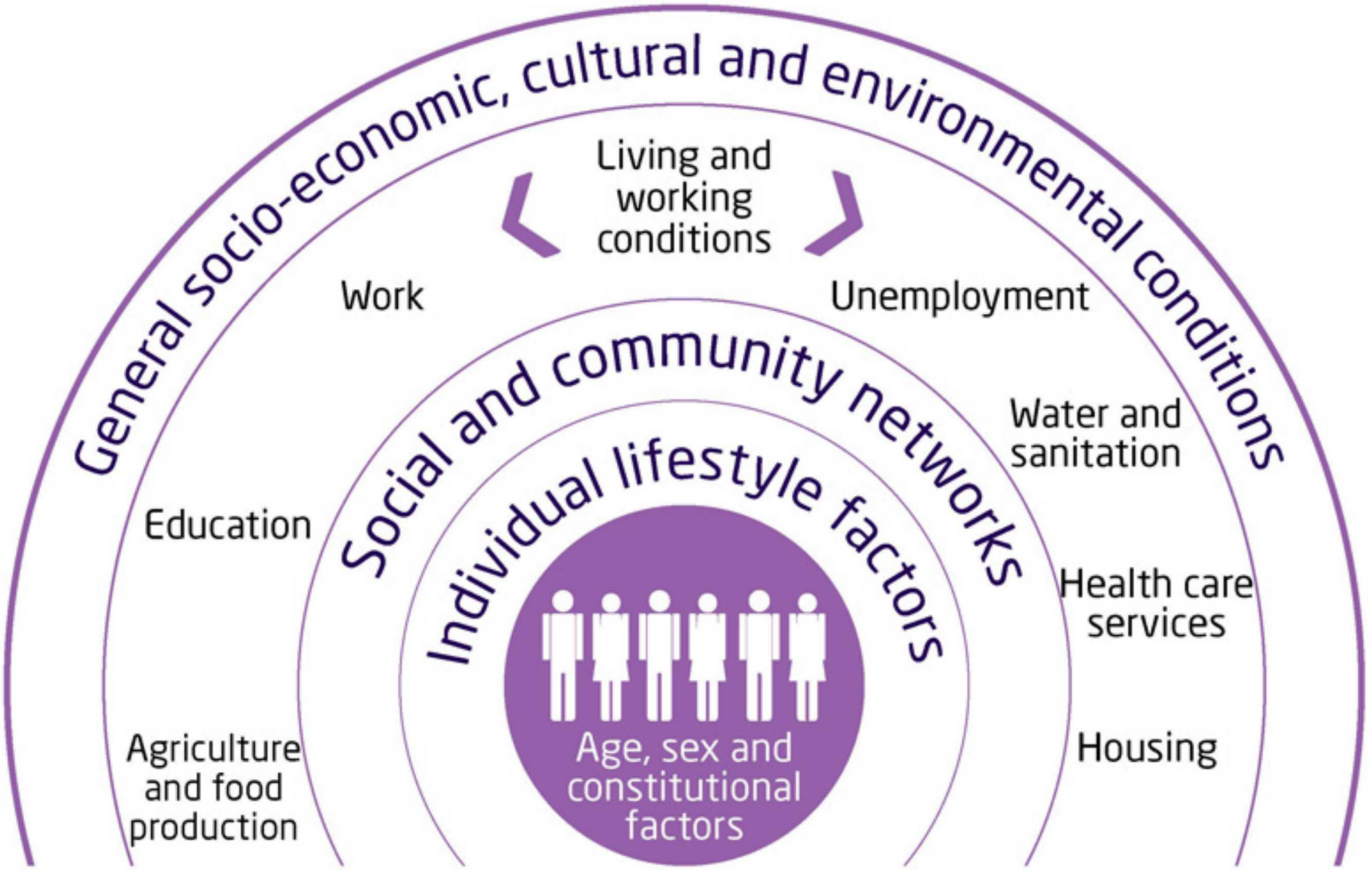
Health
Health Services
Income and Social Status
Education
Employment and Working Conditions
Social Support Networks
Physical Environments
Biology and Genetic Endowment
Social Environments
Healthy Child Development
Personal Health Practices and Coping Skills
Gender
Culture
VALUES
BELIEFS
ASSUMPTIONS

HEALTH AS A COMPLEX ADAPTIVE SYSTEM



The determinants of health

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Fattori 'costituzionali'

Età

Sesso/genere

Patrimonio genetico

https://www.youtube.com/watch?v=k50yMwEOWGU

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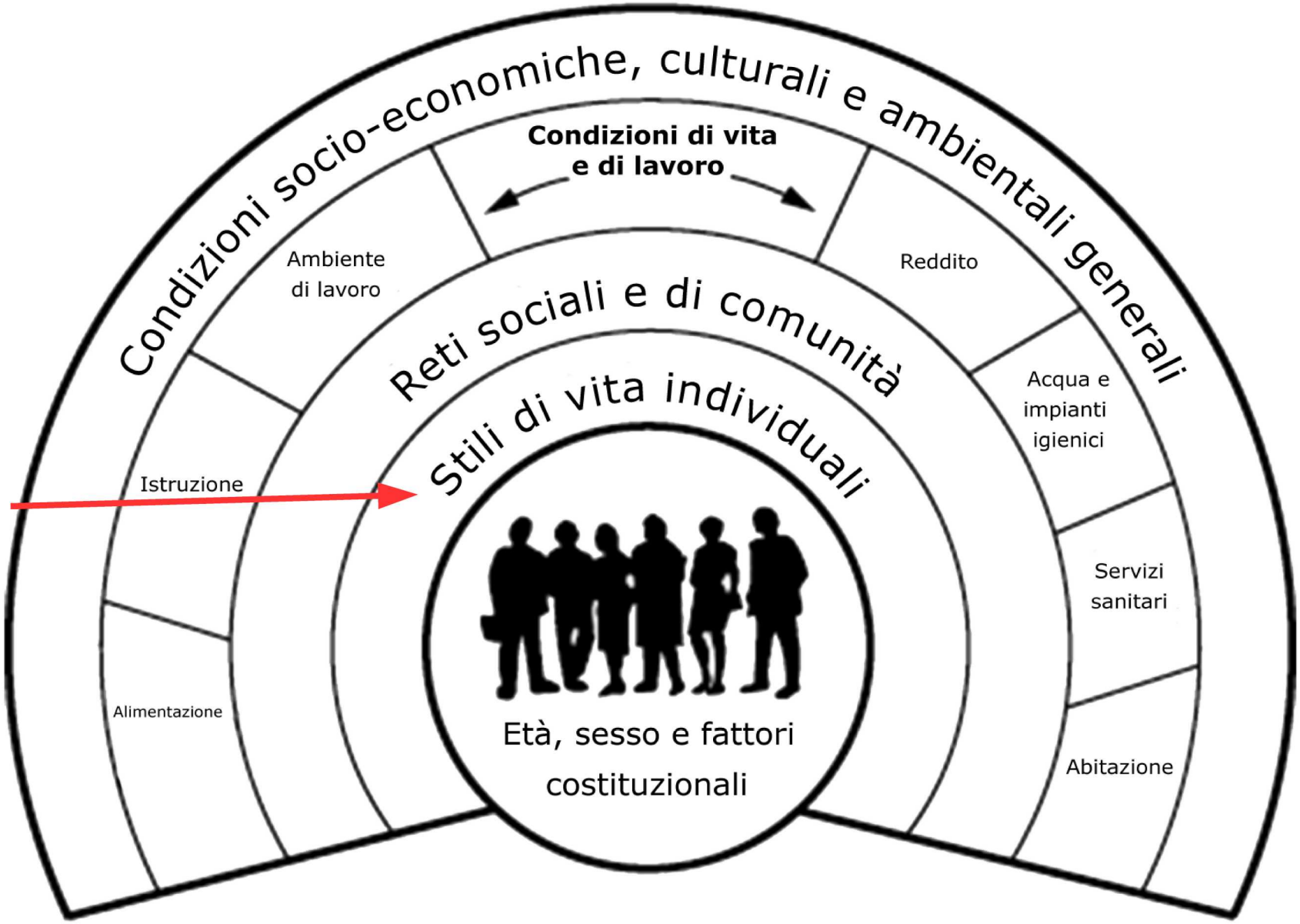
Determinanti della salute (1991)



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'Stili' di vita 'individuali'

- Fumo
- Alimentazione
- Attività fisica
- Alcol
- Sostanze
- Sessualità

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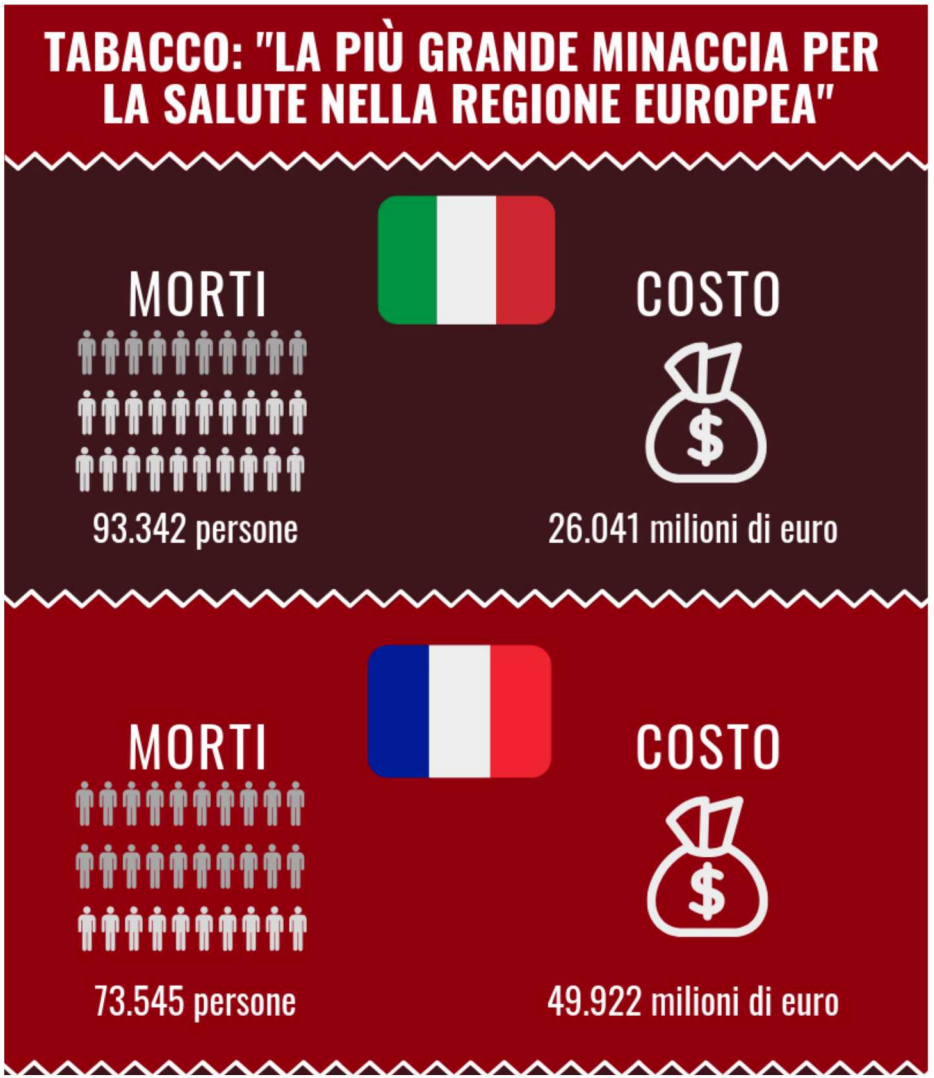
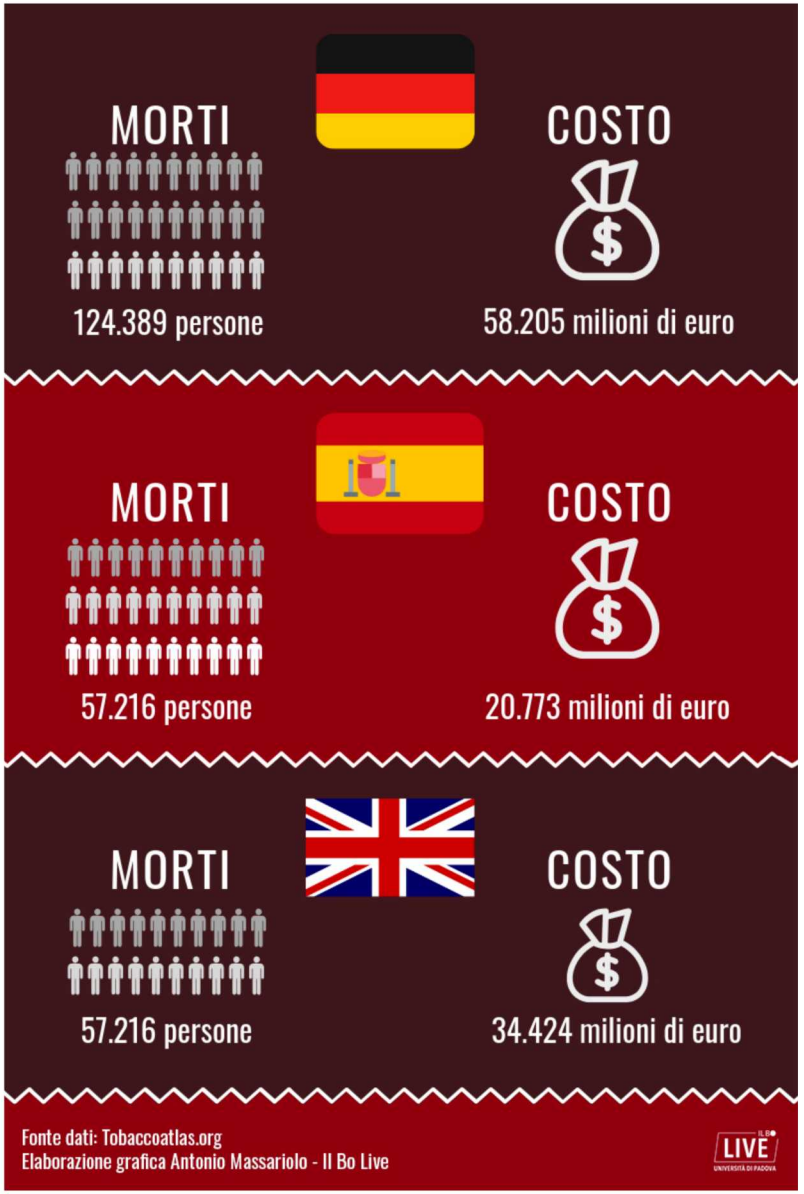
Fumo


TABACCO: "LA PIÙ GRANDE MINACCIA PER LA SALUTE NELLA REGIONE EUROPEA"
MORTI
93.342 persone
COSTO
26.041 milioni di euro
MORTI
73.545 persone
COSTO
49.922 milioni di euro


MORTI
124.389 persone
COSTO
58.205 milioni di euro
MORTI
57.216 persone
COSTO
20.773 milioni di euro
MORTI
57.216 persone
COSTO
34.424 milioni di euro
Fonte dati: Tobaccoatlas.org
Elaborazione grafica Antonio Massariolo - Il Bo Live
LIVE

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Abitudine al fumo

La prevalenza di fumatori nel 2017, tra la popolazione ≥ 14 anni è del **19,7%**, con forti differenze di genere: **24,8%** tra gli uomini, **14,9%** tra le donne.

Il fumo di sigaretta è **più frequente fra le classi socioeconomiche più svantaggiate** (meno istruiti e/o con maggiori difficoltà economiche).

Dal 2008 si osserva una **riduzione significativa** della prevalenza del fumatori in tutto il territorio Italiano (dal 30% al 26%), in particolare nelle classi sociali più agiate ma meno fra le persone economicamente più svantaggiate.

La quota di **ex fumatori** cresce all'avanzare dell'età, è maggiore fra le persone senza difficoltà economiche, fra i cittadini italiani rispetto agli stranieri e fra i residenti nelle Regioni settentrionali.

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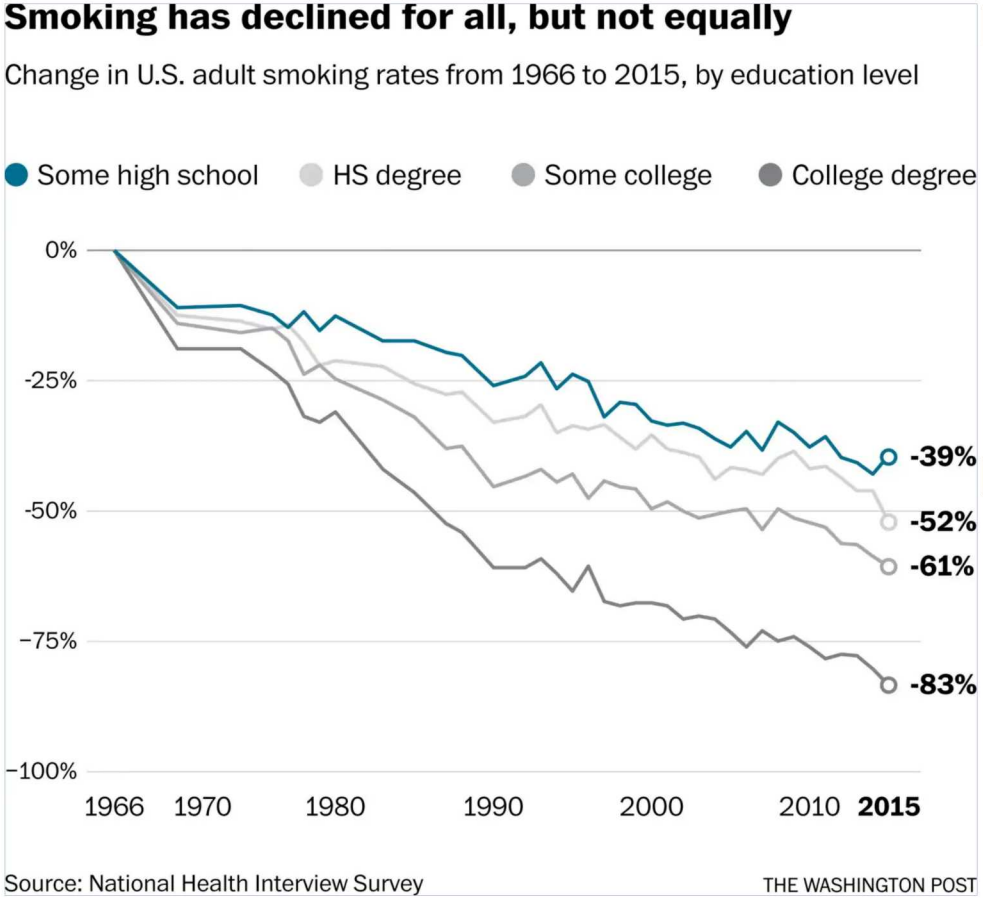
http://www.salute.gov.it/imgs/C_17_pagineAree_467_listaFile_itemName_0_file.pdf

Abitudine al fumo

USA



EUROPA

In uno studio su oltre 70 mila persone appartenenti a 27 Stati Europei nel periodo 2006-2012, sono stati confrontati attività di prevenzione e controllo del tabacco da parte degli Stati e tassi di cessazione e abbandono del fumo.

Nel periodo considerato **solo le fasce di popolazione a reddito elevato hanno mostrato un tasso di abbandono associabile** con le attività di prevenzione, mentre nelle fasce a reddito medio e basso questa correlazione non si manifesta.

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Alimentazione

Secondo l'OMS, una dieta sana è la pietra angolare di una buona salute

I tre fattori principali che condizionano la dieta di una persona sono:

- Reddito
- Istruzione
- Luogo di vita

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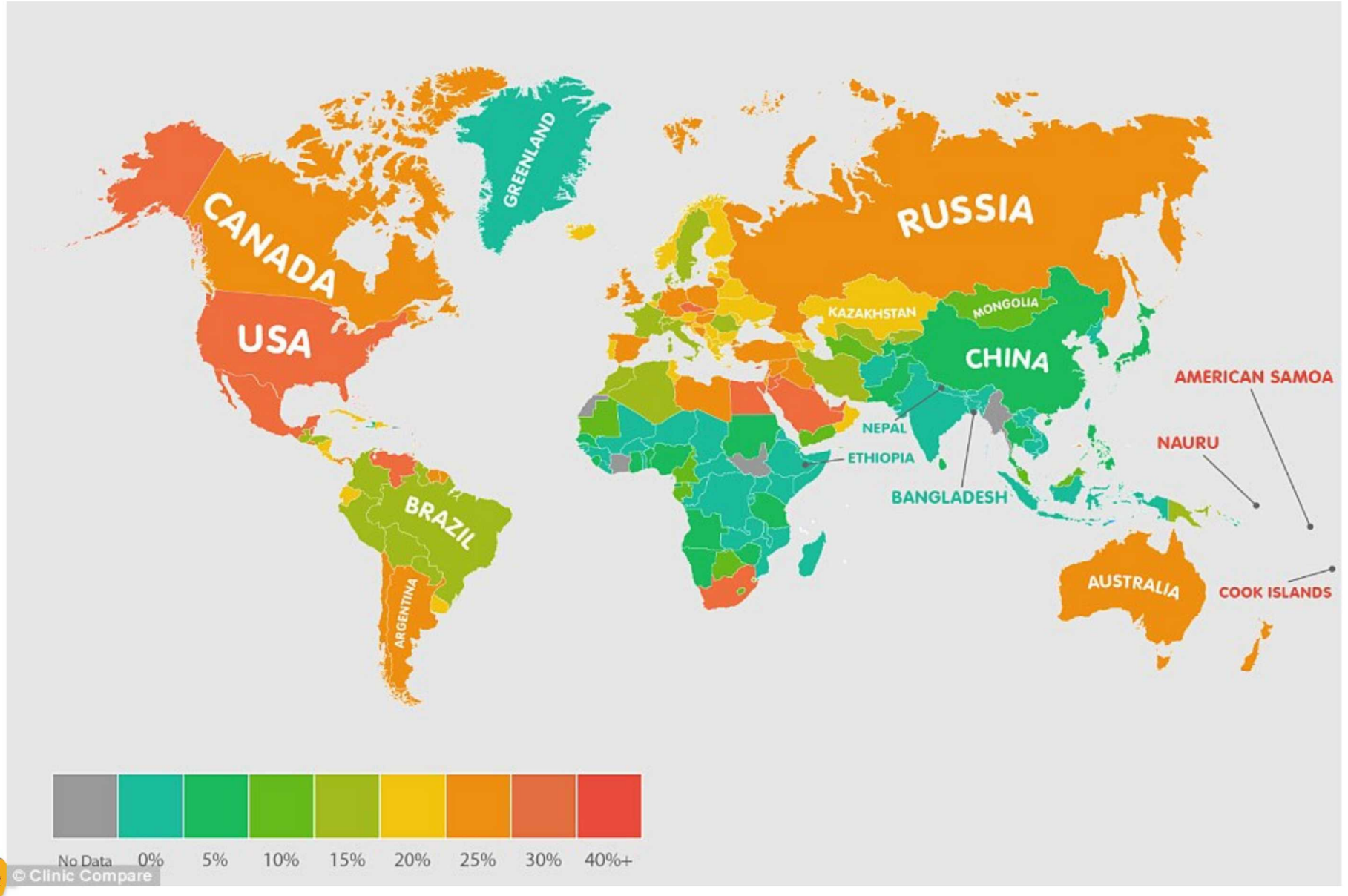
Obesità nel mondo



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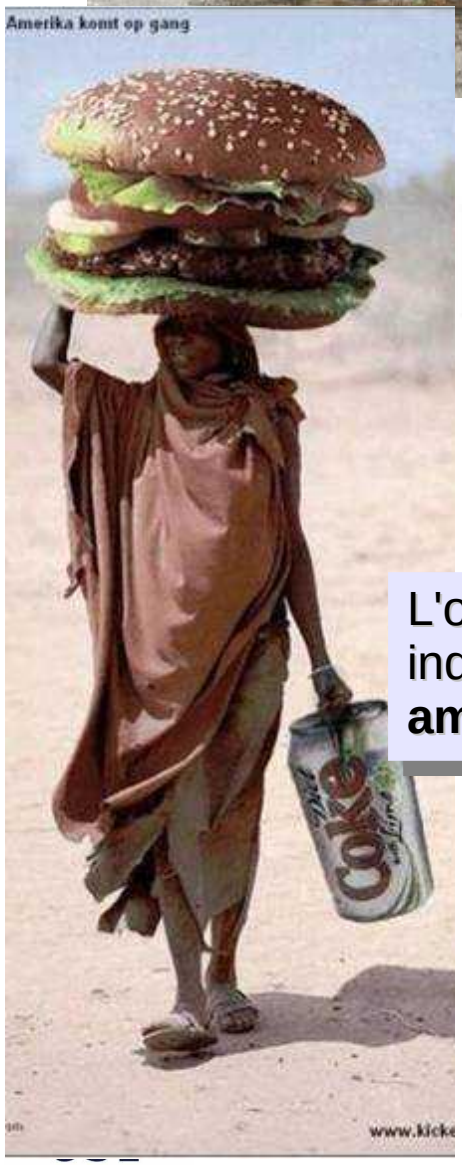
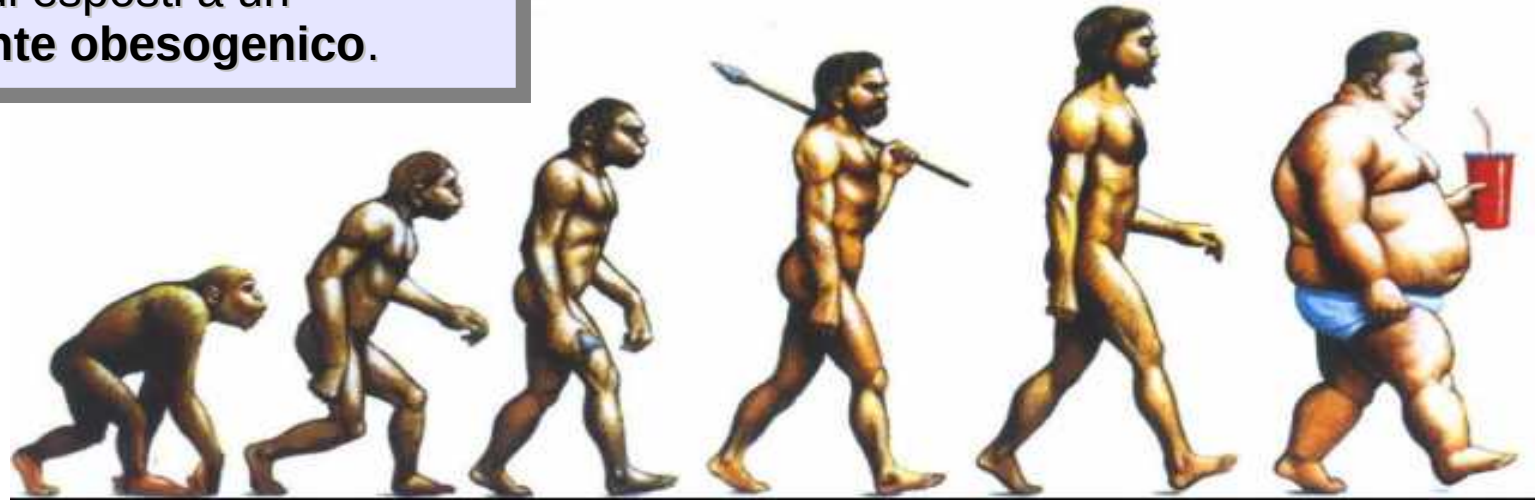


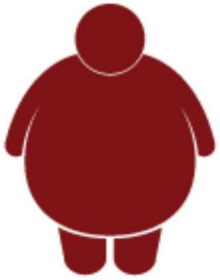
L'obesità come **reazione** degli individui esposti a un **ambiente obesogenico**.



Obesità in Europa

In the WHO/European Region

over 50%
of people are
overweight or **obese**



over 20%
of people are
obese

www.euro.who.int/obesity

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Obesità in Europa

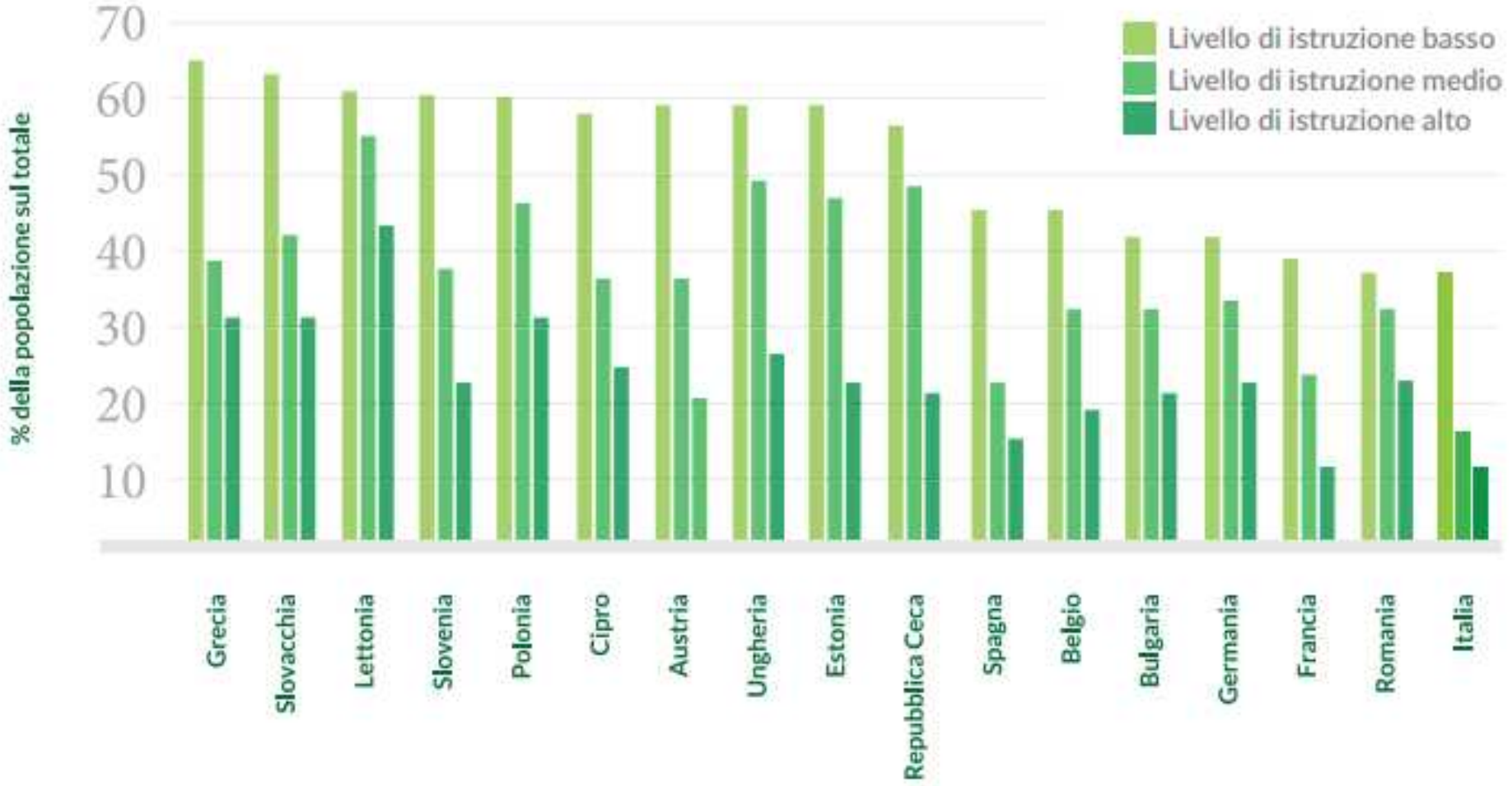

Figura 1. Rapporto tra obesità e livello di istruzione nelle donne, 2009

https://www.disuguaglianzedisalute.it/wp-content/uploads/2015/06/Obesita.pdf

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Andamento nel tempo

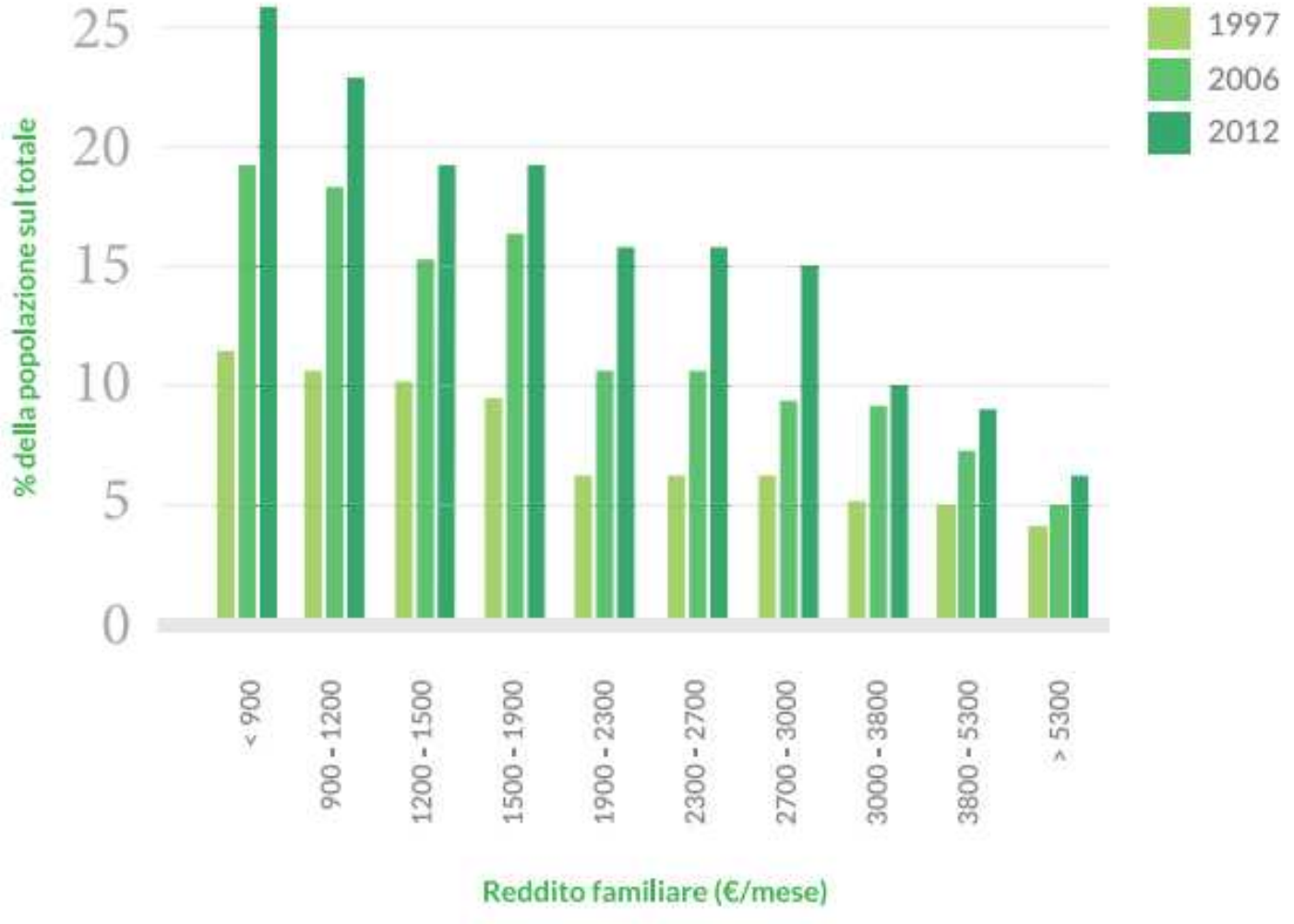

Figura 3. Francia: prevalenza di obesità nella popolazione adulta in rapporto al reddito familiare, 1997–2012

https://www.disuguaglianzedisalute.it/wp-content/uploads/2015/06/Obesita.pdf

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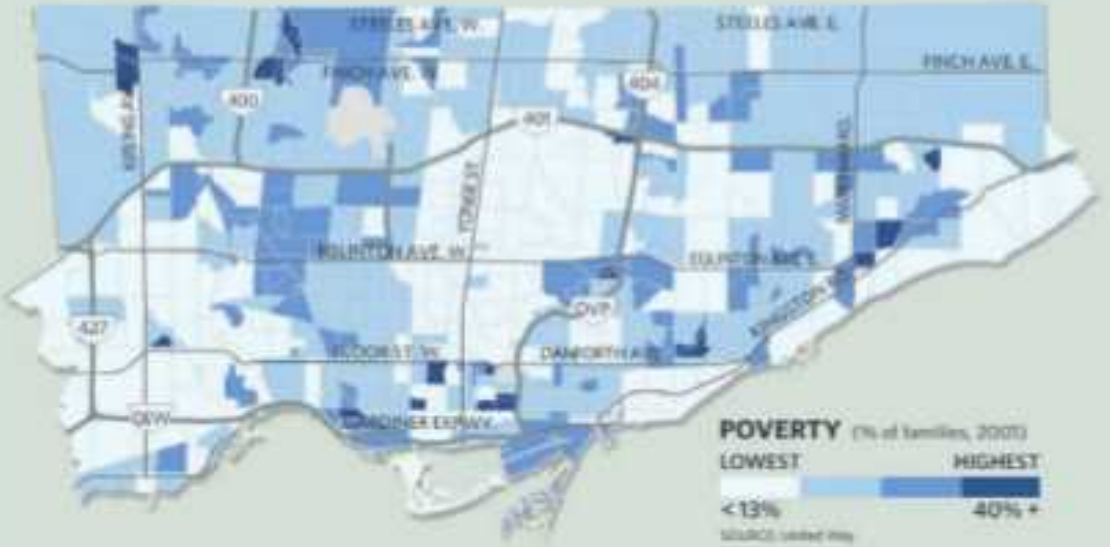
Poverty in the city

Poor parts of the city generally align with those with the highest rates of diabetes

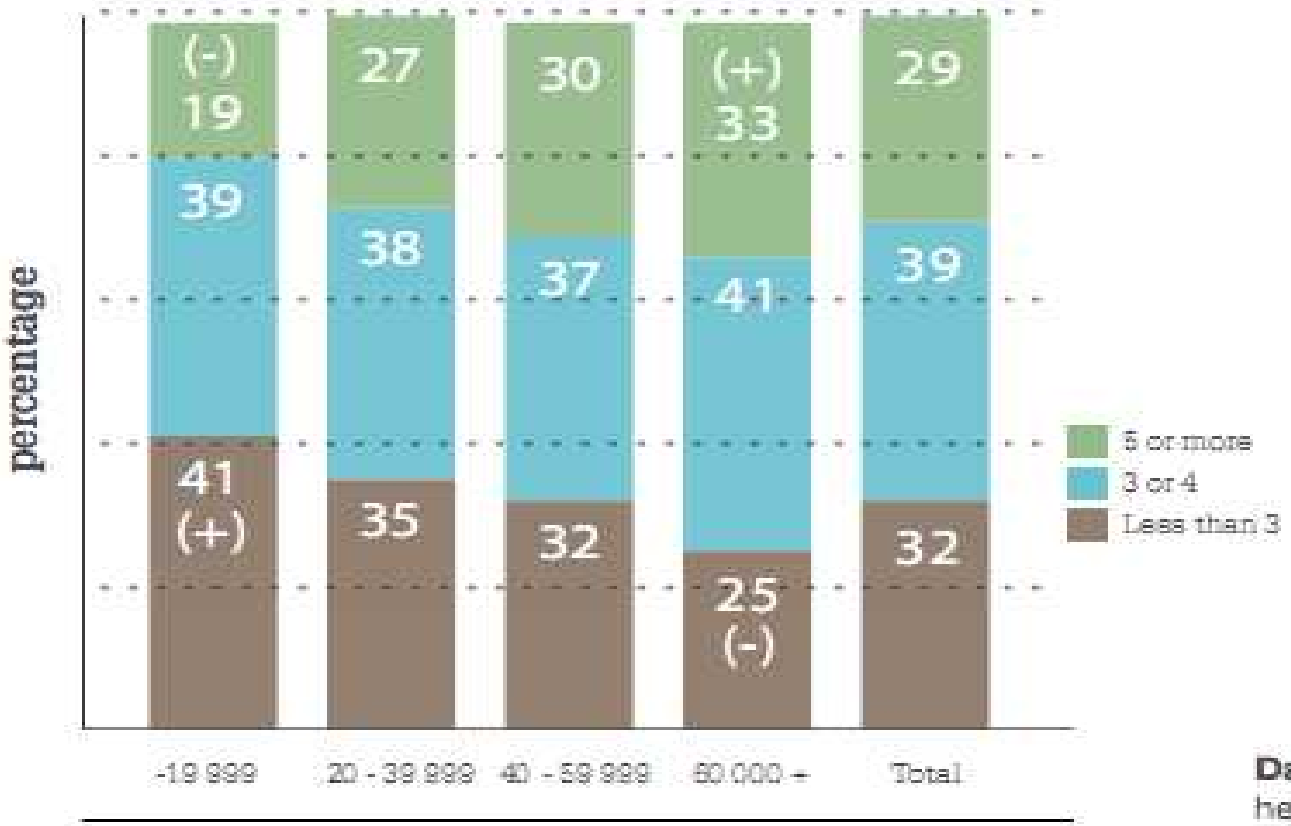


Where diabetes hits hardest

The Northwest and East of Toronto are hardest hit by diabetes

Figure 4.3. Distribution of Montrealers aged 15 and over, by family income and daily frequency of fruit and vegetable consumption, 2010

Adapted from Bertrand L, Therien F, 2011.



Data source: Biannual survey of health determinants, DSP 2010

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‘Super-diet’ development

- Healthy foods prohibitively expensive, processed foods exceedingly cheap
  - In 2009 study of supermarkets in rural South Africa, healthier foods typically cost between **10% and 60%** more when compared on a weight basis (R per 100g) and between **30% and 110%** more when compared based on the cost of food energy (R per 100 kJ)

Sources: Temple, et. al., "Price and availability of healthy food: A study in rural South Africa." Nutrition Journal 1 (2010): 1-4.

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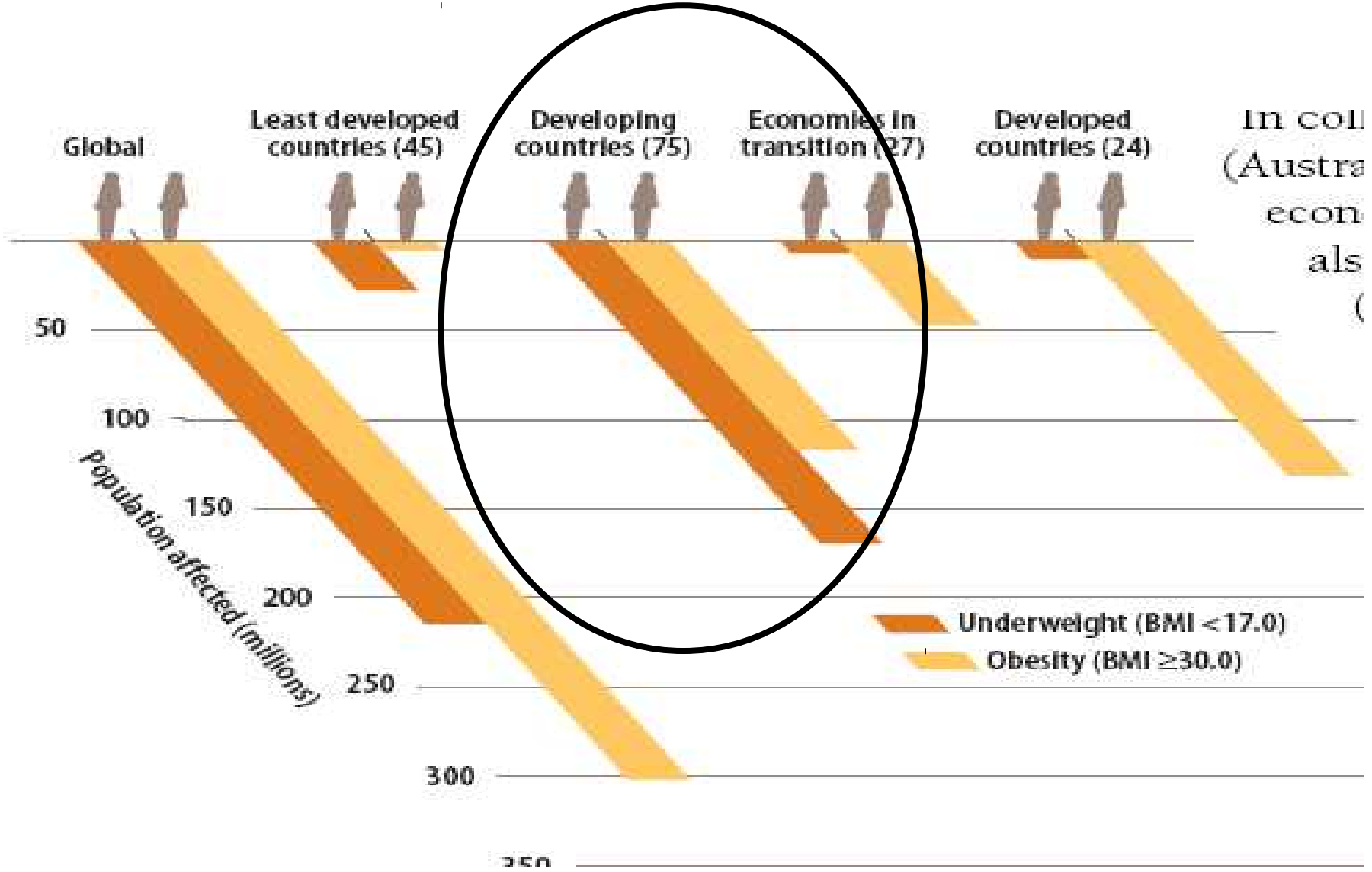
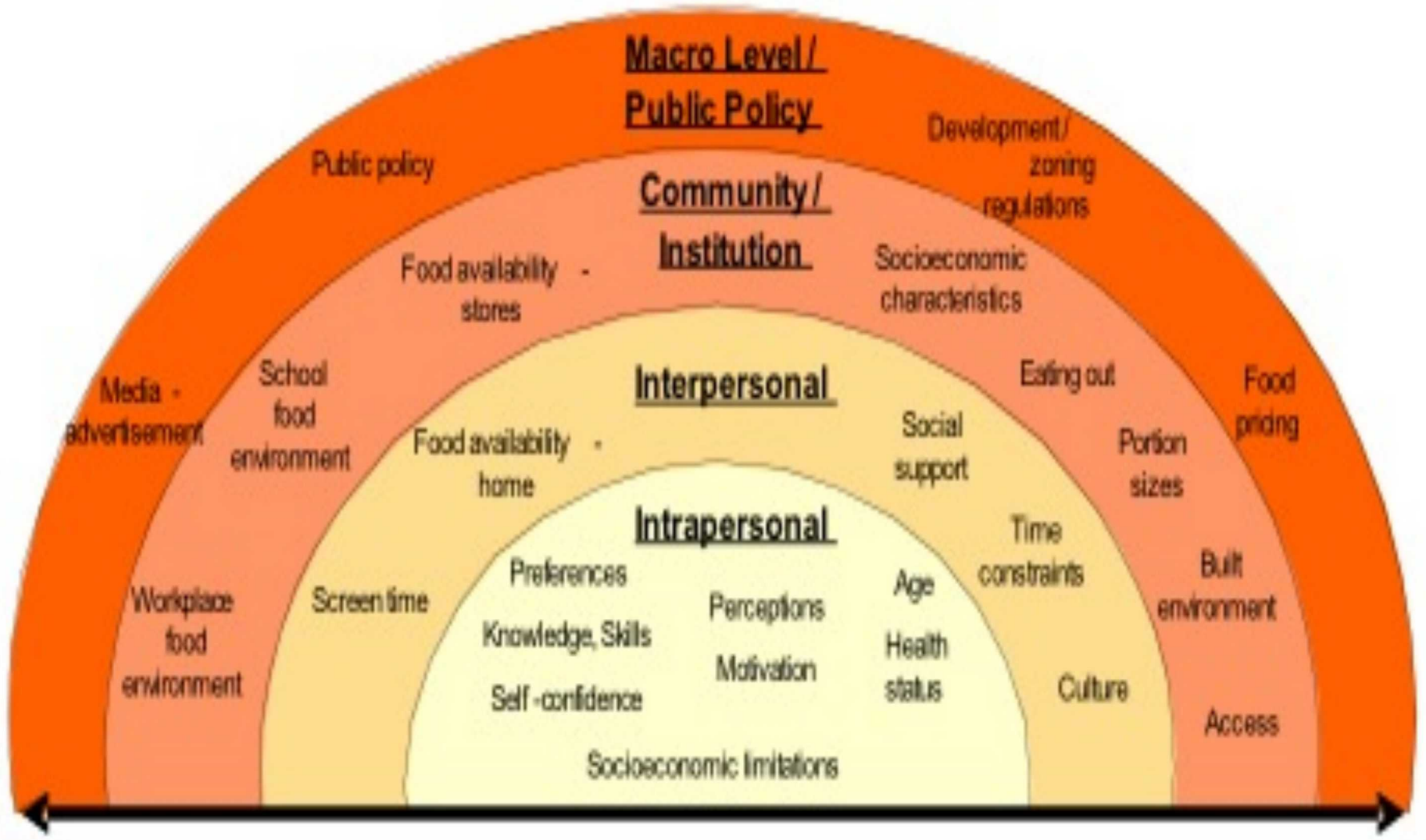
Double burden



Barriere a una vita sana



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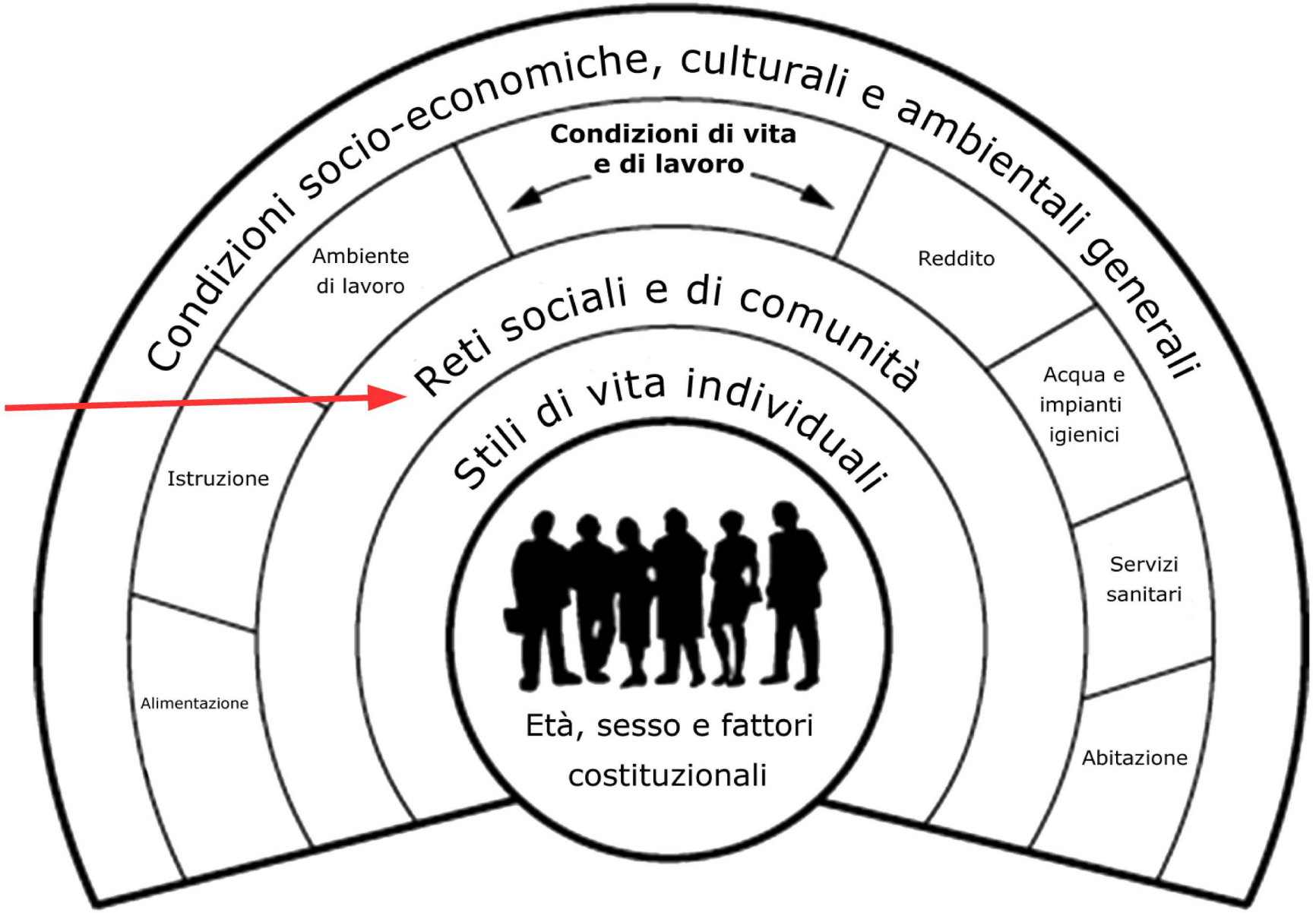
Determinanti della salute (1991)



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Reti sociali

Roseto
(Abruzzo)

Roseto, Pennsylvania
(USA)

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The Roseto effect
A 50-year comparison of mortality rates

B Egolf, J Lasker, S Wolf, and L Potvin
American Journal of Public Health, Vol. 82, Issue 8 1089-1092

Rosetans had a lower mortality rate from myocardial infarction over the course of the first 30 years, but it rose to the level of Bangor's following a period of erosion of traditionally cohesive family and community relationships.

The data confirmed the existence of consistent mortality differences between Roseto and Bangor during a time when there were many indicators of greater social solidarity and homogeneity in Roseto.

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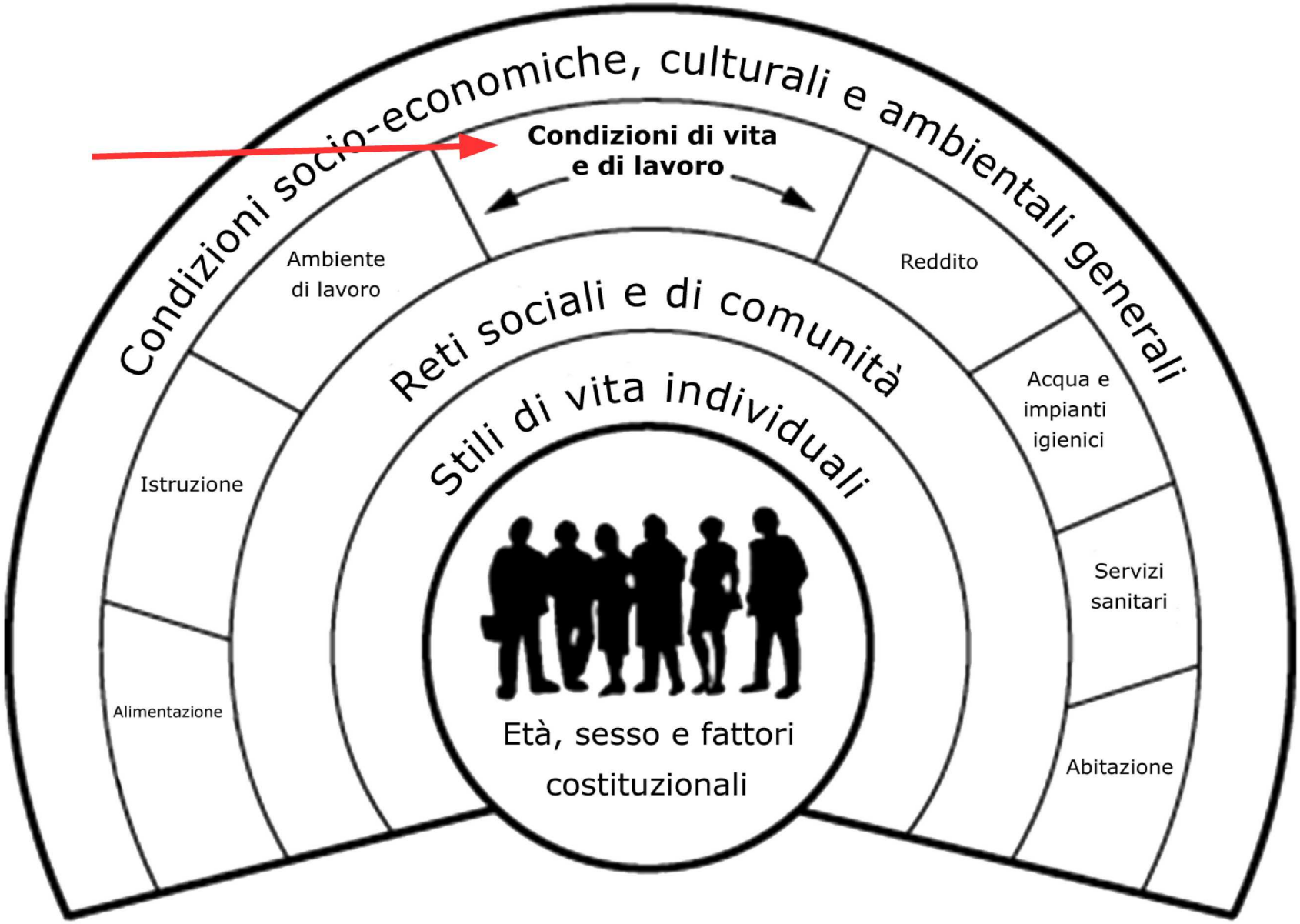
Determinanti della salute (1991)



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Condizioni di vita e di lavoro

Alimentazione

Istruzione

Ambiente di lavoro

Abitazione

Reddito

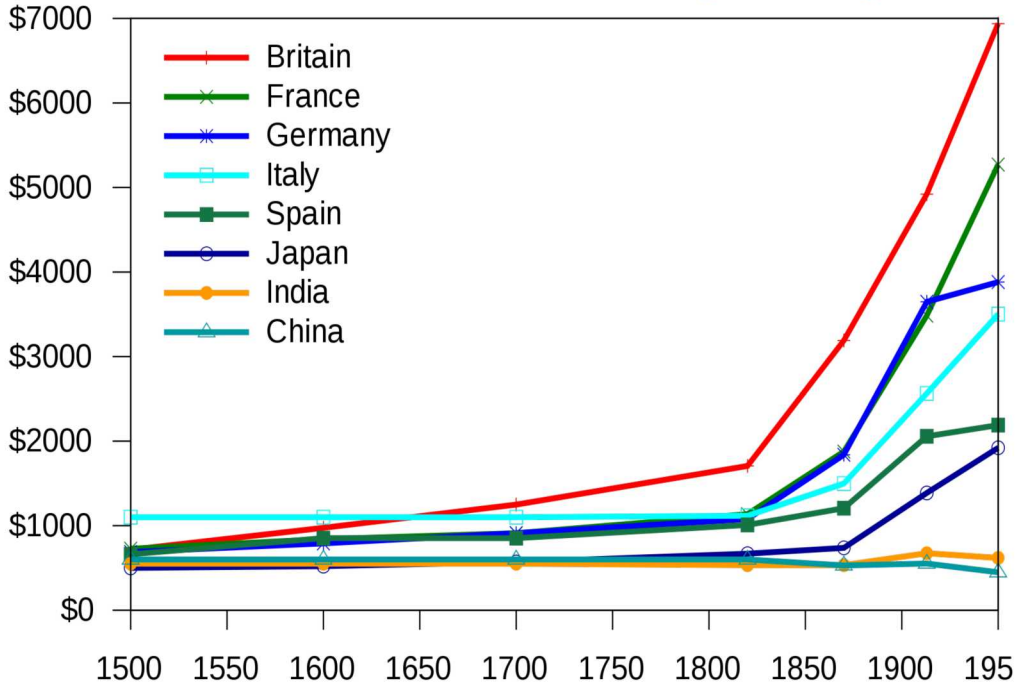
Acqua e impianti igienici

Servizi sanitari

CSI

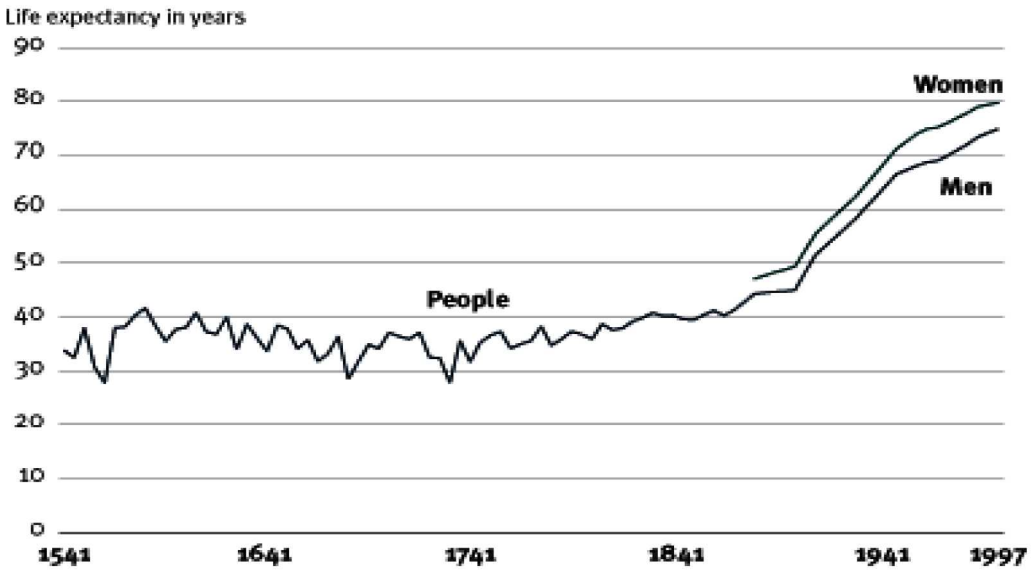
Ricchezza e salute

Prodotto Interno Lordo pro capite



PIL pro capite (aggiustato per potere di acquisto) tra il 1500 and 1950. *Dati da Contours of the World Economy, 1–2030 AD, in Essays in Macro-Economic History by Angus Maddison, Oxford University Press, 2007.*

Aspettativa di vita



Life expectancy at birth in England & Wales
Source: Office for National Statistics (see References Section)

Aspettativa di vita in Inghilterra e Galles tra il 1541 e il 1997.

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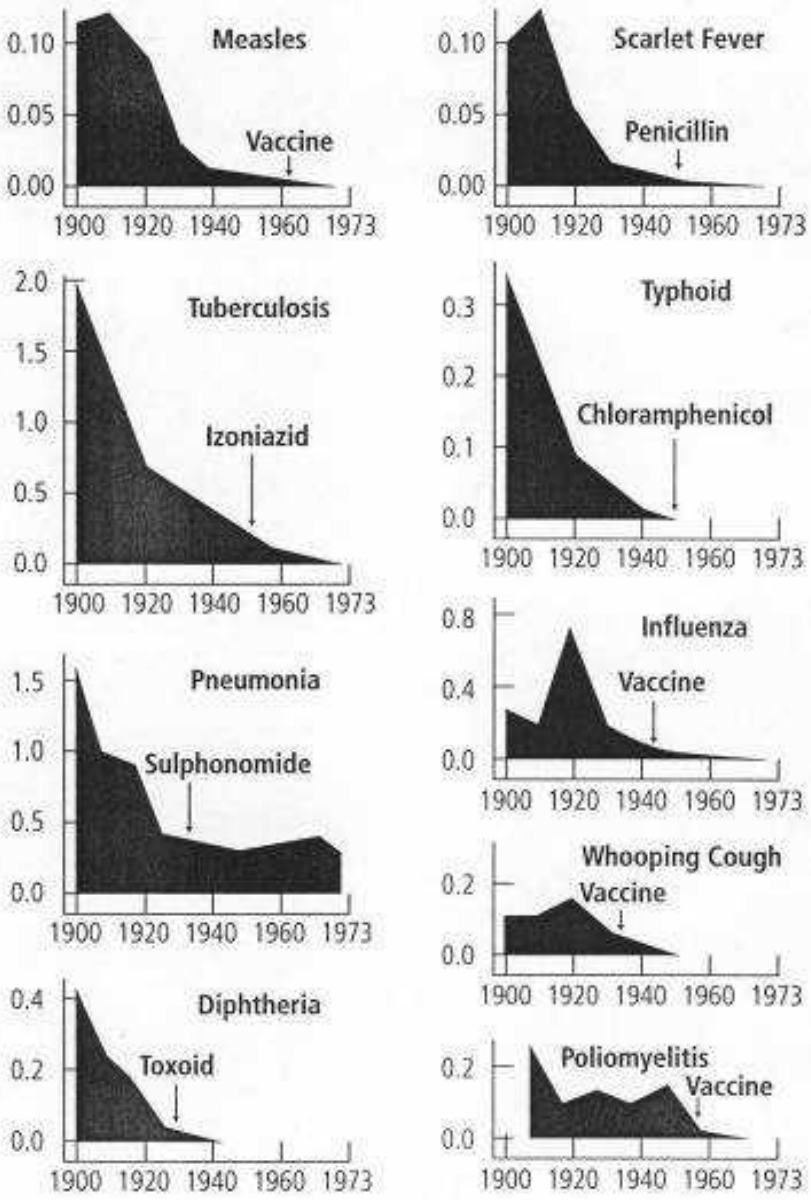
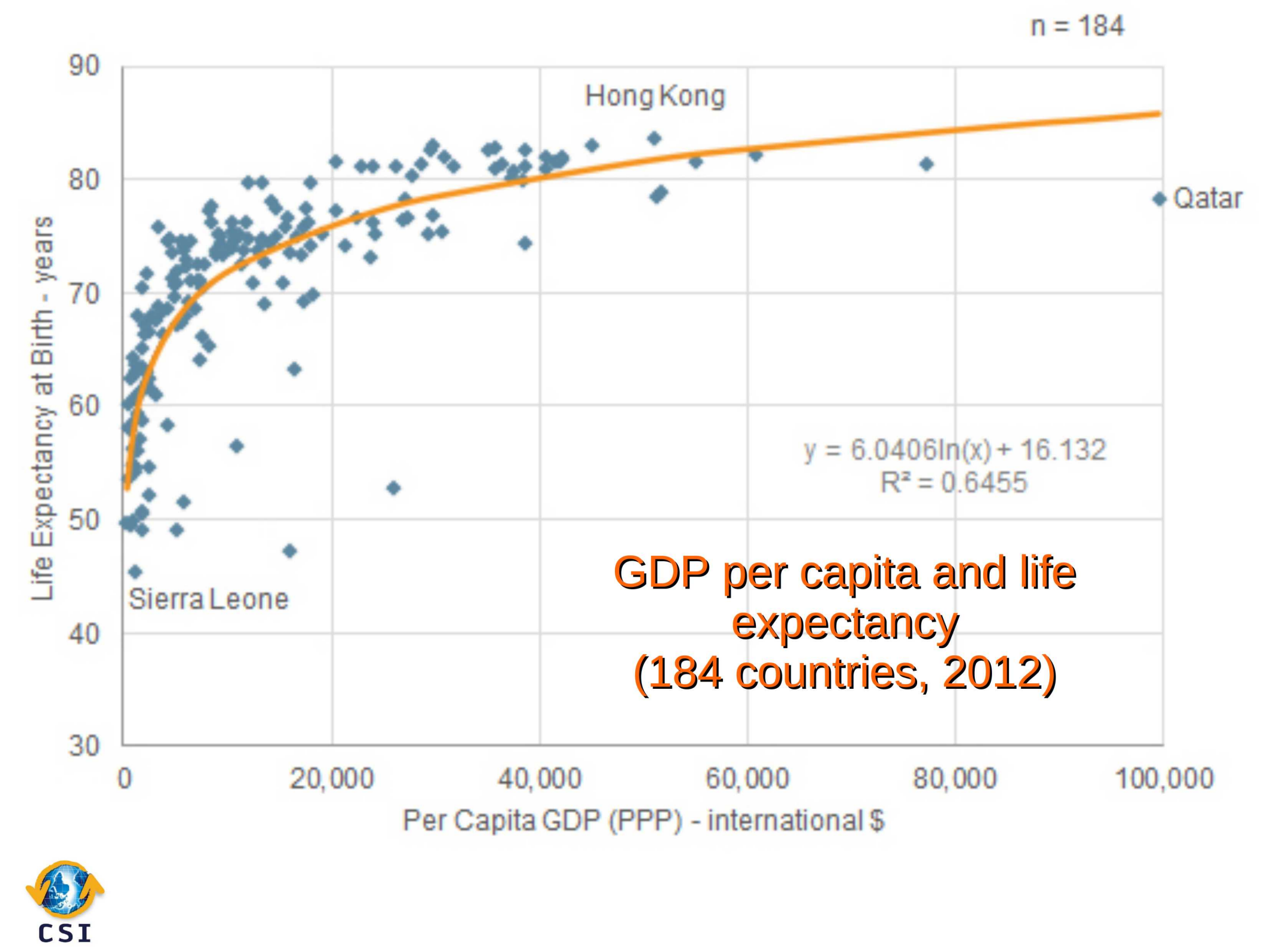
FIGURE 3.1 THE FALL IN THE STANDARDIZED DEATH RATE (PER 1,000 POPULATION) FOR NINE COMMON INFECTIOUS DISEASES IN RELATION TO SPECIFIC MEDICAL MEASURES, UNITED STATES, 1900–1973



Source: McKinlay and McKinlay (1987: 699).

Andamento del tasso di mortalità standardizzato per nove patologie infettive (USA, 1900-1973)


n = 184
Hong Kong
Qatar
Sierra Leone
y = 6.0406ln(x) + 16.132
R² = 0.6455
GDP per capita and life expectancy
(184 countries, 2012)
Life Expectancy at Birth - years
Per Capita GDP (PPP) - international $
90
80
70
60
50
40
30
0
20,000
40,000
60,000
80,000
100,000

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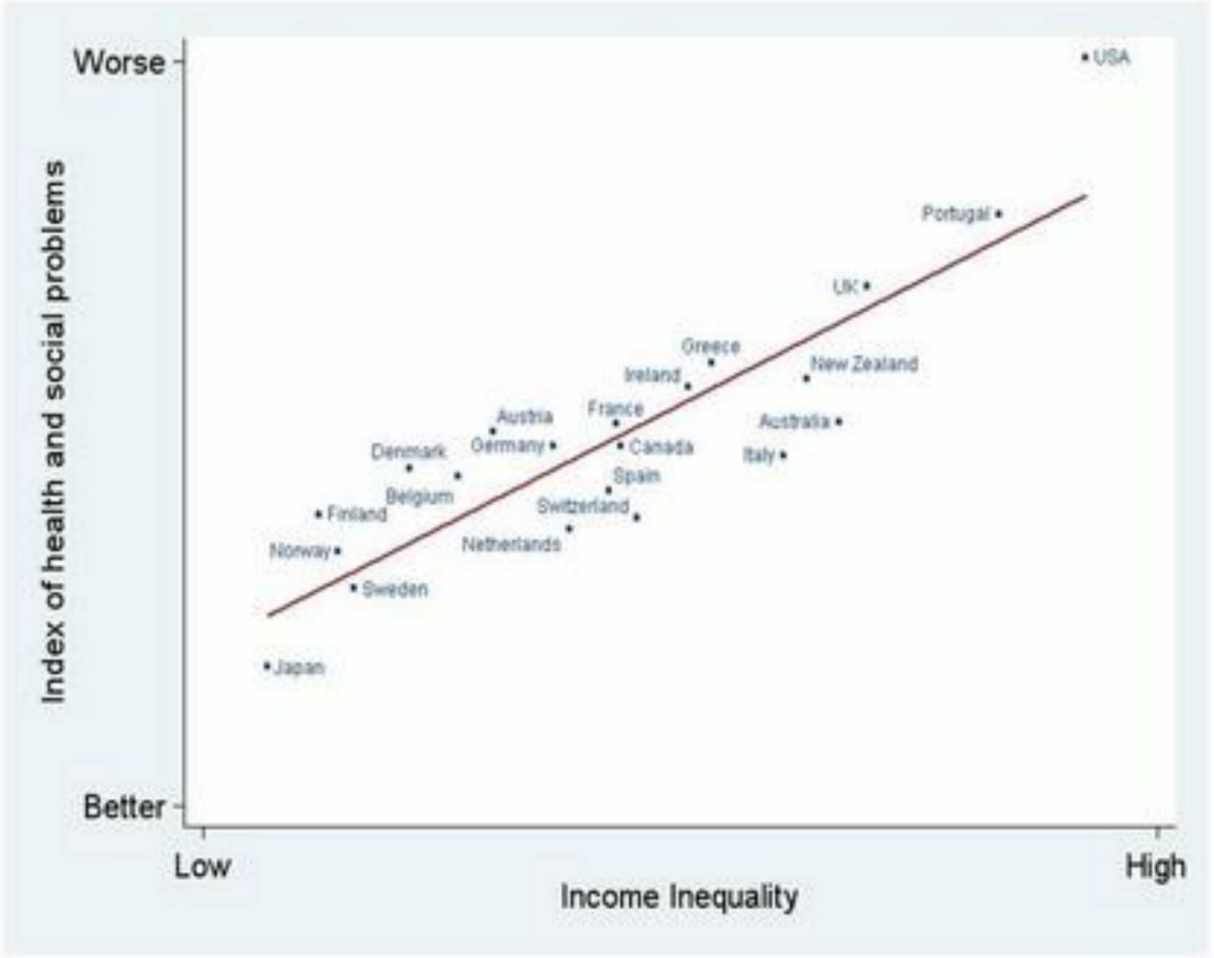
l peso de equ tà

Health and Social Problems are Worse in More Unequal Countries

Index of:

- Life expectancy
- Math & Literacy
- Infant mortality
- Homicides
- Imprisonment
- Teenage births
- Trust
- Obesity
- Mental illness – incl. drug & alcohol addiction
- Social mobility



Source: Wilkinson & Pickett, The Spirit Level (2009)

www.equalitytrust.org.uk

Equality Trust

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Le disuguaglianze in salute

Per disuguaglianze in salute si intendono quelle differenze considerate **ingiuste o originate da qualche forma di ingiustizia** ed **evitabili**.

Parlare di disuguaglianza aggiunge un significato **morale** al significato di differenza (termine descrittivo).

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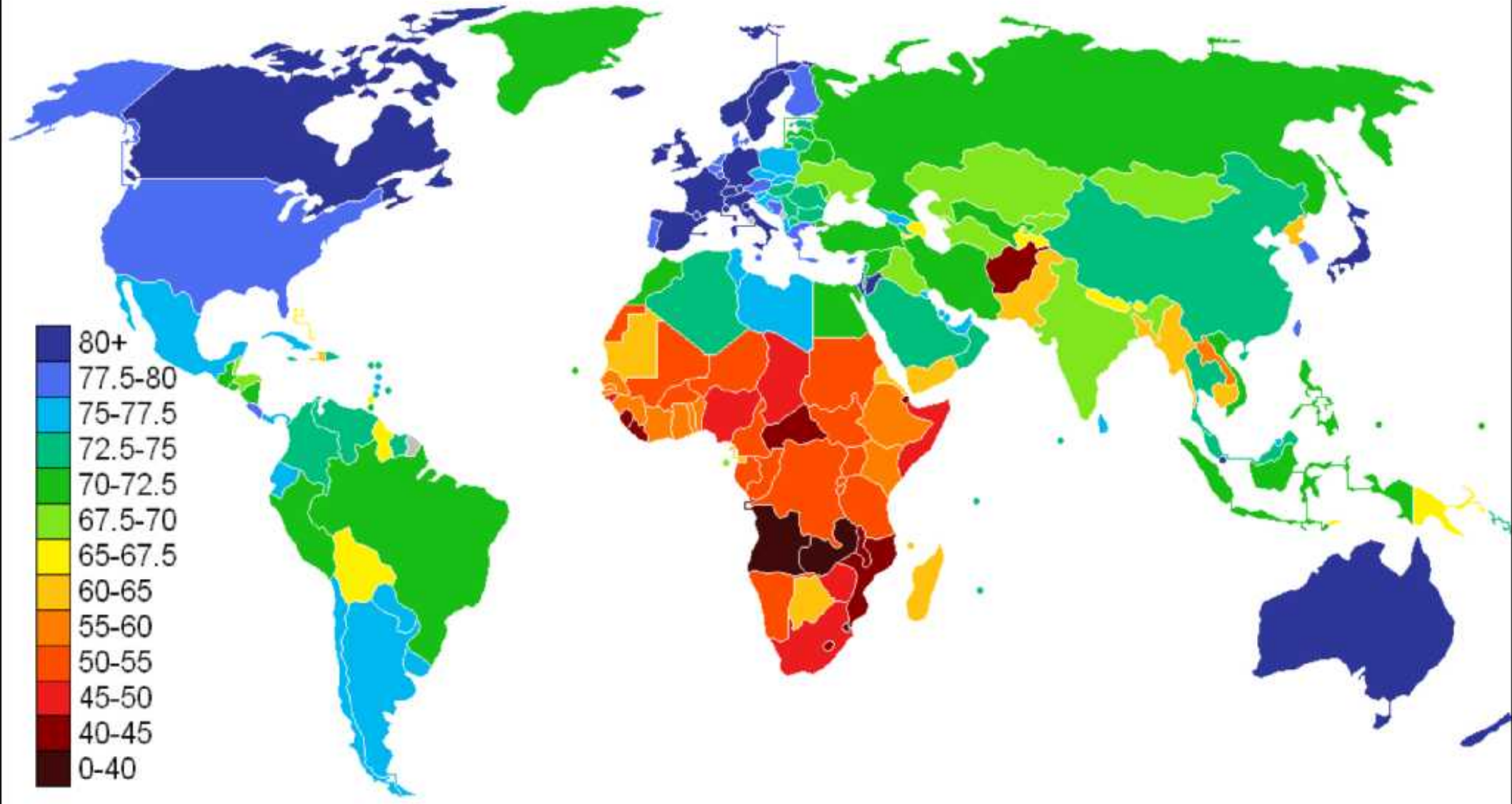
Life expectancy at birth, 2011



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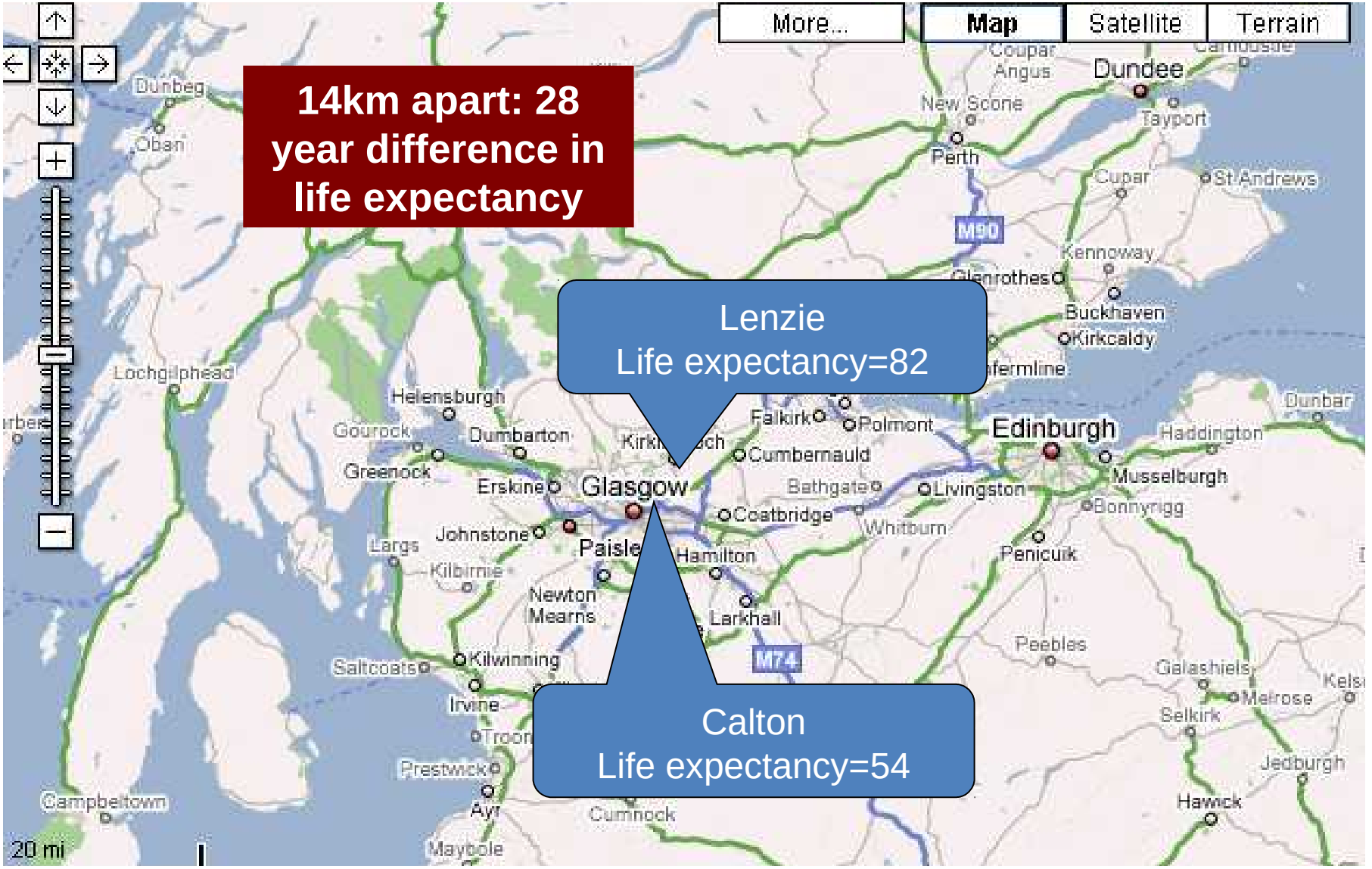
Centro Studi e Ricerche in
Salute Internazionale e Interculturale
Dipartimento di Scienze Mediche e Chirurgiche
Università di Bologna

People's Health Movement

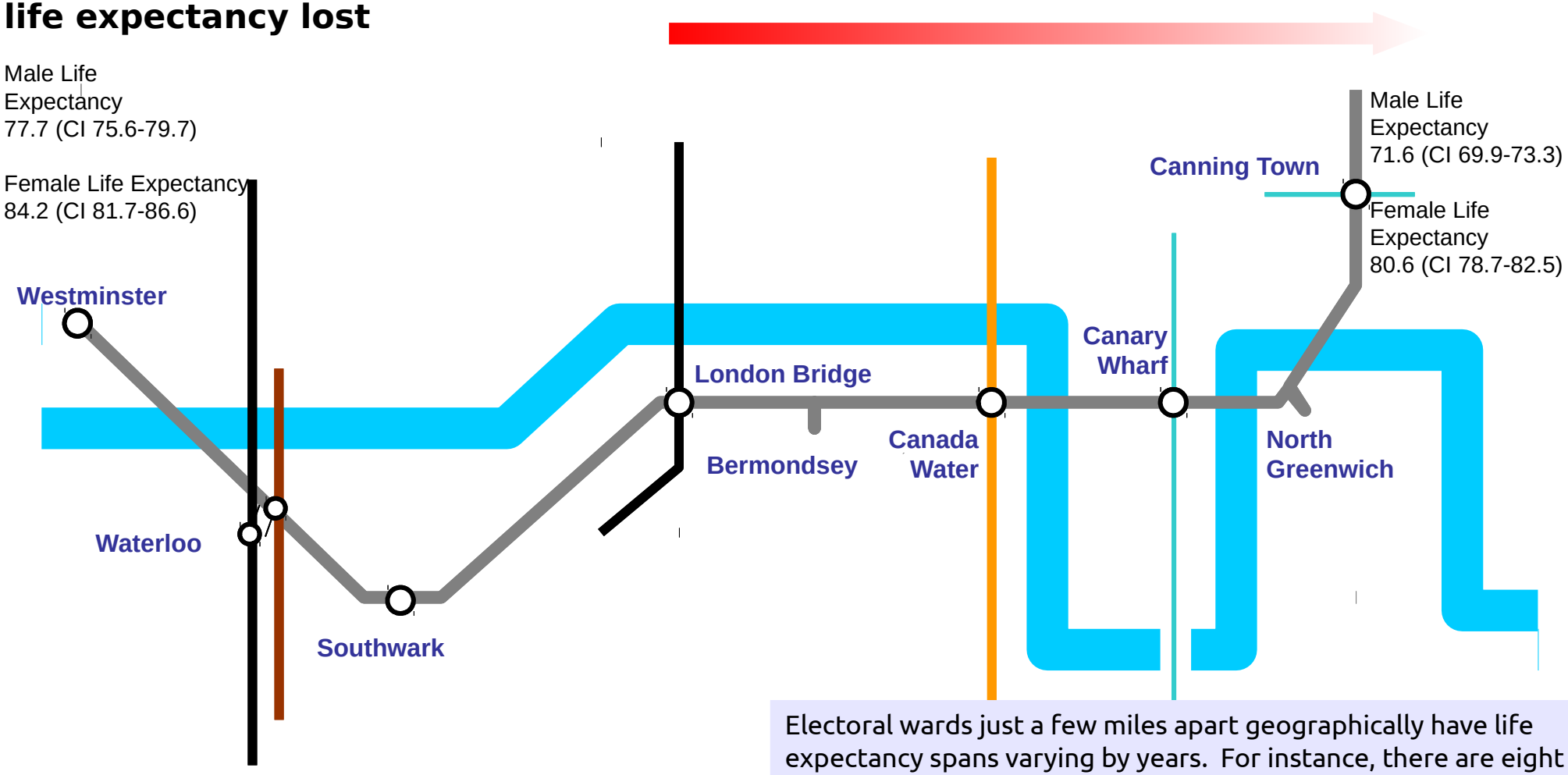
Health for ALL NOW!!

Life expectancy in Glasgow



Life expectancy in London

Travelling east from Westminster, each tube stop represents nearly one year of life expectancy lost



London Underground **Jubilee Line**

Electoral wards just a few miles apart geographically have life expectancy spans varying by years. For instance, there are eight stops between Westminster and Canning Town on the Jubilee Line – so as one travels east, each stop, on average, marks nearly a year of shortened lifespan. [1]

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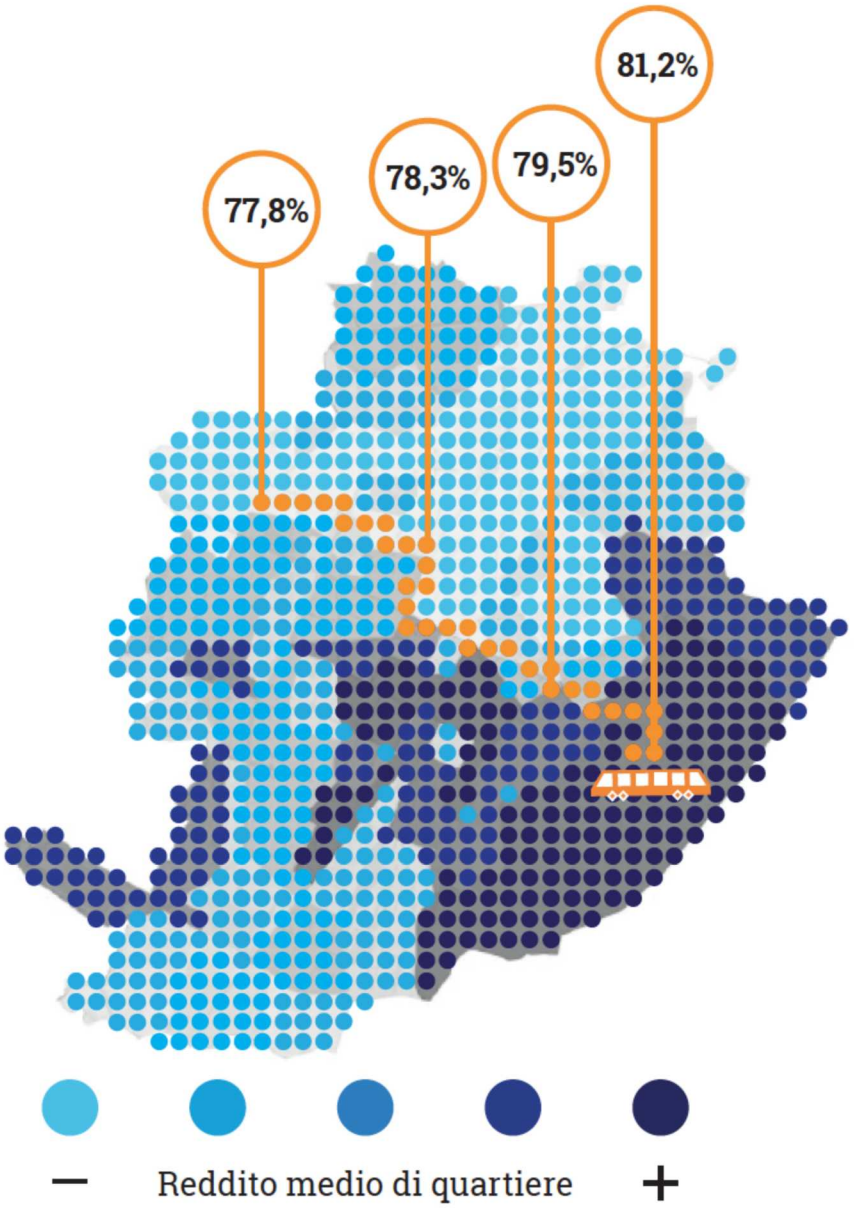
[1] Source: Analysis by London Health Observatory using Office for National Statistics data. Diagram produced by Department of Health

Life expectancy in Turin



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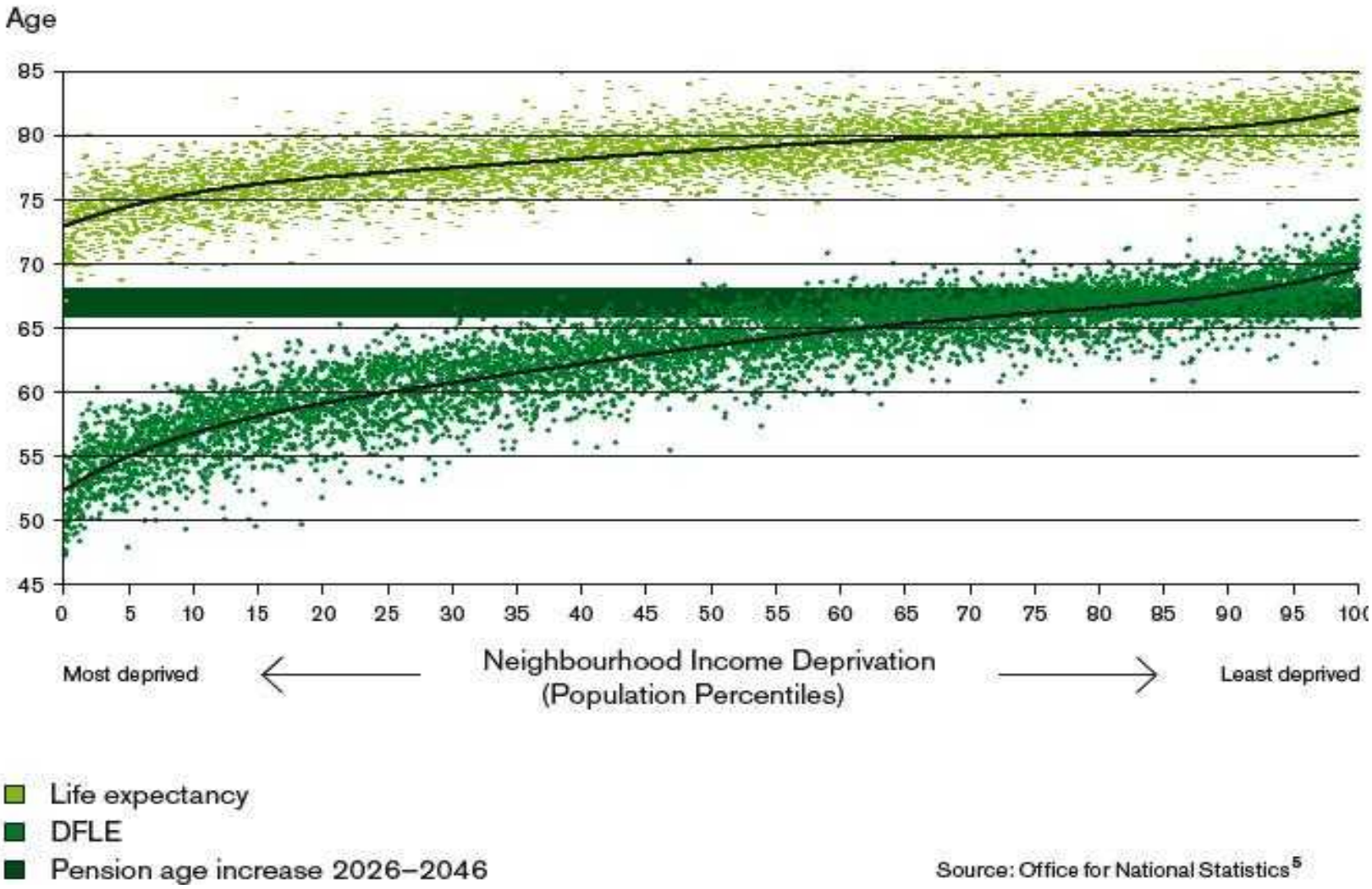
Il gradiente sociale

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]

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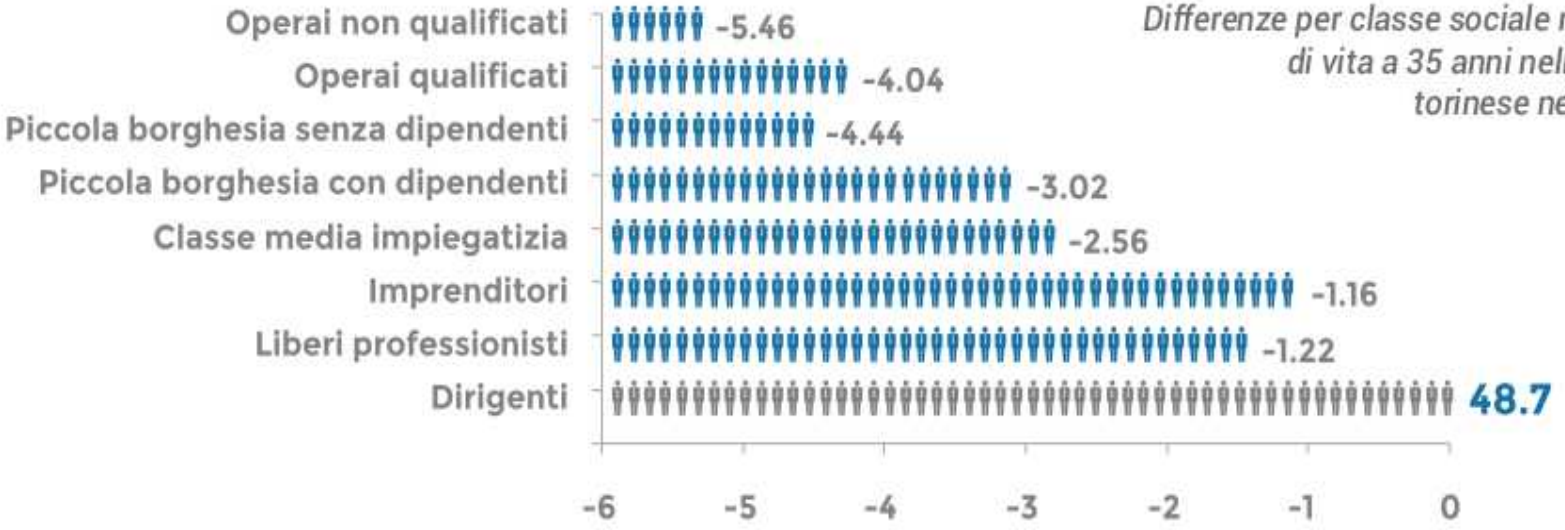
Lavoro e aspettativa di vita

Il livello di salute di una società non dipende unicamente dalle capacità del sistema sanitario di erogare cure universali e appropriate e di tutelare il benessere fisico e mentale dei cittadini ma anche - e in buona parte - dalle condizioni di vita in cui gli individui nascono, crescono, vivono, lavorano ed invecchiano.

5 ANNI E MEZZO

è la differenza nella speranza di vita tra operaio e dirigente



Differenze per classe sociale nella speranza di vita a 35 anni nella forza lavoro torinese negli anni 2000.

Costa G., Bassi M., Censini G.F., Marra M., Nicelli A.L., Zengarini N. (a cura di), 2014, L'equità in salute in Italia. Secondo rapporto sulle disuguaglianze sociali in sanità, Fondazione Smith Kline, Franco Angeli, Milano.

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Lavoro e mortalità

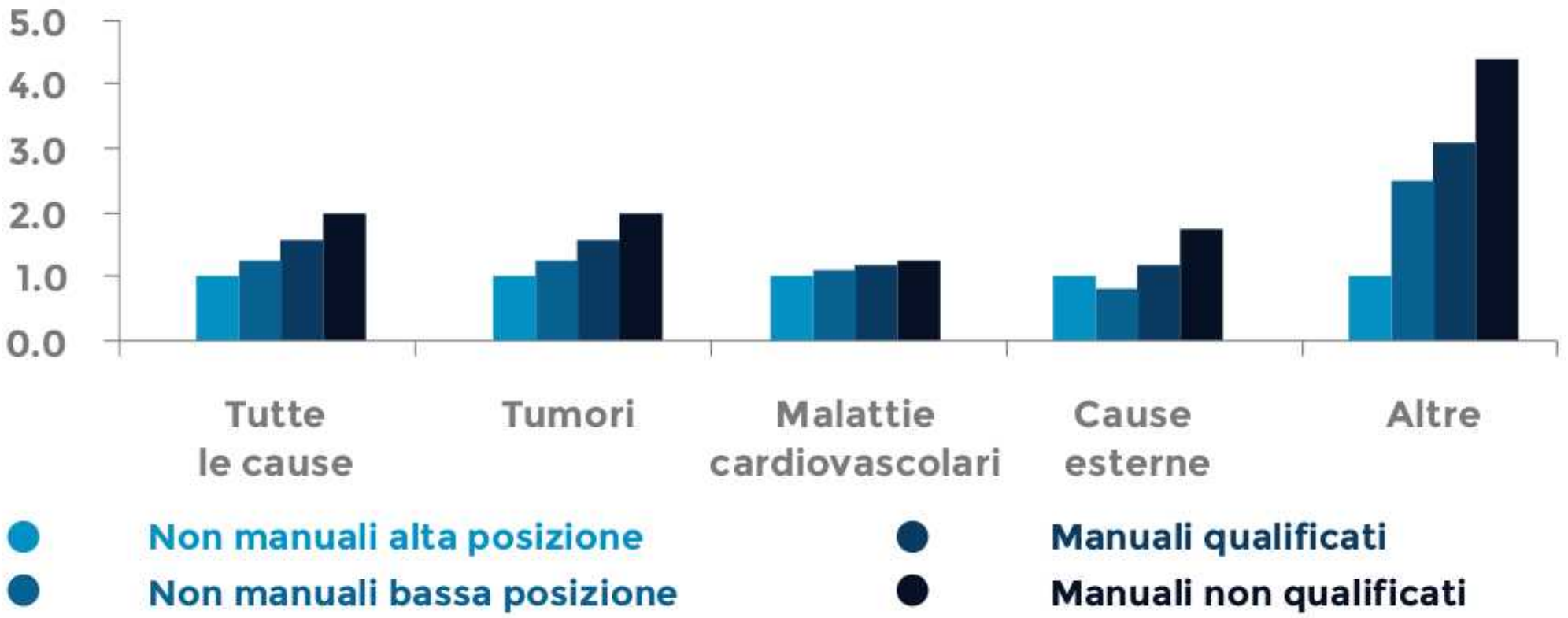

Figura 3. *Rischi relativi di morte per tipologia di lavoro e per varie cause nella popolazione maschile torinese.*

Costa G., Bassi M., Censini G.F., Marra M., Nicelli A.L., Zengarini N. (a cura di), 2014, L'equità in salute in Italia. Secondo rapporto sulle disuguaglianze sociali in sanità, Fondazione Smith Kline, Franco Angeli, Milano.

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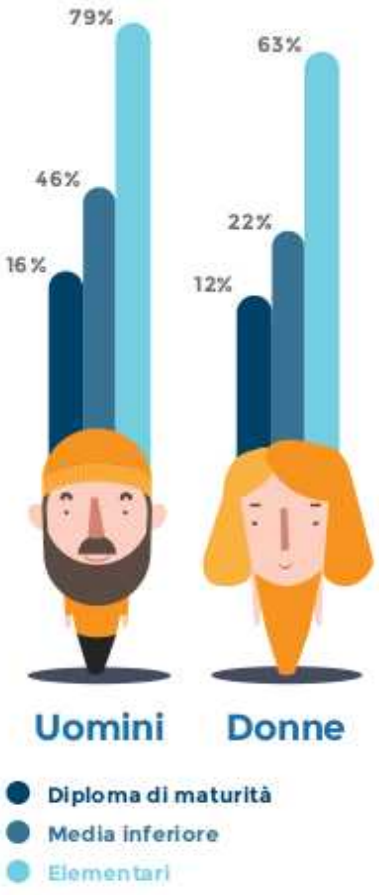
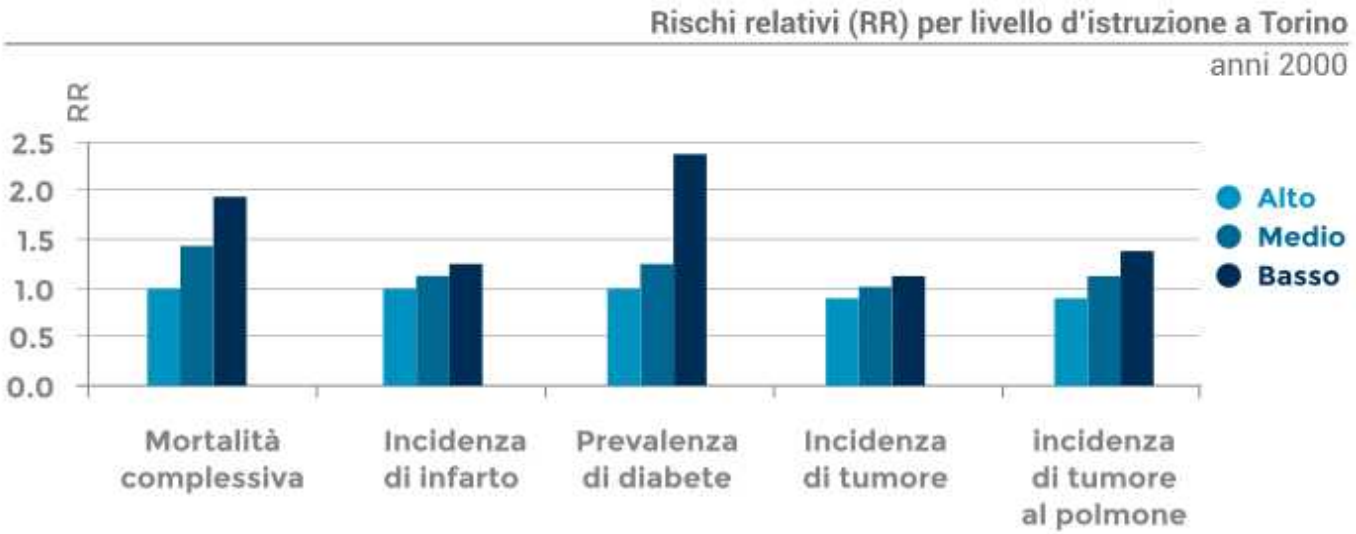
Istruzione e salute

In Italia, negli anni 2000, il rischio di morire cresce con l'abbassarsi del titolo di studio.





Tali differenze sono chiamate disuguaglianze sociali nella salute e presentano tre caratteristiche:

Tendono a colpire sistematicamente gli stessi gruppi sociali.

Non riguardano unicamente i più sfortunati:
mano a mano che si risale lungo la scala sociale gli indicatori di salute hanno valori più favorevoli, secondo quello che viene definito gradiente sociale.

Sono socialmente costruite e quindi ingiuste.

Costa G., Bassi M., Censini G.F., Marra M., Nicelli A.L., Zengarini N. (a cura di), 2014, L'equità in salute in Italia. Secondo rapporto sulle disuguaglianze sociali in sanità, Fondazione Smith Kline, Franco Angeli, Milano.

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Mortalità e 'traiettorie occupazionali'

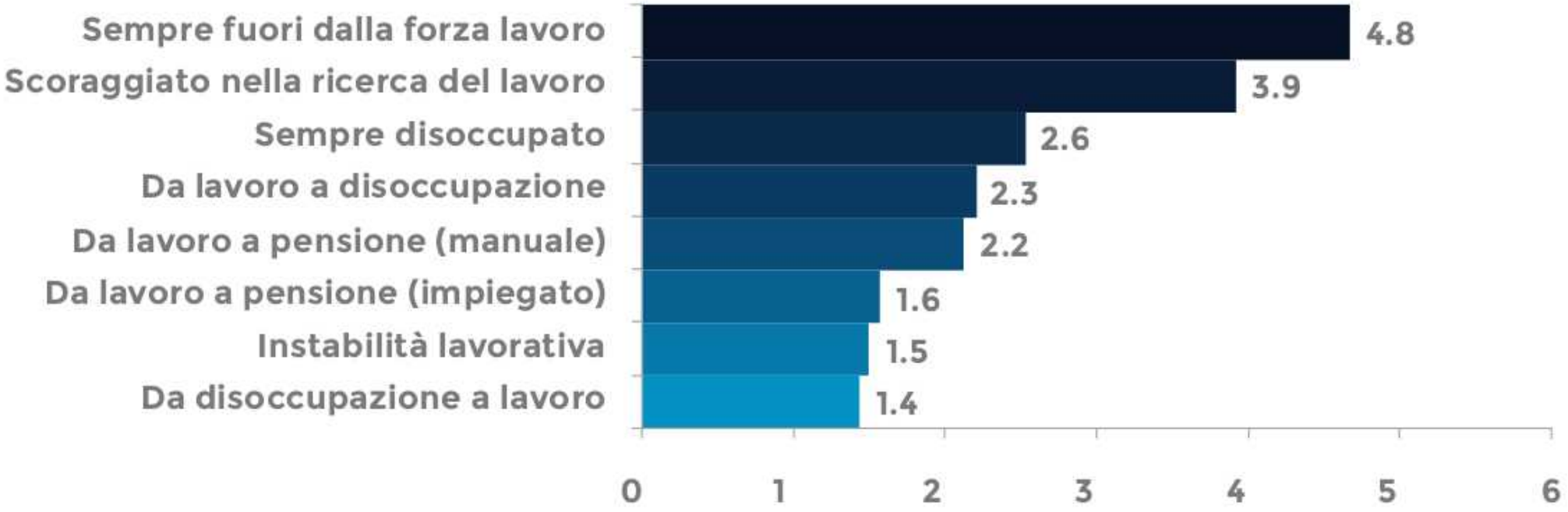

Figura 1. *Rischi relativi di mortalità, standardizzati per età, secondo le traiettorie occupazionali tra il 1971 e il 1991 (categoria di riferimento: sempre occupati) tra gli uomini a Torino, 1991-96.*

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Situazione in Italia

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Situazione in Italia

Le persone meno istruite di sesso maschile mostrano una speranza di vita alla nascita inferiore di **3 anni** rispetto alle persone più istruite; nelle regioni del Sud, indipendentemente dal livello di istruzione, i residenti perdono **un ulteriore anno** di speranza di vita. Le disuguaglianze sociali nella mortalità sono presenti in tutte le regioni, ma sono più marcate in quelle più povere del Mezzogiorno.

Le differenze geografiche, al netto delle differenti strutture della popolazione per età e titolo di studio, producono **differenziali di mortalità per tutte le cause da -15% a +30% nelle donne e da -13% a +26% negli uomini**, rispetto alla media nazionale.

Si osserva un **netto gradiente di mortalità con eccesso al Sud per le malattie cardiovascolari**, dove vi sono aree in cui la mortalità tra i più istruiti è superiore a quella dei meno istruiti residenti in alcune aree del Nord. Al contrario, **il gradiente è da Sud a Nord per la causa «Tutti i tumori» e per la maggior parte delle singole sedi tumorali**.

In Italia, la mortalità per tutte le cause attribuibili al basso livello d'istruzione, al netto della struttura della popolazione per età, è del **13,4%** nelle donne e del **18,3%** negli uomini.

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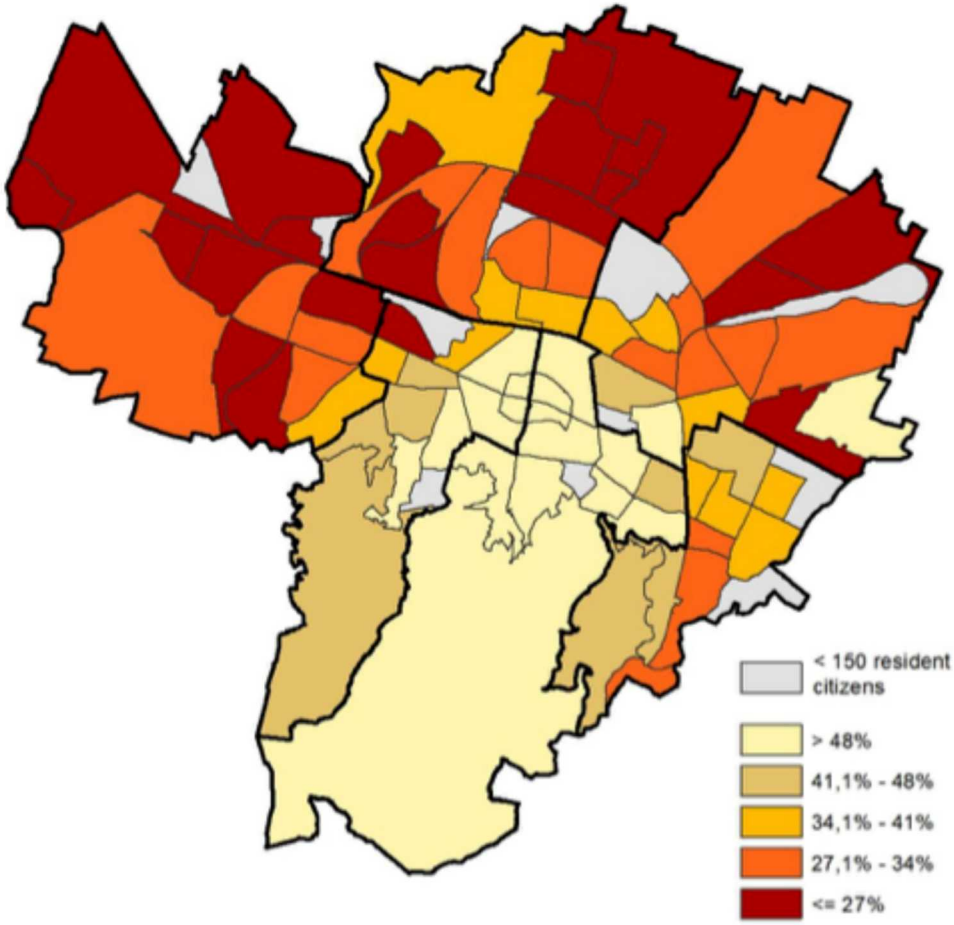
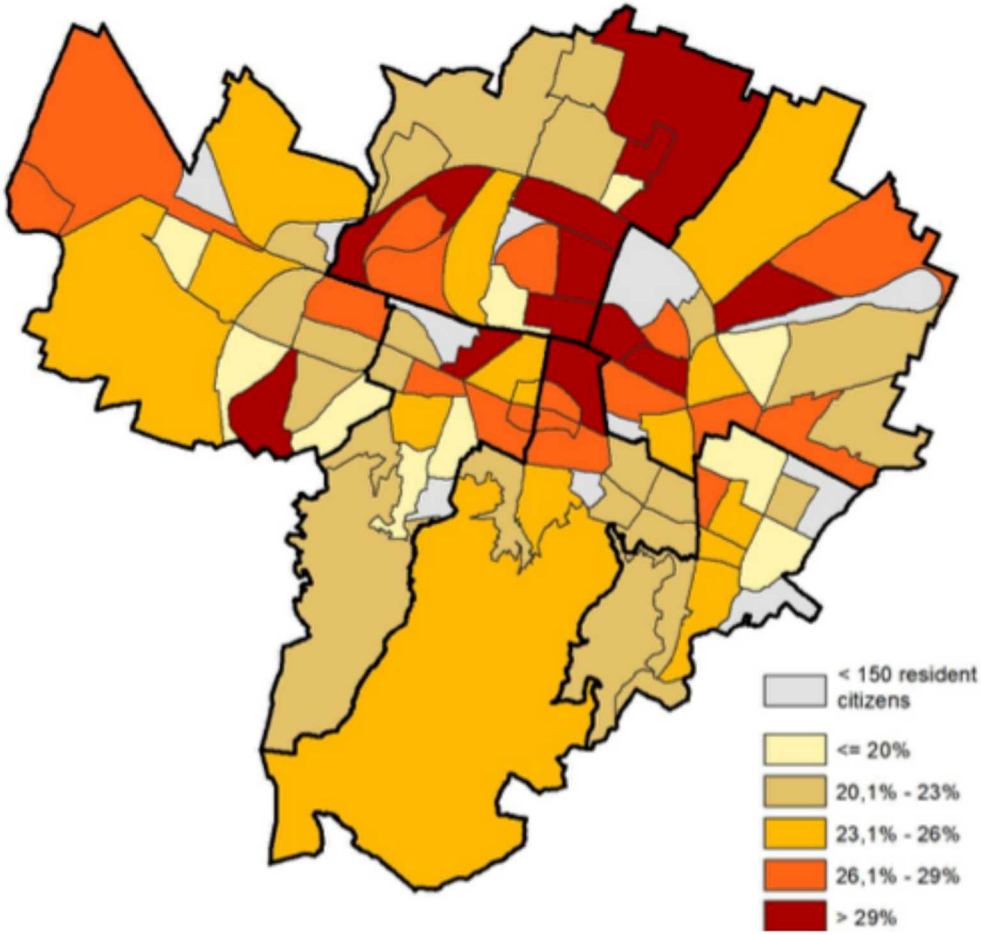
Situazione a Bologna

Proportion of graduates (25-44 years) over total population (25-44 years)



Proportion of families witha a per-capita equalised income <12.338 €



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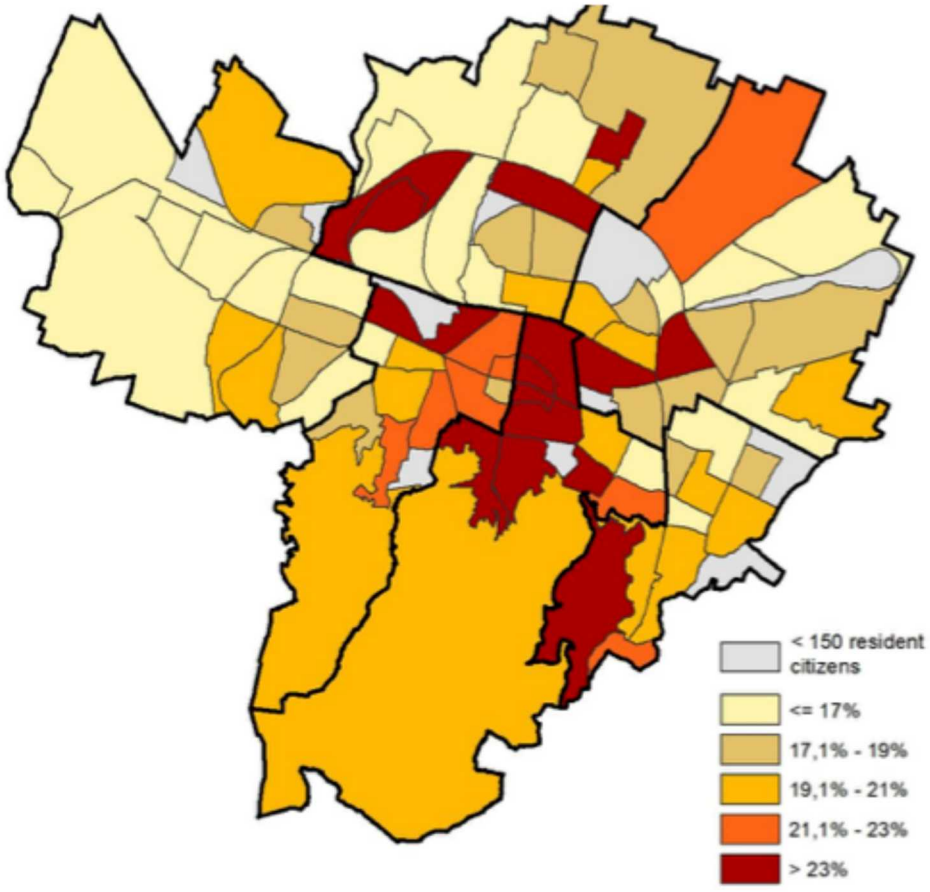
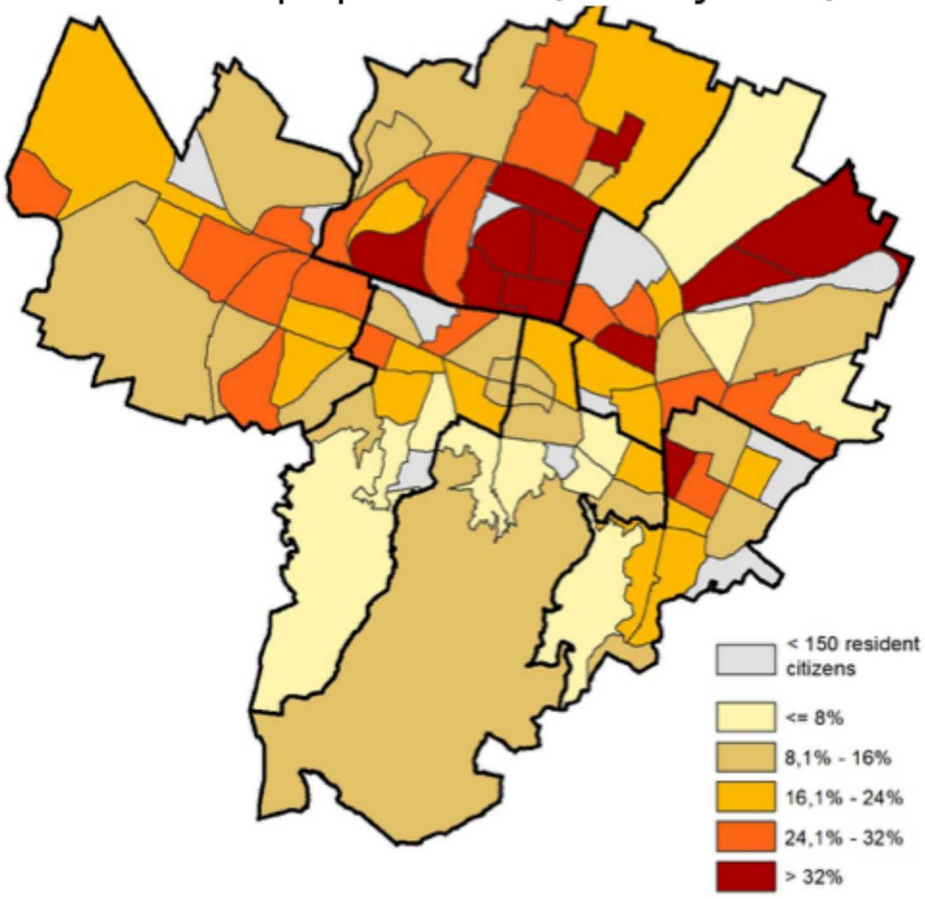
Situazione a Bologna

Proportion of underages in singleparent families over total underage population



Proportion of foreign population(0-19 years) over total population (0-19 years)



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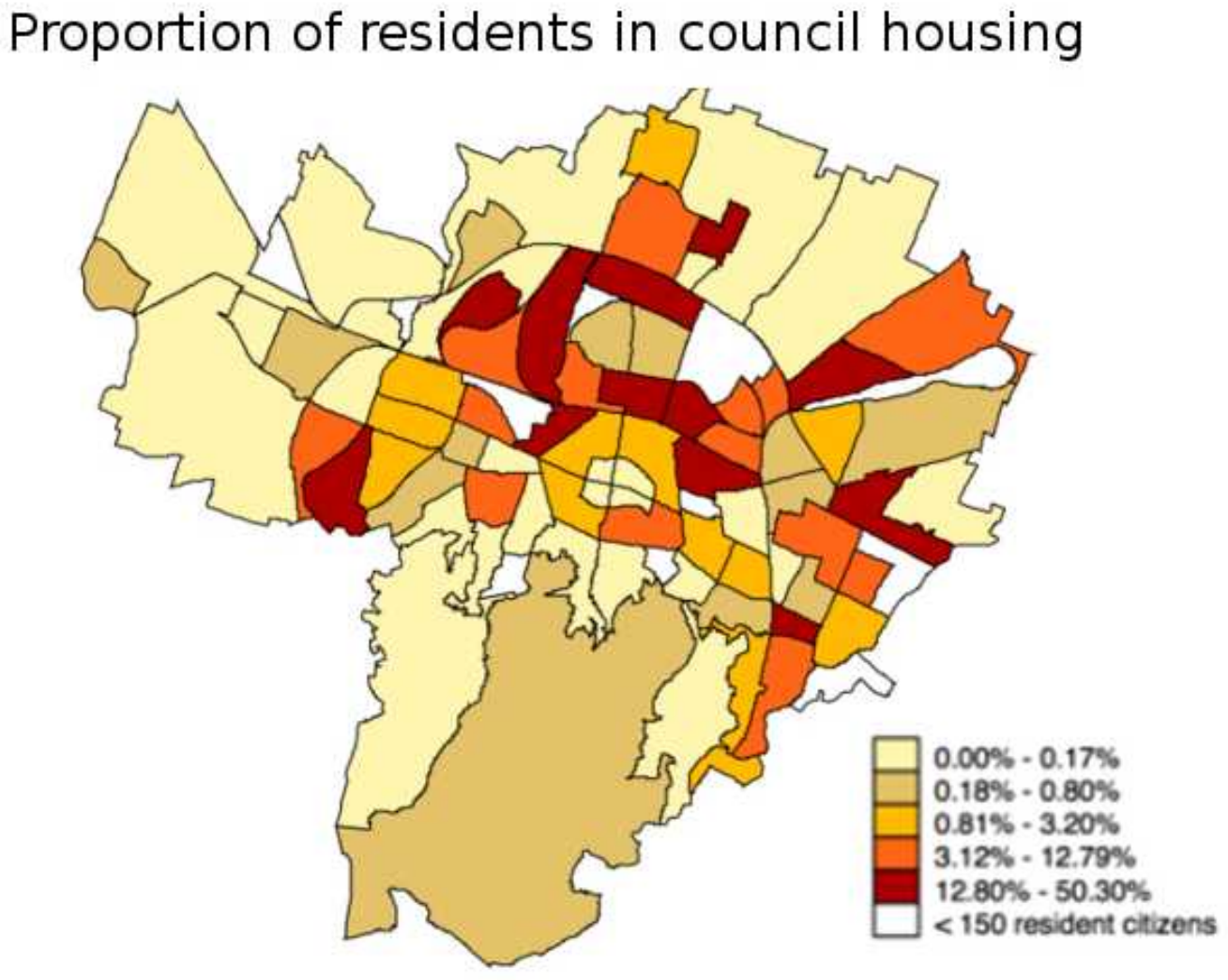
Situazione a Bologna



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Disuguaglianze in salute

"Quale che sia l'indicatore di posizione sociale impiegato - *l'istruzione, la classe sociale, le caratteristiche dell'abitazione* - il rischio di mortalità cresce in ragione inversa delle risorse sociali di cui gli individui dispongono."

G. Costa, M. Cardano, M. Demaria, Torino, storie di salute in una grande città. Città di Torino, Ufficio di statistica, Osservatorio socioeconomico torinese, 1998.

*

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Commission on
Social Determinants of Health

Commission on Social Determinants of Health FINAL REPORT

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

Dove le sistematiche differenze in salute sono considerate evitabili mediante interventi ragionevoli, esse sono, semplicemente, ingiuste. É ciò che chiamiano iniquità in salute. Raddrizzare queste iniquità – le immense e rimediabili differenze in salute tra paesi e all'interno dei paesi – è una questione di giustizia sociale. Ridurre le iniquità in salute è, per la Commissione sui Determinanti Sociali della Salute, un imperativo etico. L'ingiustizia sociale sta uccidendo persone su larga scala.

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Questa iniqua distribuzione non è un fenomeno “naturale”, ma il risultato di politiche che privilegiano gli interessi di alcuni su quelli di altri – troppo spesso quelli di una ricca e potente minoranza sugli interessi di una maggioranza privata di potere.


DARKOW
COLUMBIA DAILY TRIBUNE
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©2007
WELL, I LEFT YOU HALF!
WHAT ARE YOU, GREEDY?
THE RICH
INCOME
THE BOTTOM 90%
(THE GREAT UNWASHED)

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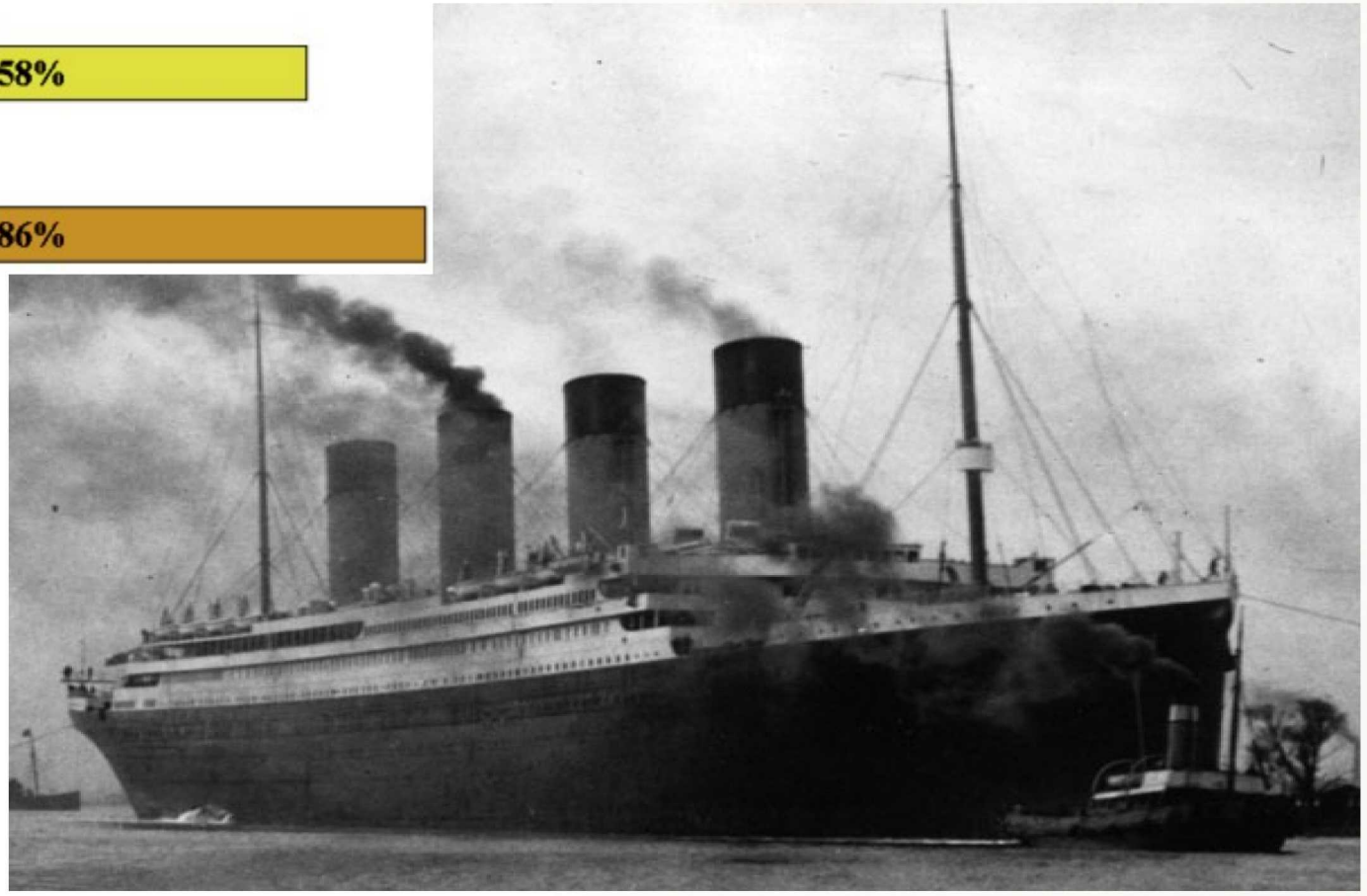
TITANIC: mortalità dei passeggeri secondo la classe di imbarco

CLASSE

I **40%**

II **58%**

III **86%**



Why?

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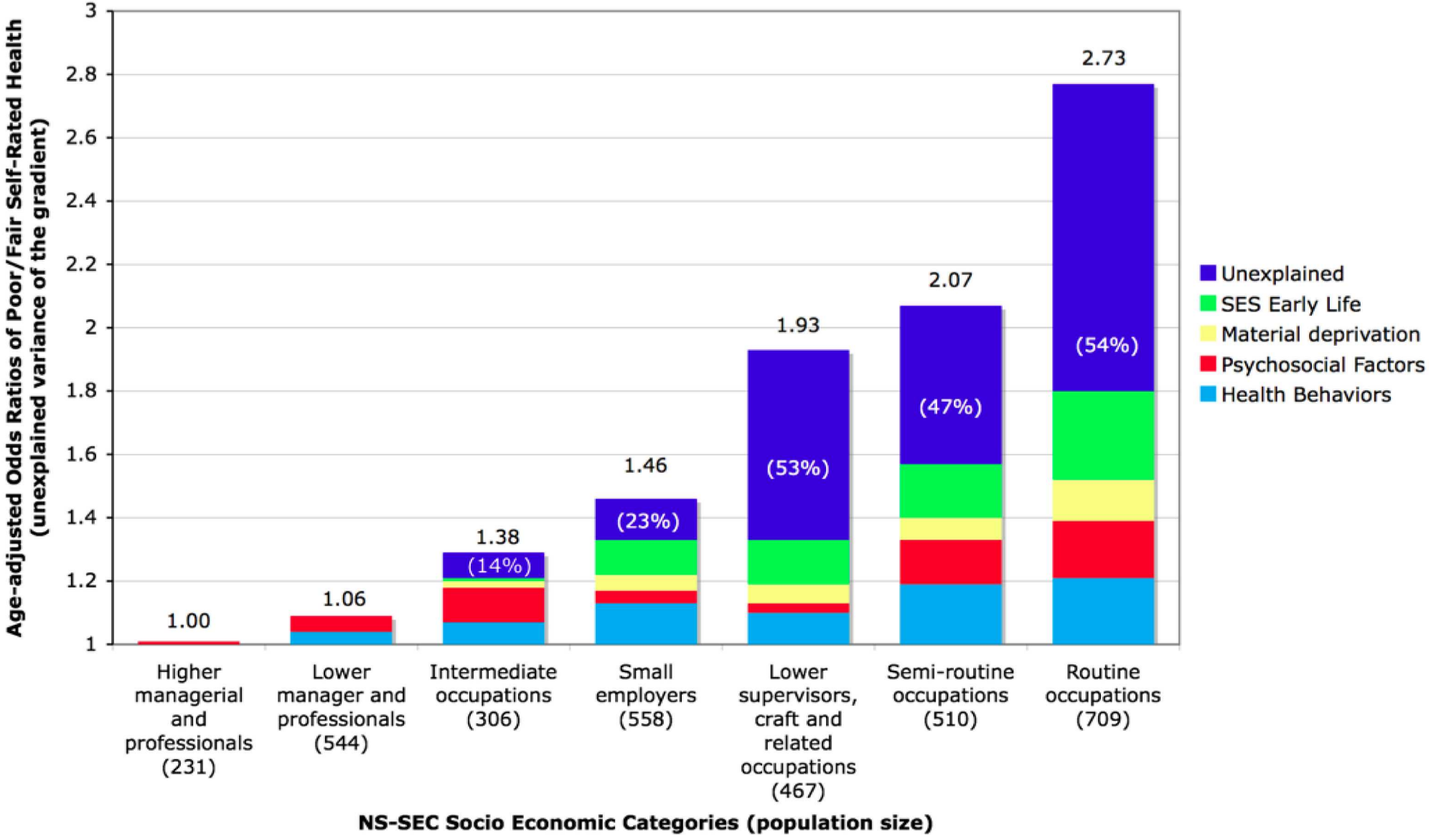
Socieconomic Gradient of Health



Data Source: Health Determinants Surveillance System (HDSS), 2003.

“Si tratta di sostituire un pensiero che separa e riduce con un pensiero che distingue e collega.” (E. Morin)

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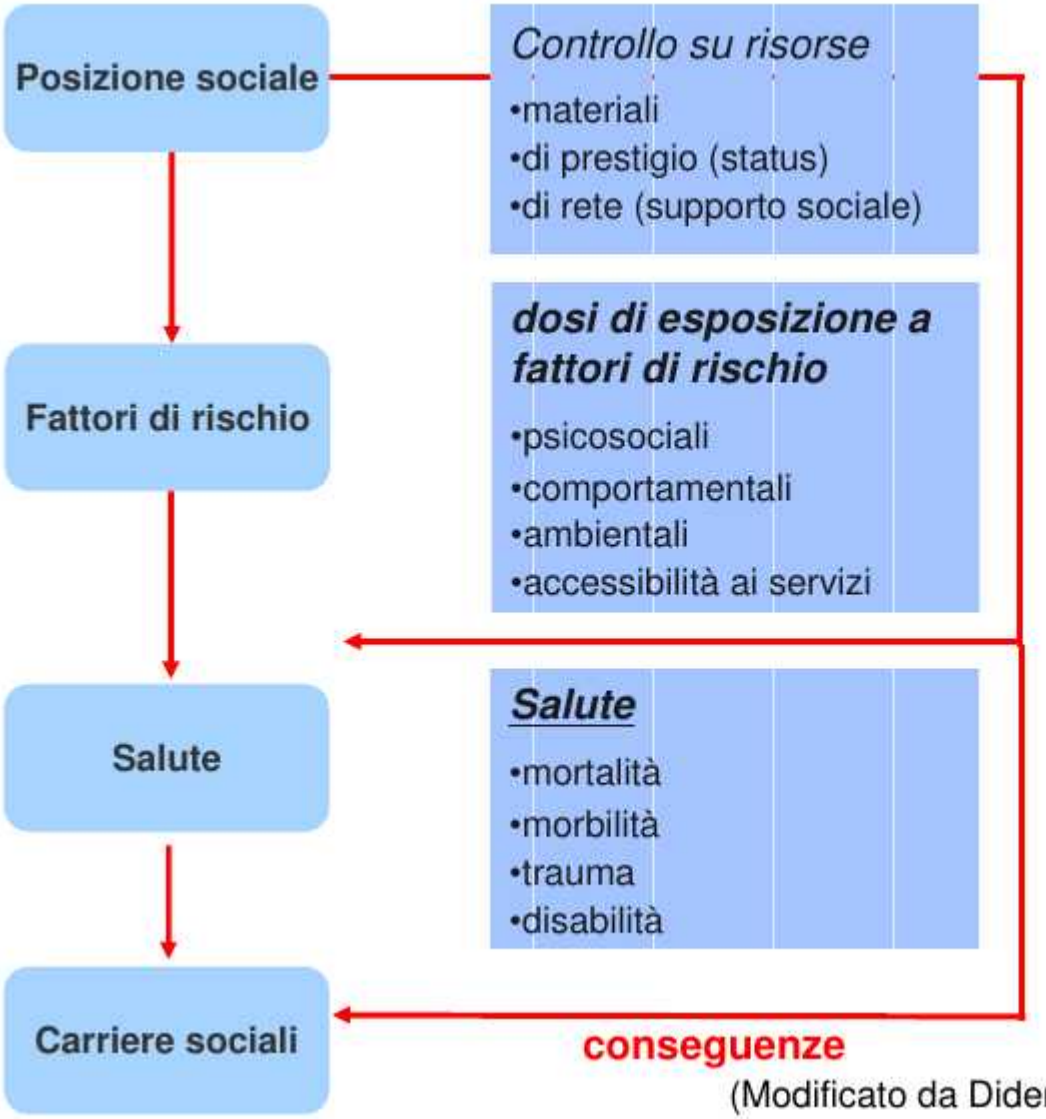
Posizione sociale e salute



(Modificato da Diderichsen et al. 2001)

Fonte: Costa, 2017

Life-course perspective

Socio-economic conditions act upon individuals' health status even at a distance in time. There is a described association between socio-economic conditions in early childhood and mortality in adulthood.

(D. Kuh et al., *BMJ* 2002; 325:1076-80)

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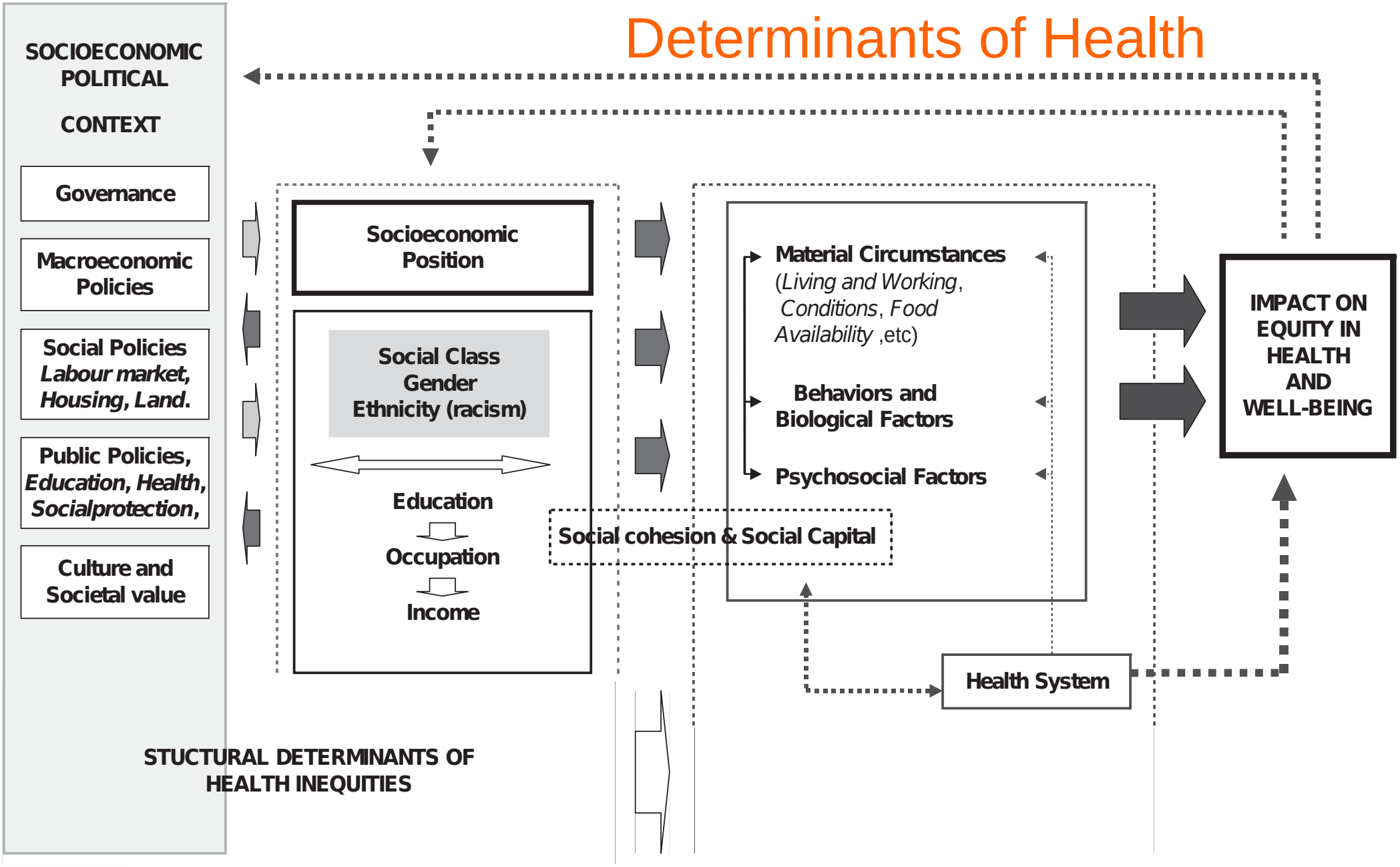
Commission on the Social Determinants of Health



Source: CSDH, WHO, 2010

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Eco-social theory (2008)

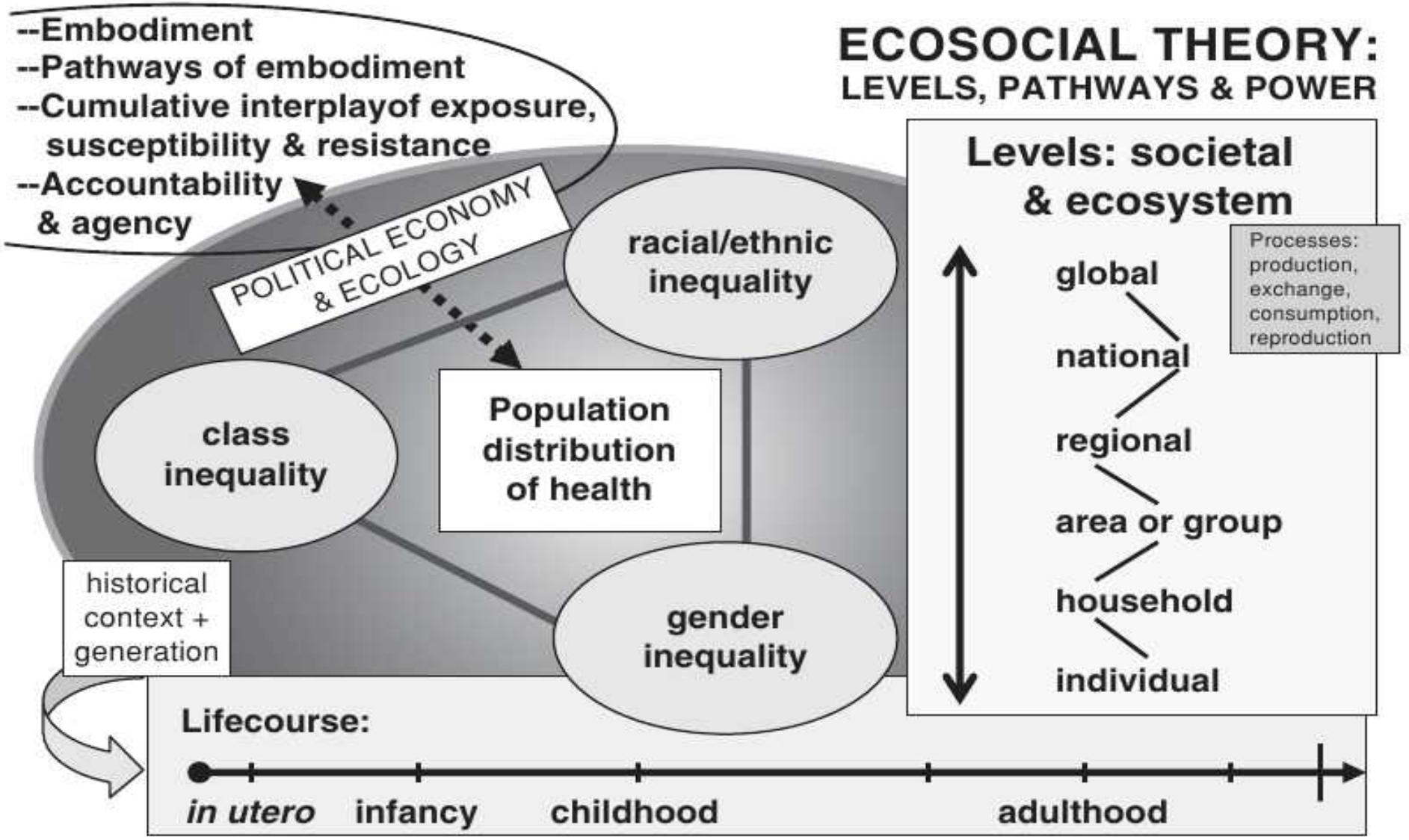

Figure 7–1. Ecosocial theory and embodying inequality: core constructs. (Krieger, 1994; Krieger, 2008a)

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10 tips for staying healthy

1. Don't smoke. If you can, stop. If you can't, cut down.	1. Don't be poor. If you can, stop. If you can't, try not to be poor for long.
2. Follow a balanced diet with plenty of fruit and vegetables.	2. Don't have poor parents.
3. Keep physically active.	3. Own a car.
4. Manage stress by, for example, talking things through and making time to relax.	4. Don't work in a stressful, low paid manual job.
5. If you drink alcohol, do so in moderation.	5. Don't live in damp, low quality housing.
6. Cover up in the sun, and protect children from sunburn.	6. Be able to afford to go on a foreign holiday and sunbathe.
7. Practise safer sex.	7. Practice not losing your job and don't become unemployed.
8. Take up cancer screening opportunities.	8. Take up all benefits you are entitled to, if you are unemployed, retired or sick or disabled.
9. Be safe on the roads: follow the Highway Code.	9. Don't live next to a busy major road or near a polluting factory.
10. Learn the First Aid ABC: airways, breathing, circulation.	10. Learn how to fill in the complex housing benefit/asylum application forms before you become homeless and destitute.
Donaldson, 1999	*Gordon, 1999*

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.

Che fare? Politiche di salute

- Analizzare lo stato di salute e di accesso ai servizi di salute usando una **lente di equità**
- Agire sui **determinanti primari**, cioè più a monte, delle disuguaglianze e delle iniquità
- Investire su un'**offerta equa**, ma anche sulla domanda di servizi
- Investire nei **periodi di maggiore vulnerabilità** lungo il corso della vita
- Investire nelle **malattie della povertà**
- Investire nei **gruppi sociali più vulnerabili**
- Assicurare l'**accesso a cure di qualità**
- Usare **obiettivi** ed **indicatori** di **equità**

(Adattato da Cattaneo A., 2008)

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- I progressi sanitari più importanti nei paesi ricchi sono stati ottenuti con politiche che hanno affrontato in primo luogo la **povertà**, e contemporaneamente le **cause intermedie di esposizione** e suscettibilità alle malattie (istruzione, lavoro, nutrizione, ambiente, etc)
- Gli interventi sanitari sono efficaci solo quando si impiantano sopra questo substrato
- Questo approccio è possibile solo se si considera la salute, ed i servizi di salute, come un **diritto**, e non come una merce o un bene di consumo
- Le scorciatoie servono solo ad alleviare a breve termine le peggiori conseguenze della disuguaglianza e della povertà, non ad intraprendere la strada di miglioramenti permanenti

(Adattato da Cattaneo A., 2008)

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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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THANK YOU!

“To do nothing is as much a political decision as to challenge an issue head-on”.

Delamothe T., 2002

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