Coordinamento Regionale Collegi IPASVI - FVG

IPASVI

md studio congressi

LE COMPETENZE DELL'INFERMIERE:
UNA CHIAVE PER IL CAMBIAMENTO DEL SISTEMA SALUTE

Giovedì 14 Novembre 2013 - Grado – Palazzo dei Congressi

Le linee di fondo per una razionalizzazione del SSN/R un ripensamento non più rinviabile e le esigenze delle organizzaizioni/strutture

Ardigò Martino
Centro Studi e Ricerche in Salute Internazionale e Interculturale

ardigo.martino@unibo.it
www.csiunibo.org

1) I sistemi sanitari nel contesto globalizzato

Globalizzazione

Simboli:

> Informazione

> mode

Governance:

>Istituzioni

>Servizi

>Protezione

Ambiente
Fisico
Culturale
Sociale
Politico

Beni e servizi:

>Valore

>Abitudini

>F. di rischio fisico

Mobilità:

>Turismo

>Lavoro

>Migrazione

The Growing Impact of Globalization for Health and Public Health Practice

Ronald Labonté, Katia Mohindra, and Ted Schrecker

Institute of Population Health, University of Ottawa, Ottawa, Ontario K1N 6N5, Canada; email: rlabonte@uottawa.ca, katia.mohindra@gmail.com, tschrecker@gmail.com

Annu. Rev. Public Health 2011. 32:263–83

First published online as a Review in Advance on December 21, 2010

The *Annual Review of Public Health* is online at publhealth.annualreviews.org

This article's doi: 10.1146/annurev-publhealth-031210-101225

0163-7525/11/0421-0263$20.00

Keywords

economic integration, trade, neoliberalism, global health diplomacy

Abstract

In recent decades, public health policy and practice have been increasingly challenged by globalization, even as global financing for health has increased dramatically. This article discusses globalization and its health challenges from a vantage of political science, emphasizing increased global flows (of pathogens, information, trade, finance, and people) as driving, and driven by, global market integration. This integration requires a shift in public health thinking from a singular focus on international health (the higher disease burden in poor countries) to a more nuanced analysis of global health (in which health risks in both poor and rich countries are seen as having inherently global causes and consequences). Several globalization-related pathways to health exist, two key ones of which are described: globalized diseases and economic vulnerabilities. The article concludes with a call for national governments, especially those of wealthier nations, to take greater account of global health and its social determinants in all their foreign policies.

Published online ahead of print April 18, 2013 | American Journal of Public Health

Crisis and Opportunities

Economic Crisis, Restrictive Policies, and the Population's Health and Health Care: The Greek Case

Elias Kondilis, MD, PhD, Stathis Giannakopoulos, MD, PhD, Magda Gavana, MD, PhD, Ioanna Ierodiakonou, MD, PhD, Howard Waitzkin, MD, PhD, and Alexis Benos, MD, PhD

The global economic crisis has affected the Greek economy with unprecedented severity, making Greece an important test of the relationship between socioeconomic determinants and a population's well-being.

Suicide and homicide mortality rates among men increased by 22.7% and 27.6%, respectively, between 2007 and 2009, and mental disorders, substance abuse, and infectious disease morbidity showed deteriorating trends during 2010 and 2011. Utilization of public inpatient and primary care services rose by 6.2% and 21.9%, respectively, between 2010 and 2011, while

THE CURRENT GLOBAL ECO-nomic crisis, manifested in 2007 with the collapse of the subprime mortgage market and the bankruptcy of several financial institutions in the United States, affected the Greek economy—viewed by some as the Eurozone's weakened economic link—with unprecedented severity.

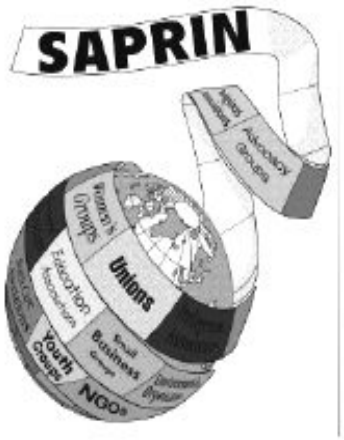
Many commentators in the past and present have debated whether the ongoing international economic turmoil, the worst since the Great Depression, threatens the health of the population both in the United States and throughout the developed and less-developed world.[1–5] The World

ECONOMIC CRISIS AND RESTRICTIVE HEALTH POLICIES

After 14 years of continuous economic expansion since 1994, Greece's gross domestic product (GDP) started showing zero or close to zero growth rates since the fourth quarter of 2007 and negative growth rates from the fourth quarter of 2008 onward (Figure 1).[8] During the 5-year period of recession (2008–2012), GDP (in 2005 constant market prices) cumulatively dropped by 20.8%, shrinking to its 2002 level.[8] The unemployment rate, 7.2% of total labor force in the third quarter

with very low work intensity, with income below 60% of national median, and with severe material deprivation.[11] As of 2011, an estimated 20 000 people were homeless (12 280 more than in April 2009),[12] and more than 20 000 people in the 2 largest cities of Greece were receiving daily food rations from nongovernmental organizations and other community-based agencies.[13]

In the midst of the crisis (November 2009–May 2010), international financial markets started focusing on the growing Greek government deficit (15.4% of GDP in 2009, compared with 9.8% in 2008 and 6.5% in



INVESTIGATION BY CIVIL SOCIETY AND WORLD BANK CHALLENGES STRUCTURAL ADJUSTMENT PROGRAMS

Publication of the SAPRI Report Highlights
Bank's Continued Inaction on Policy Findings

Following a multi-year participatory investigation undertaken with the World Bank and the governments of countries on four continents into the impact of economic adjustment programs, the international citizens' network, SAPRIN, released the findings of the Structural Adjustment Participatory Review Initiative (SAPRI) in April 2002 at a public forum held at the European Union in Brussels. Reissued in January 2004 in expanded form by Zed Books and Third World Network, *Structural Adjustment – The SAPRI Report*: *The Policy Roots of Economic Crisis, Poverty and Inequality* presents an incisive view of the devastating effects of the liberalization, privatization and deregulation agenda of the international financial institutions.

THE POLICY ROOTS OF ECONOMIC CRISIS AND POVERTY

A Multi-Country Participatory Assessment of Structural Adjustment

Based on Results of the Joint World Bank/Civil Society Structural Adjustment Participatory Review Initiative (SAPRI) and the Citizens' Assessment of Structural Adjustment (CASA)

Executive Summary

Chapter 8: The Impact of Public Expenditure Reforms on Health Care, Education and Other Public Services

Fiscal reforms have been a central part of structural adjustment packages, involving public-expenditure controls and, more often, cuts in spending on social services as a means of curbing budget deficits and reining in inflation. Yet, reforms have gone beyond cutbacks in social spending and have been applied to transform the social sector from one in which the state plays a major redistributive role to one that is subject to free-market forces. The consequent decline in the state's ability to allocate resources to the social sector, as well as the general deterioration in access to affordable quality services by important population groups, resulted in a worsening of poverty and inequality.

Education and health care are key social services affected by public-sector reforms and were areas of particular concern in several of the countries studied. Investigations in Ghana, Zimbabwe, Mexico and Hungary focused primarily on the impact of reforms on access to and the quality of these services, while the Uganda and Philippines assessments looked at the impact on spending for education and health care. The review in Ecuador focused on social subsidies, addressing the more overarching issue of the role of the state in the social sector and the question of state support for universal vis-a-vis targeted coverage.

In general, the investigations concurred in their conclusions that reforms have weakened the role of the state in the social sector by limiting its functions and reducing its expenditures for education and health care, or at least failing to improve their allocation and effectiveness. As a result, market forces, for which the only criterion for success is profit maximization, have been left to determine the access that much of the population can gain to key services such as education and health care. SAPRIN found that, in the face of low wages and high unemployment levels, the imposition of user fees and the rising cost of services have increased hardships on the poor. The strategy of targeting subsidies to benefit only those in extreme poverty has failed to address the broader problems of the poor or to stop the growth of poverty and inequality. Specific conclusions are as follows:

Tropical Medicine and International Health doi:10.1111/j.1365-3156.2011.02941.x

VOLUME oo NO oo

Public health services, an essential determinant of health during crisis. Lessons from Cuba, 1989–2000

Pol De Vos[1], Anaí García-Fariñas[2], Adolfo Álvarez-Pérez[2], Armando Rodríguez-Salvá[2], Mariano Bonet-Gorbea[2] and Patrick Van der Stuyft[1]

1 *Institute of Tropical Medicine, Antwerpen, Belgium*
2 *National Institute of Hygiene, Epidemiology and Microbiology, Havana, Cuba*

Abstract During the 1990s, Cuba was able to overcome a severe crisis, almost without negative health impacts. This national retrospective study covering the years 1989–2000 analyses the country's strategy through essential social, demographic, health process and health outcome indicators. Gross domestic product (GDP) diminished by 34.76% between 1989 and 1993. In 1994 slow recuperation started. During the crisis, public health expenses increased. The number of family doctors rose from 9.22 to 27.03 per 104 inhabitants between 1989 and 2000. Infant mortality rate and life expectancy exemplify a series of health indicators that continued to improve during the crisis years, whereas low birth weight and tuberculosis incidence are among the few indicators that suffered deterioration. GDP is inversely related to tuberculosis incidence, whereas the average salary is inversely related to low birth weight. Infant mortality rate has a strong negative correlation with the health expenses per inhabitant, the number of maternal homes, the number of family doctors and the proportion of pregnant women receiving care in maternal homes. Life expectancy has a strong positive correlation with health expenses, the number of nursing personnel and the number of medical contacts per inhabitant. The Cuban strategy effectively resolved health risks during the crisis. In times of serious socio-economic constraints, a well conceptualized public health policy can play an important role in maintaining the overall well-being of a population.

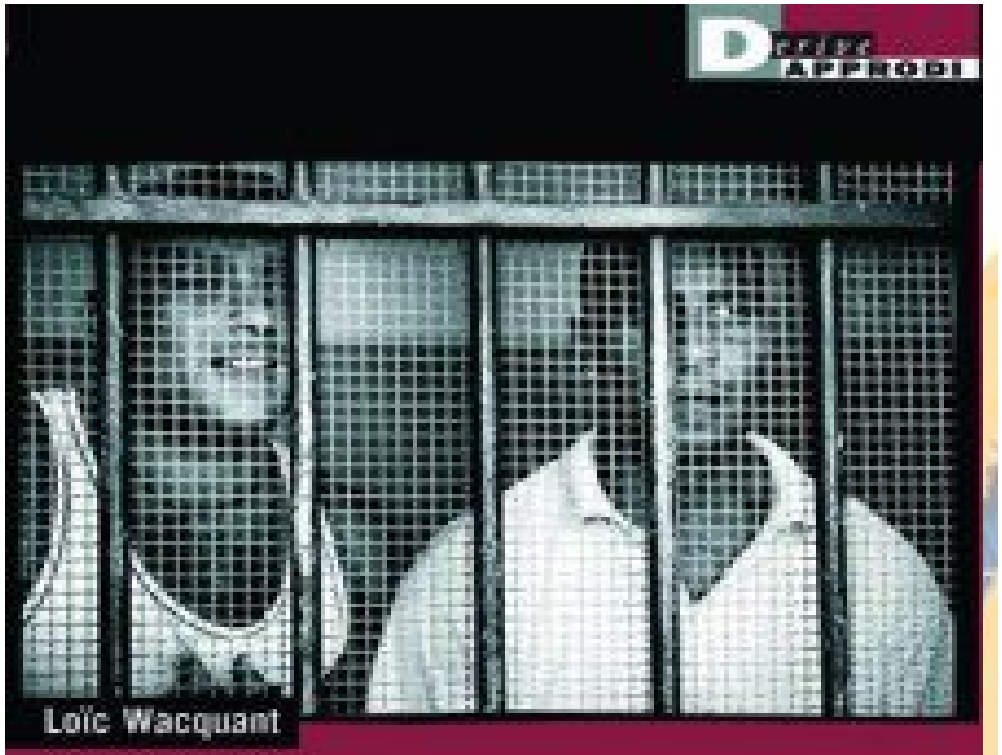
keywords public health, determinants of health, health services, economic crisis, Cuba, international health

Linee di fondo / competenze

- Capacità di comprensione dei processi globali nel locale

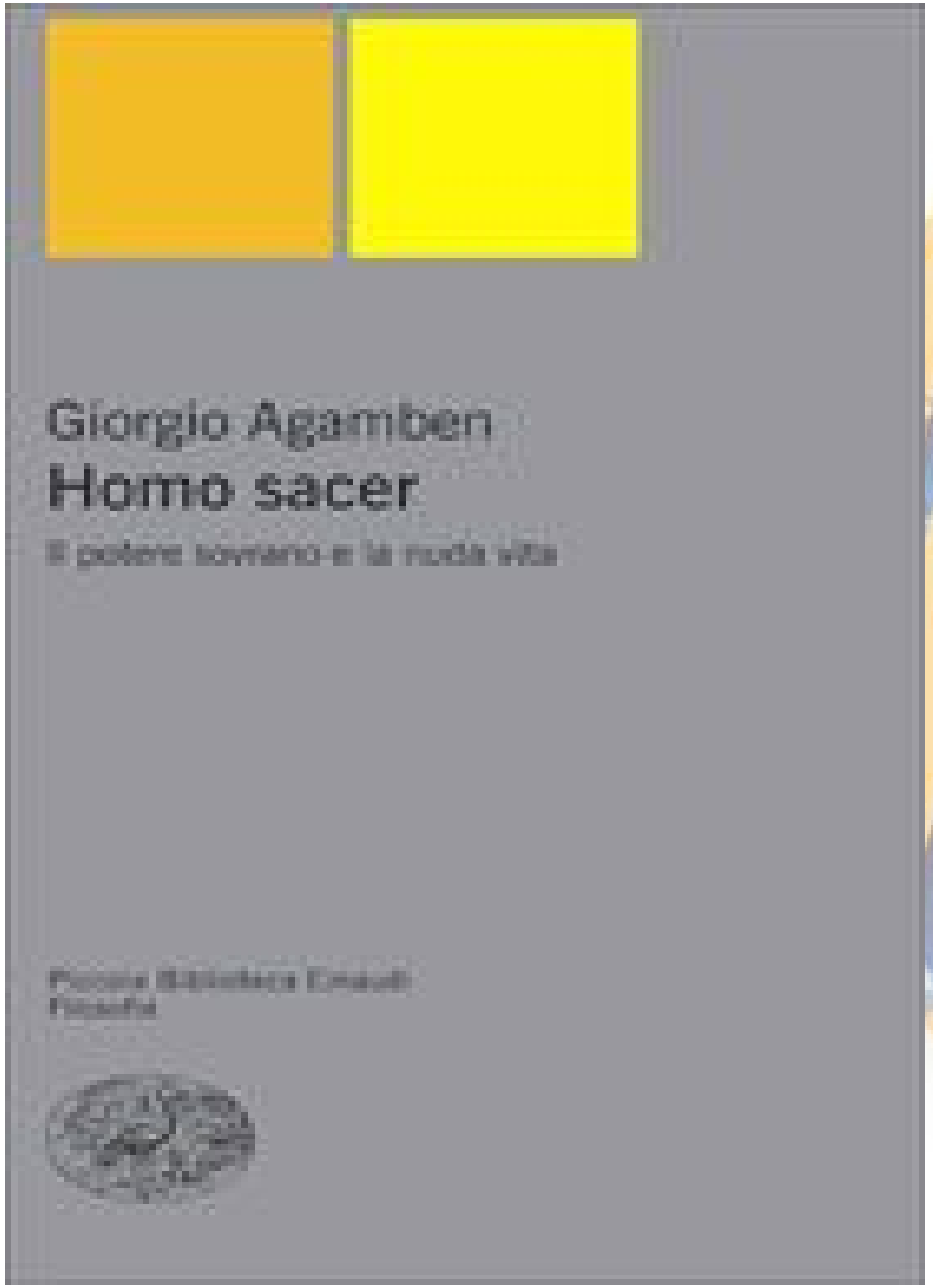
- Costruire una rete di relazioni tra locale e globale che porti l'esperienza e le istanze locali nello spazio globale e non solo il peso del globale nel locale

2) sistemi sanitari e l'integrazione tra discipline e professioni

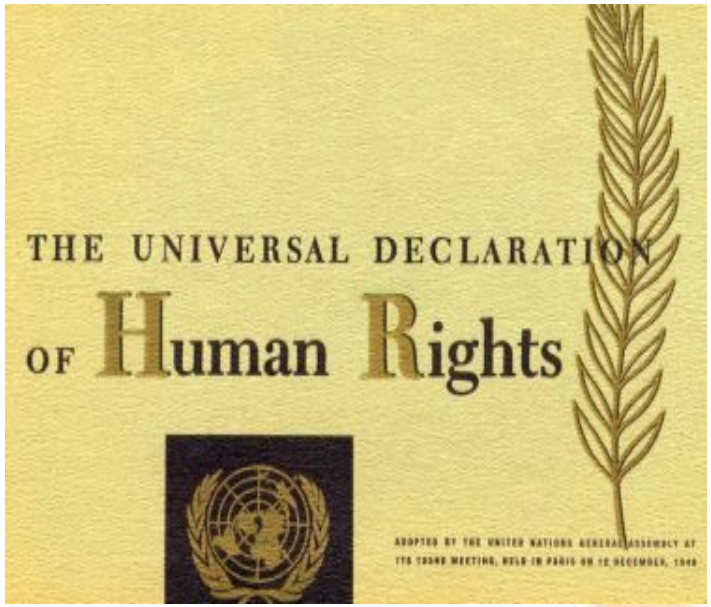


Punire i poveri

Il nuovo governo dell'insicurezza sociale



Servizi sanitari e interventi rivolti all'individuo come individuo biologico. Come se una persona si esaurisse nella sua esistenza biologica nella “nuda vita”



Articolo 25

1. Ogni individuo ha il diritto ad un tenore di vita sufficiente a garantire la salute e il benessere proprio e della sua famiglia, con particolare riguardo all'alimentazione, al vestiario, all'abitazione, e alle cure mediche e ai servizi sociali necessari, ed ha diritto alla sicurezza in caso di disoccupazione, malattia, invalidità vedovanza, vecchiaia o in ogni altro caso di perdita dei mezzi di sussistenza per circostanze indipendenti dalla sua volontà.

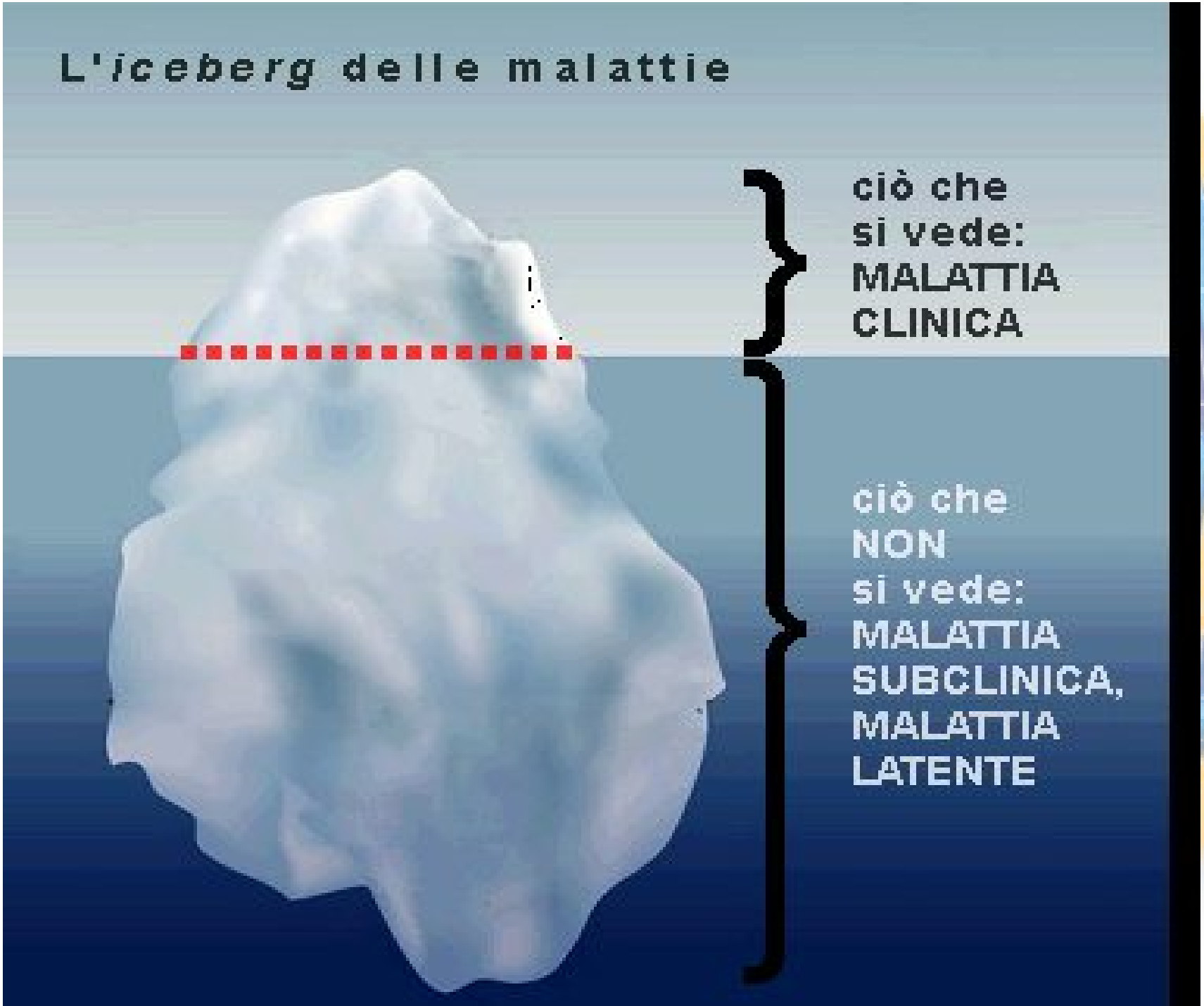
2. La maternità e l'infanzia hanno diritto a speciali cure ed assistenza. Tutti i bambini, nati nel matrimonio o fuori di esso, devono godere della stessa protezione sociale.

Articolo 32

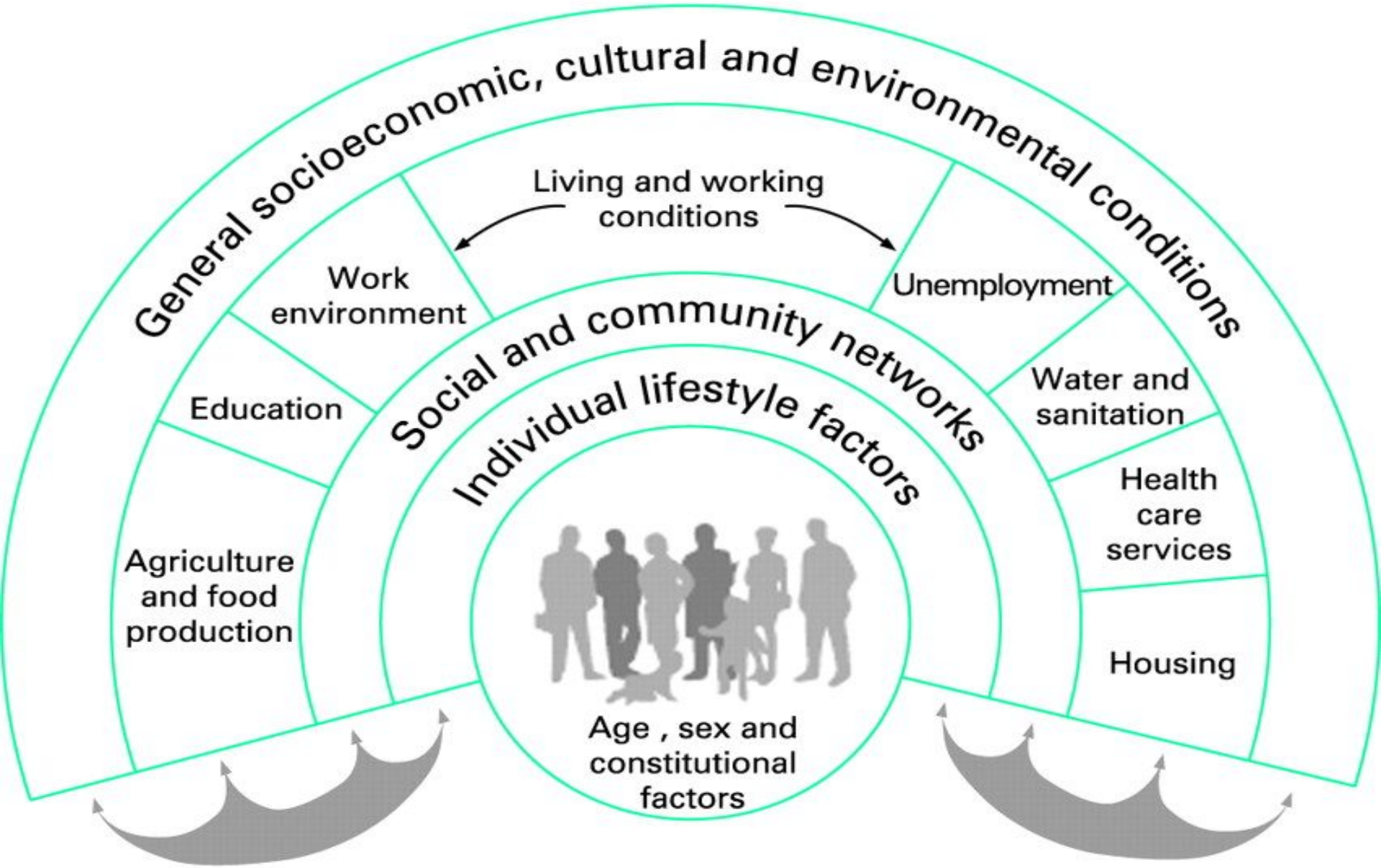
La Repubblica tutela la salute come fondamentale diritto dell'individuo e interesse della collettività, e garantisce cure gratuite agli indigenti.

Nessuno può essere obbligato a un determinato trattamento sanitario se non per disposizione di legge. La legge non può in nessun caso violare i limiti imposti dal rispetto della persona umana.

L'*iceberg* delle malattie



A



Souce: Dahlgren and Whitehead, 1993

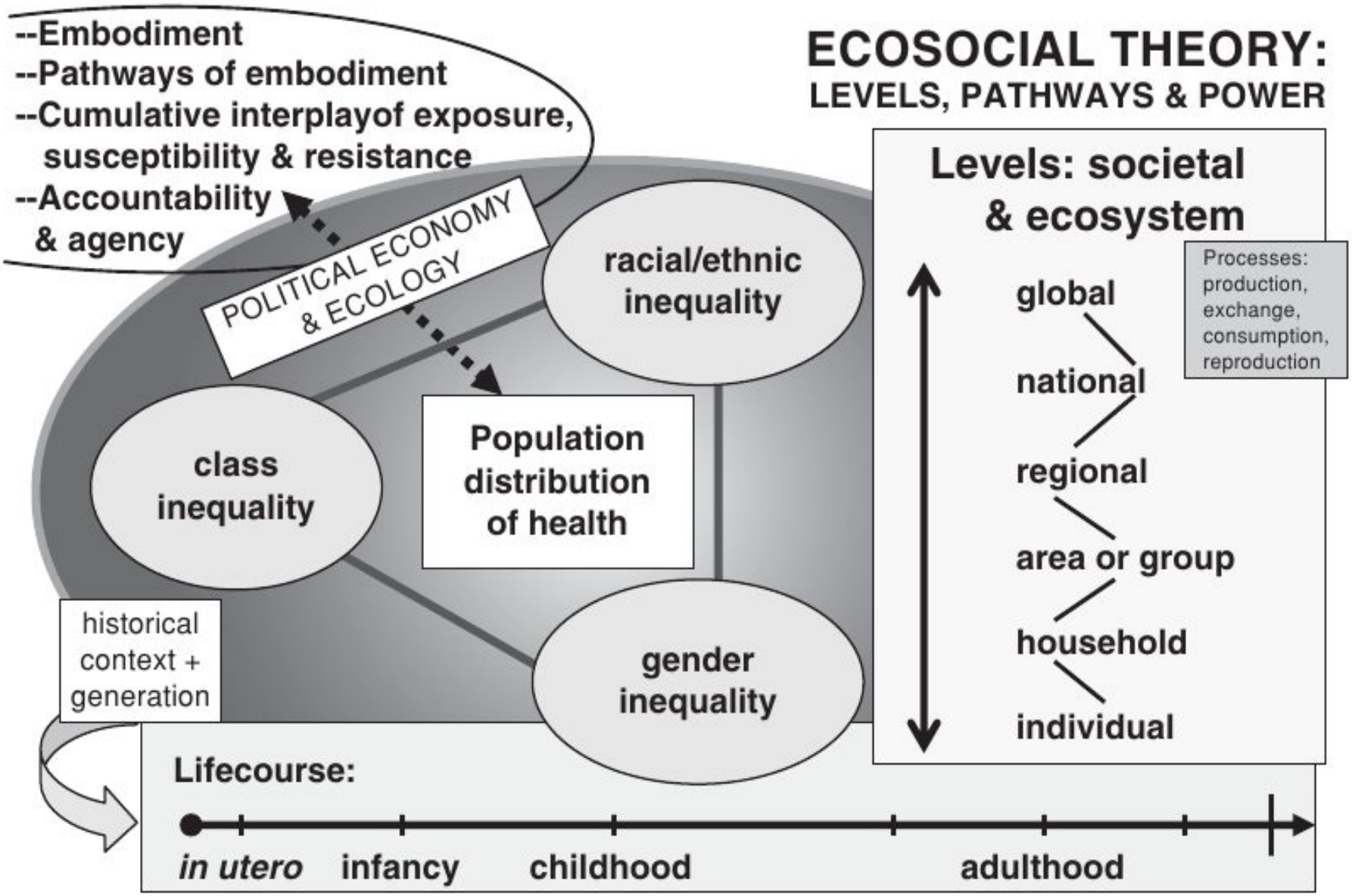
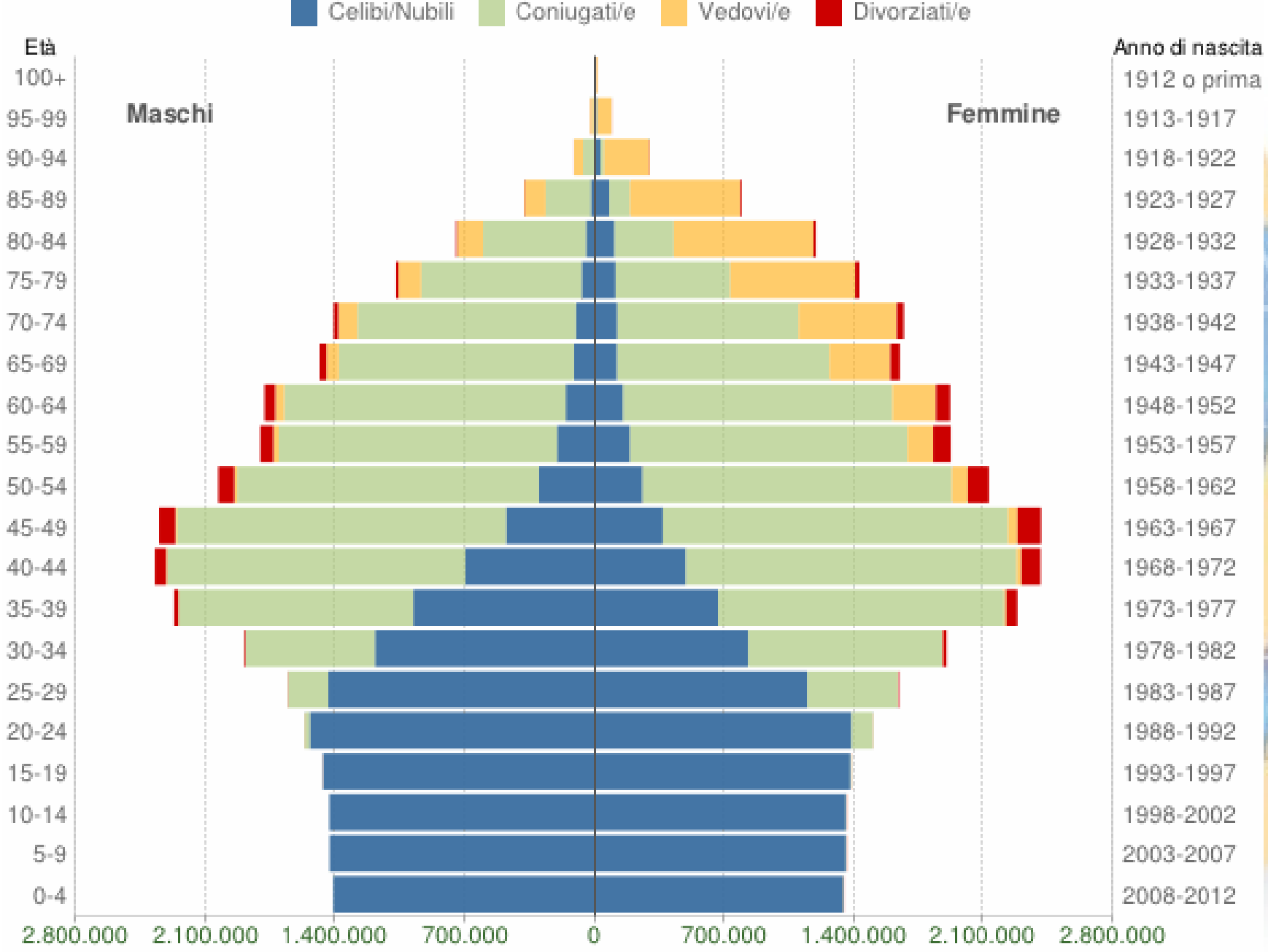


Figure 7–1. Ecosocial theory and embodying inequality: core constructs. (Krieger, 1994; Krieger, 2008a)

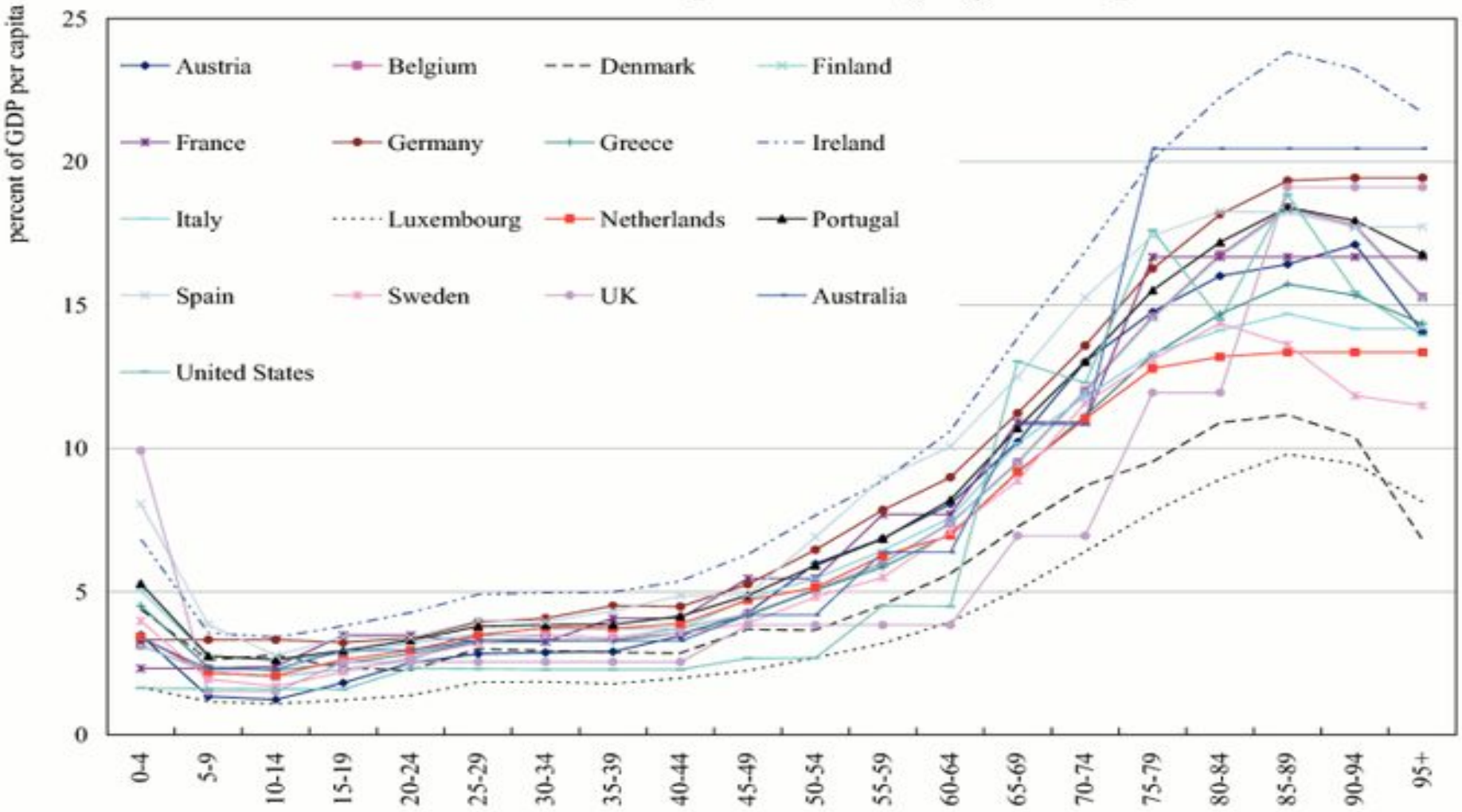


Popolazione per età, sesso e stato civile - 2012

ITALIA - Dati ISTAT 1° gennaio 2012 - Elaborazione TUTTITALIA.IT

Figure 4

Public Health Care Expenditure by Age Groups*



* Expenditure per capita in each age group divided GDP per capita.
Source: ENPRI-AGIR, national authorities and Secretariat calculations.

Lancet. 2010 Nov 13;376(9753):1689-98

Chronic Diseases: Chronic Diseases and Development 1

Raising the priority of preventing chronic diseases: a political process

Robert Geneau, David Stuckler, Sylvie Stachenko, Martin McKee, Shah Ebrahim, Sanjay Basu, Arun Chockalingham, Modi Mwatsama, Razmin Jamal, Ala Alwan, Robert Beaglehole

Chronic diseases, especially cardiovascular diseases, diabetes, cancer, and chronic obstructive respiratory diseases, are neglected globally despite growing awareness of the serious burden that they cause. Global and national policies have failed to stop, and in many cases have contributed to, the chronic disease pandemic. Low-cost and highly effective solutions for the prevention of chronic diseases are readily available; the failure to respond is now a political, rather than a technical issue. We seek to understand this failure and to position chronic disease centrally on the global

Le malattie croniche - specialmente le malattie cardiovascolari, il diabete, il cancro e le malattie respiratorie croniche - sono trascurate, nonostante la consapevolezza del grave carico che esse provocano

Le politiche globali e nazionali non sono riuscite a fermare – in molti casi anzi hanno contribuito a diffondere – le malattie croniche. Attualmente sono facilmente disponibili soluzioni a basso costo e di alta efficacia per la prevenzione delle malattie croniche; **il fallimento nella risposta è oggi un problema politico, piuttosto che tecnico.**

Adattata da
prof. Gavino Maciocco
Università di Firenze

Malattie croniche.
La catena delle cause

Adattata da prof. Gavino Maciocco Università di Firenze

Innovative Care for Chronic Conditions

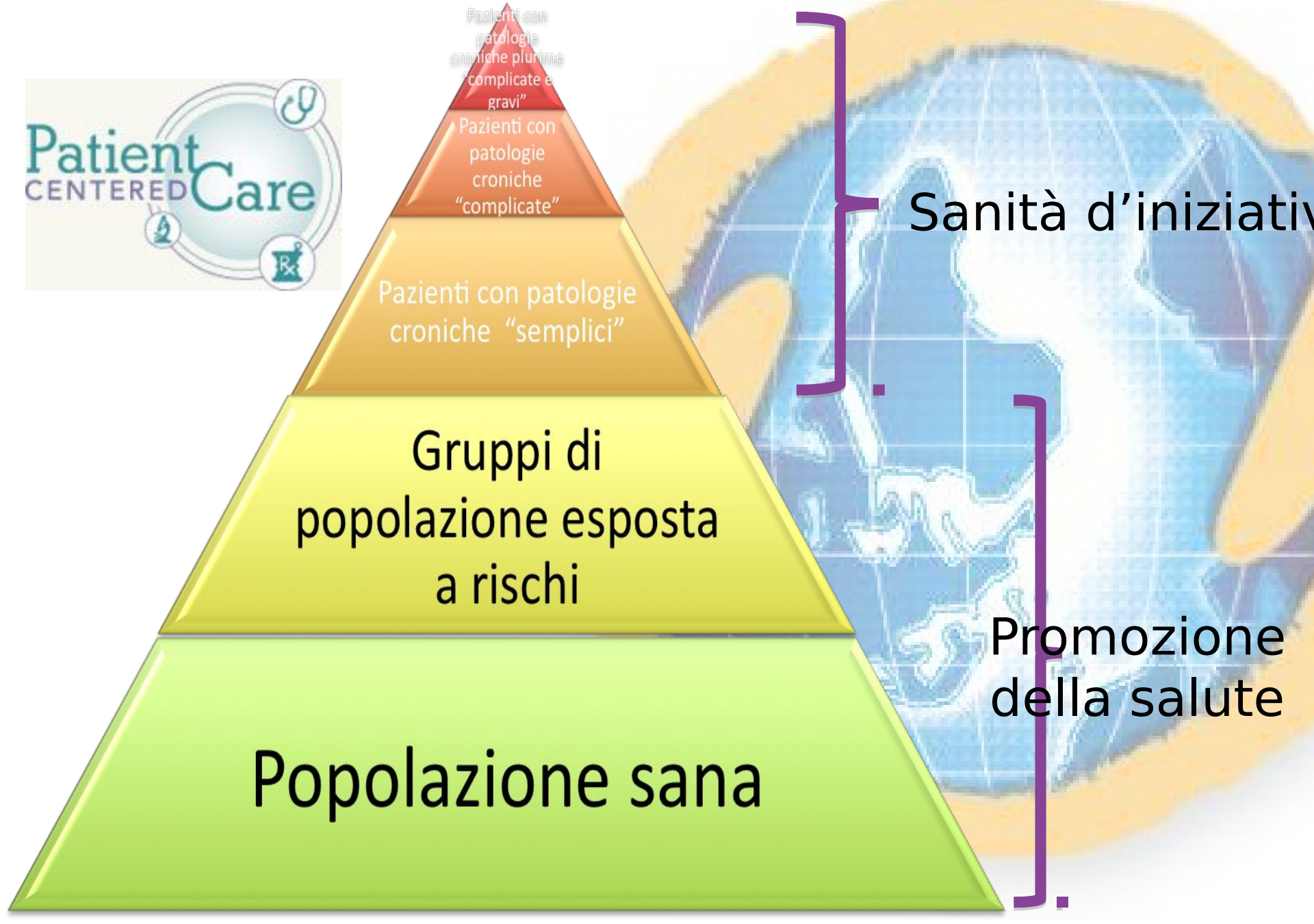
Organizing and Delivering High Quality Care for Chronic Noncommunicable Diseases in the Americas

Adattata da prof. Gavino Maciocco Università di Firenze

TABLE 1. Attributes of Effective Care for Chronic Conditions

OUTDATED CARE	EFFECTIVE CARE
• Disease-centered	• Patient-centered
• Specialty care/hospital-based	• PHC–based
• Focus on individual patients	• Focus on population needs
• Reactive, symptom-driven	• Proactive, planned
• Treatment-focused	• Prevention-focused

Adattata da prof. Gavino Maciocco Università di Firenze



Deciding the right approach

It is important to have the information and knowledge to be able to carr
populations to i

Level 3

As people develop
becomes dispropo
and social care sys
worker (often a nurse) actively managing and joining up care for these people.

Lev
Dise
high
maj
of c
spe
– pa
records.

Livello 3
Pazienti molto complessi
CASE MANAGEMENT

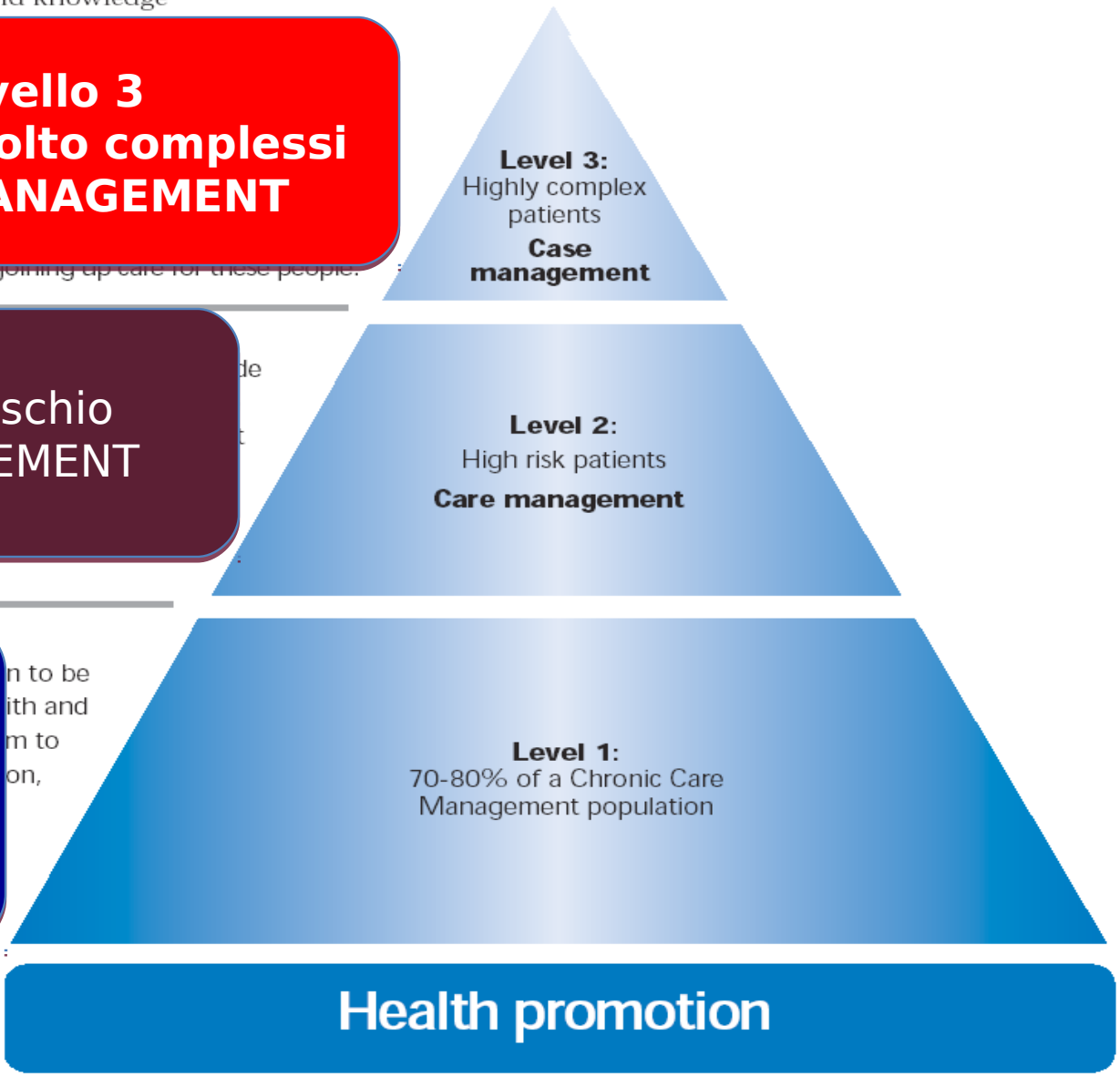
Livello 2
Pazienti a alto rischio
DISEASE MANAGEMENT

70-80% dei pazienti
Livello 1
Con il giusto supporto
le persone possono
imparare a essere attivi
protagonisti della loro
condizione

PROMOZIONE DELLA SALUTE

Population management

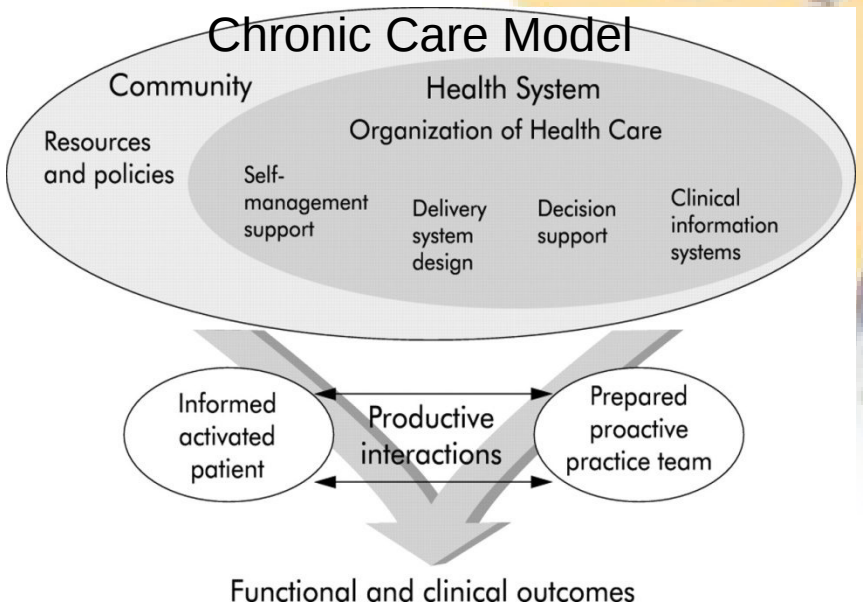
More than care and case management



Adattata da prof. Gavino Maciocco Università di Firenze

Le buone pratiche per la gestione delle malattie croniche

La sanità d'iniziativa.



Adattata da prof. Gavino Maciocco Università di Firenze

SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA
Azienda Unità Sanitaria Locale di Modena

invito

A un anno dal terremoto, guardando al futuro

inaugurazione

del primo stralcio della

CasadellaSalute FinaleEmilia

Sabato 18 maggio 2013 ore 11.00
Piazza A. Gramsci Finale Emilia | Modena

CASA DELLA SALUTE DI

SAN SECONDO PARMENSE

CASA DELLA SALUTE REGIONE EMILIA-ROMAGNA

CasadellaSalute AltoFrignano


Operatore
Operatore
Paziente

Contesto eco-sociale

Policlinico S.Orsola-Malpighi

Bologna


Piani per la Salute:
il percorso svolto,
la nuova progettualità
Comunità
Paziente
Servizio

Linee di fondo / competenze

- Integralità
- Universalità
- Continuità della cure

- Partecipazione
- Inclusione
- Equità
- Solidarietà
- Capacità di contribuire a migliorare i servizi a partire dai bisogni

- Trans-disciplinarità
- Multi-settorialità
- Multi-professionalità
- Lavoro in team
- Orizzontalità
- Formazione specifica a partire dalle pratiche

Grazie

Ardigò Martino

Ardigo.martino@unibo.it

Centro Studi e Ricerche in Salute Internazionale e Interculturale

Dipartimento di Scienze Mediche e Chirurgiche

Università di Bologna

www.csiunibo.org