Gruppo Nazionale di Bioingegneria

XLI ANNUAL SCHOOL

BIOMEDICAL ENGINEERING FOR SUSTAINABLE DEVELOPMENT

BRIXEN, SEPTEMBER 12-15, 2022

Healthcare in low-resource settings and medicine of poverty

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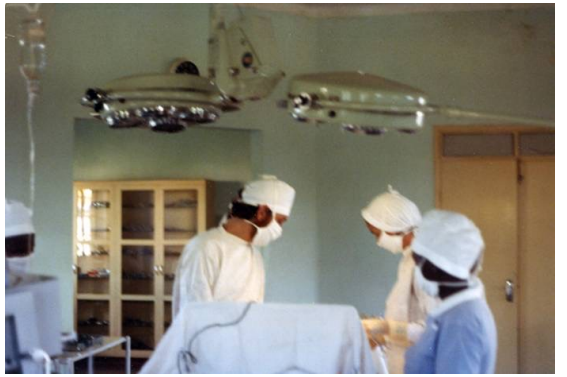
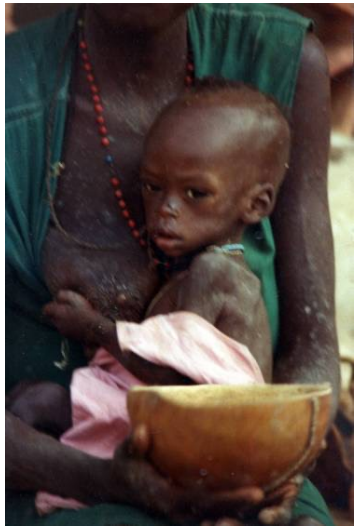
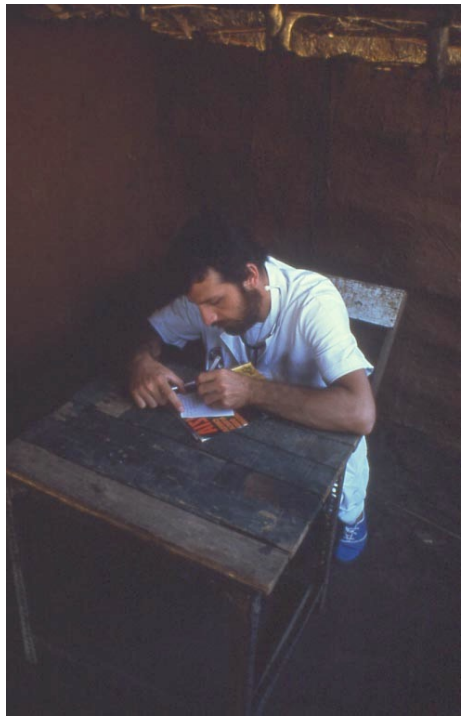
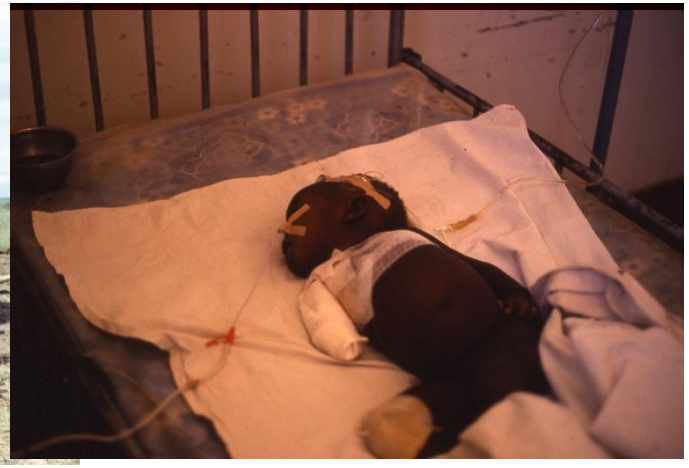
12/09/2022





The Tropical Doctor as a Saviour?





Outline

- Tropical medicine and **colonial health**
- **Health policies of LMICs** over the last few decades
- Hospitals and **accessibility** to health care
- Human society and **health improvement**
- Health systems and **social determinants of health**

Tropical medicine and colonial health

- The “tropics” as a **conceptual space** as well as physical, and as a new scientific paradigm
- Medicine first “**for the sake of the empire”**
- **Socio-economic** situations vs specific **ecological** conditions
- The need to take a **post-colonial perspective** of global health

«FOR THE SAKE OF THE EMPIRE»

Health policies of LMICs

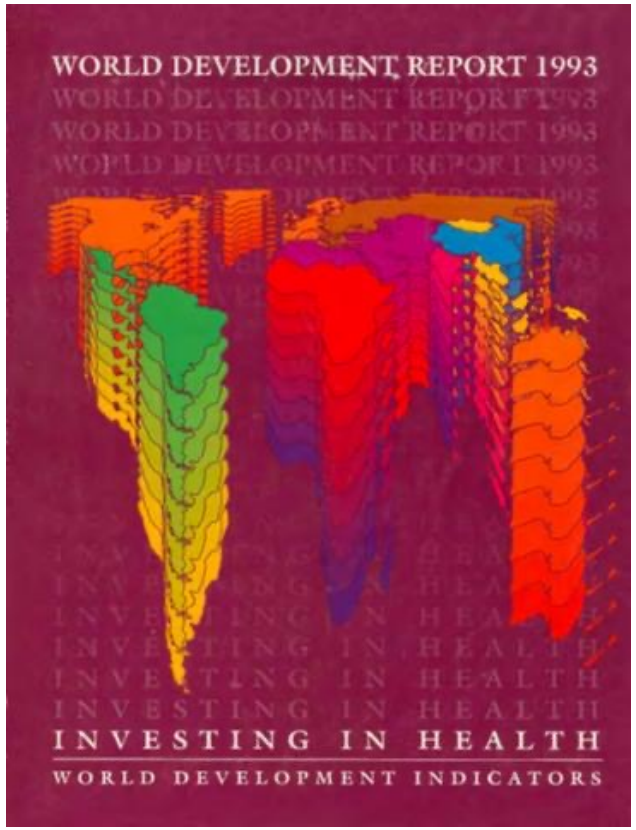
- **Traditional healers vs Western views** of health and medicine
- National independence's new policies
  - Local élites as first beneficiaries
  - Revolutionary experiences (Mozambique, China, Cuba, Kerala)
- WHO-sponsored **Alma Ata Conference** (1978) proposing Primary Health Care (PHC) strategy
- The medical establishment's powerful reaction and the gradual **decline of WHO's leadership**

Key differences between CPHC and SPHC

Elements	Comprehensive PHC	Selective PHC
Health paradigm	Holistic, ecological and salutogenic	Biomedical
View of health	Positive wellbeing	Absence of disease
Locus of control over health	Communities and individuals	Health professionals
Major focus	Health through social justice, equity and community empowerment	Medical solutions for disease eradication
Health care providers	Multi-disciplinary teams	Medical doctors
Strategies for health	Multi-sectoral collaboration	Medical interventions

The World Bank's global health policy recipe

1) Governments should provide a **basic service package**;
2) Hospital care is **paid directly** by the patient;
3) Other services must be provided by the **market** and by non-governmental organizations;
4) Money must be spent '**efficiently**'.



Hospitals and healthcare reforms

- Granting increasing **autonomy** to larger hospitals (“corporatization” of healthcare) leading to new **public-private** relationships (competition)
- The **financing** of hospitals away from general taxation to direct payment by the user and private insurance
- Evaluations showing negative **impact on access** to health care
  - The social utility of the hospital is often sacrificed to the laws of the market
  - The need to improve the allocation of resources between hospital and non-hospital activities

The issue of accessibility to health care

ACCESS is made of different components:

- ✓**Availability** (physical)
- ✓**Affordability** (financial)
- ✓**Acceptability** (cultural)

Access = opportunity / freedom to use a health service

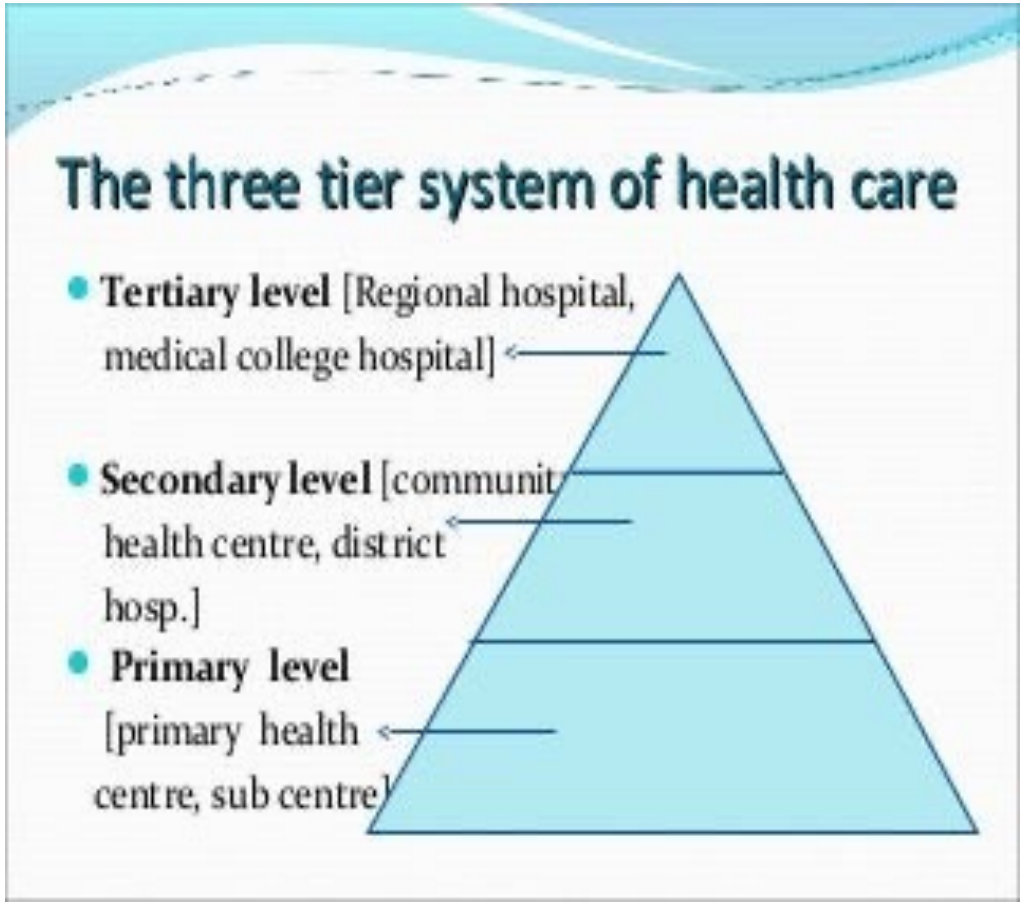
Utilization = informed decision to exercise the freedom to use health care

Improving hospital's efficiency: the need for a multi-level health care

- Major difficulties of health sectors in LMICs:
  - Malfunctioning of the **hierarchical organization** of the health system
  - Low quality health care at **rural and peri-urban** levels
  - **Hospitals** providing services (primary and preventive) they are not supposed to
  - High social costs, inequity, inefficiency
- Importance of a wider system to meet the **health needs of the entire population**: the REFERRAL SYSTEM.

Towards an effective Referral System

- Based on the concept of **regionalization**
- To **rationalize** the use of health resources, i.e. health care is offered from the lowest possible level of the system
- Distributed **hierarchically**
- Providing the best quality care **at the most appropriate level** of the health system (the ’right patient’ at the ‘right place’, as close to their homes as possible)



Human society and health improvement

- XX century **health improvement** preceded, rather than followed, major medical and scientific discoveries
- Importance of social and behavioural **determinants of health**

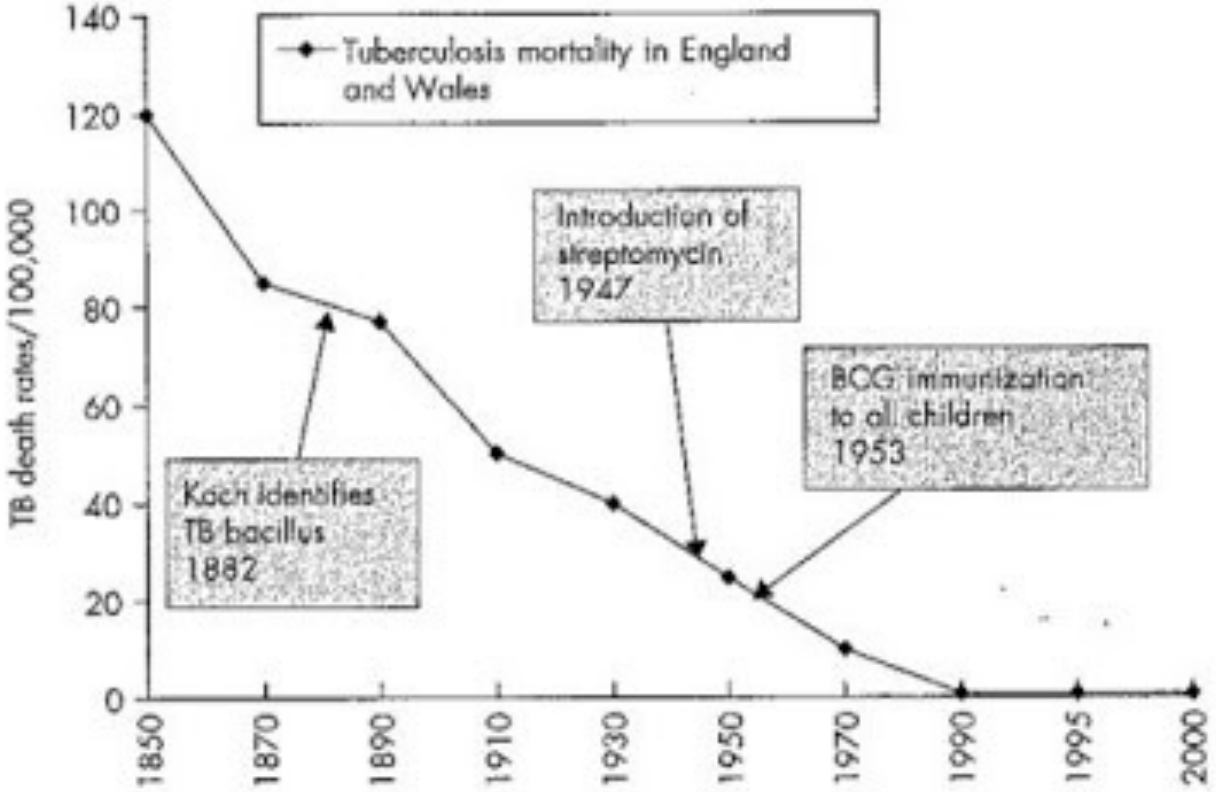
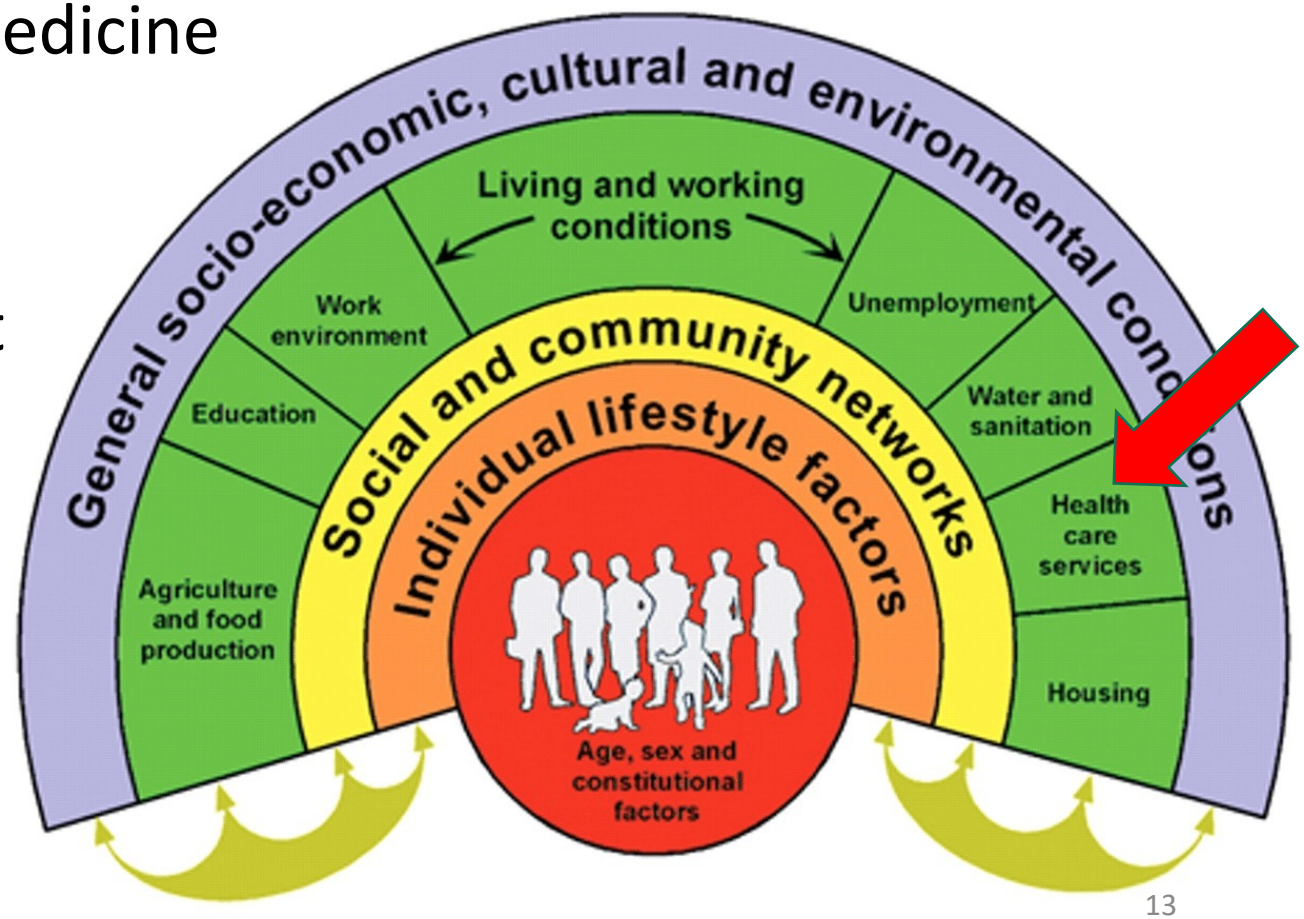


Figure 2–2 Tuberculosis mortality and medical interventions.
Source: Based on McKeown, Record, and Turner (1975).

Health systems as social determinants of health

- Tropical medicine vs Poverty medicine
- Health care systems as determinants of health and mechanisms for empowerment



The real challenge

“As health professionals we have a responsibility to describe, in medical terms, what happens when impoverishment takes its toll on the most vulnerable groups in society. We need to make the 'pathology of poverty' understandable and show that the growing gap between rich and poor is directly associated with disease and death.» Steffan Bergstrom, Swedish academic and Pascoal Mokumbi, African prime minister

The real issue: *How to expose the* ***‹social production of health / disease›***

Readings

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