Health Inequalities and Disparities

Medical Student International

Issue 23, March 2011 ISSN1026-5538
IFMSA

was founded in May 1951 and is run by medical students, for medical students, on a non-profit basis. IFMSA is officially recognised as a non-governmental organisation within the United Nations’ system and has official relations with the World Health Organisation. It is the international forum for medical students, and one of the largest student organisations in the world.

is to offer future physicians a comprehensive introduction to global health issues. Through our programs and opportunities, we develop culturally sensitive students of medicine, intent on influencing the transnational inequalities that shape the health of our planet.
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Above: The sign in Mayara Clinic, Namibia, reveals many inequalities and disparities. Photo: Anny Huang, Australia
Cover: Some have everything, while others have none. Graphics: Anny Huang, Australia
Editorial

How does one even try to introduce a topic as broad as “Health Inequalities and Disparities”? Start close to home by pointing out the obvious difference in the salary of a consultant versus the lack thereof of a medical student? Or attempt something all-encompassing and obvious, like telling you that if you can read and understand this, you are much better off than many of your patients? As far as health goes, one can find as many differences between hospitals and systems as there are patients.

To illustrate some of these differences, let me tell you about Wilcannia and Menindee, two small country towns with populations around 600 (roughly half of them Aboriginal Australians), about 100km apart in outback Australia. I was lucky enough to spend a couple of weeks on clinical placements in each of these towns over two consecutive years.

The first time I went to the area, I stayed in Menindee. For those who live in Australia, the name Menindee is synonymous with grapes, and indeed, the fruit-growing industry employs the majority of the citizens of the town. As a result of high employment rates, the people in Menindee are on the whole a happy bunch, with low levels of crime and youth-related problems such as teenage pregnancies. In addition, much of the Menindee population is made up of retirees from the city, who move to the countryside in search of peace and tranquillity.

Wilcannia, on the other hand, is the exact opposite in many of these areas. Although in terms of demographics and size, it is quite similar to Menindee, in terms of social and health problems it is not. Not only are most people in Wilcannia unemployed, but teenage crime and pregnancy rates are high, and police intervention is often required for violence. In addition, many health problems stem from high levels of alcohol use and the fact that fresh fruit and vegetables are only available once every two weeks in the town.

Why are these neighbouring towns so unlike each other? The crucial difference lies in the fact that Menindee has water, and Wilcannia does not. The water from the Menindee Lakes allows fruit to be grown in the region, and many people to be employed to grow and pick the fruit. As well as this, the prospect of water sports attracts many retirees and highly qualified people to live in the town. The connection between these factors and the general feel of the town is obvious.

Sure, differences are normal and inevitable, but when does a difference become an inequality? In other words, when should we try to do something about the differences that we find? When we identify an inequality, what should we do about it? Why do inequalities even exist in the first place? In this issue of MSI, we grapple with these issues and more with articles written by authors from all of the five IFMSA regions.

To conclude, I would like to thank every member of our Publications Team for their hard work in creating this publication. A special thank you goes to my editors for the dedication that they have shown to all of their tasks.

Anny Huang
IFMSA Publications Support Division Director
2010-2011

Right: The Kangongo Clinic in Namibia is barely larger than two small huts. Photo: Anny Huang, Australia
Message from the President

The month of September, in the year 2000 stands out in the International Health calendar for the adoption and commitment by world leaders to the eight Millennium Development Goals (MDGs), amongst other things. The MDGs were adopted with the ultimate goal to achieve a universal improvement in health and quality of life by the year 2015, through international and multi-sectoral collaboration. Only four years are left in the timeline for the achievement of the comprehensive goals in this declaration. It therefore should come as no surprise, that we, as medical students and future health-care practitioners have taken time out to share experiences and evaluate the progress being made in the MDGs, by taking an in-depth look at Health disparities and inequalities among nations.

The diversity among IFMSA members ensures that we have first hand experiences to share with each other, about the levels of progress made in our different countries within the MDGs. As young people and medical students, we have definitely come face to face with the effects of poverty, illiteracy, poor environmental conditions and lack of access to essential medicines on the health of many members of our communities. We have also been confronted with the difficulties abound in the lack of adequate health care for mothers and children alike. Looking only at a few aspects of the MDGs, we can all realize that our daily experiences do indeed give rise to many stories. These stories of course leave nagging questions in our minds. Why is the progress in achieving the MDGs slow in so many countries and regions? Why is the progress unequal in many countries? Is the commitment within the International Health community adequate to ensure that the MDGs are achieved?

As IFMSA members, we already work ceaselessly in our local committees through our numerous projects and campaigns. We already are committed to working towards achieving health for all. Although many of our questions about the progress in achieving the MDGs may remain unanswered, we do have an identifiable role to play in eliminating Health disparities and inequalities among nations in achieving the MDGs. Let us then use this opportunity to re-energize ourselves and renew our commitments to serving our communities. Let us also use this opportunity to demand stronger commitments from the rest of the International Health community. We indeed are a unique group of medical students and live in an age where the International Health community has the knowledge and technology to achieve the MDGs. We have to continue making efforts, as the future leaders of health, to see that these resources count as we strive to achieve health for all. I do believe that we, as IFMSA members will continue working to eliminate the glaring disparities and inequalities that still exist in health among nations. 2015 may only be a few years away, but we will make the time left count.

Let us keep working for a healthier tomorrow.

Chijioke Kaduru
President 2010/2011
International Federation of Medical Students’ Associations (IFMSA)

Accra, Ghana.

Below: Almost any abandoned building can be turned into a shop that sells alcohol in Zambia, fuelling health and social problems, and widening the gap in the health disparity between the educated and the uneducated, and between urban and rural populations. Photo: Anny Huang, Australia
Health inequalities in a country - What is it? And why is it there?

BY OMAR SAFA, EGYPT

What is meant by “Health Disparities”?
The Health Resources and Services Administration defines health disparities as “population-specific differences in the presence of disease, health outcomes, or access to health care” [1].

The Institute of Medicine’s 2002 report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare (“the IOM Report”) defines disparities in health care as “differences in the quality of health care that are not due to access-related factors or clinical needs, preferences or appropriateness of intervention” [2].

In the United States, health disparities are well documented in minority populations such as African Americans, Native Americans, Asian Americans, and Latinos [3]. When compared to whites, these minority groups have higher incidence of chronic diseases, higher mortality, and poorer health outcomes [4].

A review of the research literature suggests that a multitude of complex factors contributes to health disparities, but little is known about the relative importance of these factors. In the 1985 Health and Human Services’ “Report of the Secretary’s Task Force on Black and Minority Health,” health is said to be “influenced by the interaction of physiological, cultural, psychological, and societal factors that are poorly understood for the general population and even less so for minorities” [5]. In short, it is challenging for social scientists to find ways to determine if, how and to what extent each of these factors are related to health disparities experienced by minorities.

Health disparities are evident in the developing world, where the importance of equitable access to healthcare has been cited as crucial to achieving many of the Millennium Development Goals [6].

What Causes Health Disparities?
To better understand these causes we can simplify this by dividing them into 3 major categories:

Health Before Care: Disparities in health can arise from personal, socioeconomic, and environmental characteristics or variables that are external to the health care system and exist prior to the individual entering the system. Disparities in health status are known to correlate with income levels, adequacy and safety of housing, employment status, education level, lifestyle choices (e.g., tobacco use, alcohol use, diet, exercise), environmental conditions (e.g., air and water quality, pesticides, green space), and social conditions (e.g., crime rates, employment opportunities).

Access to Health Care: Disparities in health care access are most often associated with barriers of entry into the health care delivery system. Factors impeding access to health care include a lack of financial resources, a cultural preference that discourages health-seeking behaviour, low health literacy levels, language barriers, lack of diversity in the health care workforce, and a mistrust of the health care system due to a prior negative experience. Additional impediments to access include systemic barriers such as the lack of available and proximate providers, the lack of transportation, the lack of or poor health insurance coverage, the lack of access to a regular source of care, and legal or bureaucratic barriers to receiving public aid.

Health Care Delivery: Once entry to the health care delivery system is gained, disparities can arise in the quality of care received. Studies show that diagnoses, treatments, and quality of care all vary according to insurance coverage and type, provider cultural competency, patient-provider communications, provider bias and discrimination, differential treatments based on population group, patient preferences and adherence to treatment plans, language barriers, diversity of the health care workforce, appropriateness of care, and effectiveness of care.

Disparities in Access to Care:
1. Lack of Insurance Coverage:
Health insurance coverage directly affects access to medical care, regardless of race. Without it, patients are more likely to postpone seeking medical care, more likely to go without needed medical care, and more likely to go without prescription medicines [7]. Some of the disparity in coverage is related to differences in income level and type of employment. Low-income working adults face the highest risk of being uninsured because they work in low-wage jobs that do not offer insurance or cannot afford the high cost of private insurance [7].

2. Lack of a Regular Source of Care:
Without access to a regular source of care, patients have more difficulties obtaining care, make fewer doctor visits, and have more difficulty accessing prescription drugs [8]. Adults with a regular source of care have higher rates of receiving preventive services than those without, and children with a regular source of care have higher rates of immunization than those without [9].

3. Structural Barriers:
According to the “National Healthcare Disparities Report,” “Structural barriers—poor trans-
portation, inability to get care (e.g., schedule appointments quickly or during convenient hours), and excessive time spent in the waiting room—affect a person’s ability and willingness to obtain...needed care” [10].

4. Scarcity of Providers: Access to medical care is further limited by the scarcity of primary care practitioners, medical specialists, and diagnostic facilities in inner cities and rural areas—communities with high concentrations of minority populations. Thus, minority groups are more likely to report that they have little or no choice in where they obtain care [11]. In addition, minorities have difficulty filing prescriptions in areas with inadequate pharmacy services. In New York City, for instance, a study found that 75% of pharmacies in non-white neighbourhoods do not stock or have adequate supplies of prescription opioids (painkillers) compared to 28% of pharmacies in white neighbourhoods [2].

5. Linguistic Barriers: Language differences can restrict access to medical care for minorities who cannot understand the official language. For example, according to a survey of non-English-speaking women in the United States, those who did not see a doctor for cervical cancer screening cited the inadequacy of the translated materials as a contributing factor [12].

6. Health Literacy: A recent survey revealed that between 20 and 25% of minorities in the United States believe that staying healthy is a matter of luck (versus doing something). A recent survey revealed that between 20 and 25% of minorities in the United States believe that staying healthy is a matter of luck (versus doing something). A recent survey revealed that between 20 and 25% of minorities in the United States believe that staying healthy is a matter of luck (versus doing something).

Disparities in Health Care Delivery:

1. Patient-Provider Communication Problems: Communication between patients and physicians is critical to the delivery of appropriate and effective treatment and care. Regardless of patient race or ethnicity, miscommunication can lead to incorrect diagnosis, improper use of medications, and failure to receive follow-up services—all of which can adversely affect health or contribute to death. Among non-English-speaking populations in the United States (about 18% of the total population) [13] the linguistic barrier is huge, and it is exacerbated by limited access to language interpreters. Less than half of the non-English speakers that said they needed an interpreter during a health care visit reported always or usually having one [11].

2. Provider Discrimination: The IOM’s 2002 report, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,” suggests that unconscious or conscious discrimination on the part of providers accounts for a portion of the unequal, inferior treatment of minorities. Differences in treatment by race and ethnicity are particularly well-documented for cardiovascular disease, diabetes, kidney disease, HIV, and cancer. The IOM Report cites studies to support that, even after adjusting for socioeconomic status and health insurance coverage, minorities are less likely to receive antiretroviral therapy and protease inhibitors for HIV, to undergo cardiac catheterization and bypass surgery for cardiovascular disease, to receive haemodialysis for kidney failure, to be referred for a kidney transplant once on dialysis, or to receive pain medication in the emergency room for a long bone fracture. According to the report, other studies investigating the appropriate level of care found that such disparities are not due to overuse of services. Discriminatory tendencies on the part of providers are supported by a study that is based on actual clinical encounters. In that study, “doctors rated black patients as less intelligent, less educated, more likely to abuse drugs and alcohol, more likely to fail to comply with medical advice, more likely to lack social support, and less likely to participate in cardiac rehabilitation than white patients, even after patients’ income, education, and personality characteristics were taken into account” [14]. In addition, there is evidence of unequal treatment on the part of providers when it comes to patient medical bills. In a study by the Allegheny County Health Department in Pennsylvania, African Americans were more likely to be asked about their ability to pay for treatment (independent of insurance status), less likely to receive payment allowances, and more likely to be referred to medical bill collection agencies than their white counterparts [15].

Conclusion:

Sorting through the underlying causes of racial and ethnic health disparities is difficult and sometimes controversial. What is clear, however, is that patients, providers, and systemic factors all play a role in the problem, and therefore must all play a role in its solution. In this article, we have been talking about two of the major three categories for Health Disparities causes, Access to Health Care and Health Care Delivery, where it is important to note that improvement in these latter two areas will not guarantee a healthier minority population. Socioeconomic conditions, environmental conditions, and personal behaviours play an important, and likely larger, role in determining health. Thus, while it is important to identify sources of disparities in access and delivery and to develop strategies to address them, it is equally important to investigate interventions that would reduce the need for medical services in the first place. Programs aimed at improving the safety of housing, increasing community green space, reducing air and water pollution, and reducing alcohol and tobacco use will help to eliminate access and delivery disparities by reducing the need for services.

Above: The entirety of the Emergency Department at Andara Catholic Hospital, Namibia. Photo: Amy Huang, Australia

6. Vandemoortele M, The MDGs and equity Overseas Development Institute, 2010
The Millennium Development Goals (MDGs) have shaped the international response to health inequalities across the globe for the last ten years, and are unprecedented in terms of their international ratification and the effect they have had in directing the work of global health in terms of both projects and funding. Having reached the ten-year milestone since the adoption of the MDGs, attention has now focused on what should replace them in 2015. This has stemmed from the recent United Nations Summit reporting on a decade of the MDGs [1]. Other discussions have been concerned with their successes and failures as well as looking to their replacements post-2015. There is much controversy about their content, and the conversation is beginning to turn towards how the global community will decide what should replace them. What should they contain? And is the UN the appropriate body to make this kind of decision?

This is a brief report from the facilitators of a workshop at the recent Medsin-UK Global Health Conference concerning the future of the MDGs. The purpose of the workshop was to establish the opinion of young professionals, who plan to be working in global health or related fields when the current MDGs expire, as to what should replace the MDGs in 2015. The workshop involved 20 participants, including medical students, students of other disciplines and qualified healthcare professionals. The group was facilitated by Jonnie Currie (immediate past-President of Medsin) and Tim Crocker-Buque (Medsin Trustee and junior doctor). A presentation was delivered regarding the history of the MDGs, from inception to the recent UN Summit. Three questions were posed to the participants and the conclusions of the group are outlined below.

1. Should there be new targets, and if so, what form should they take?

There was consensus amongst the group that the current MDGs have been important aspirational targets and that some form of target system should remain. The group noted that the nature of current targets might have skewed work and funding towards specific diseases, and any replacements should take a broader approach. Targets should be used as a baseline and local communities and organisations should build on these to focus them towards specific population needs. Any new targets should bring a stronger focus on broader issues such as communicable diseases, water and sanitation, health systems, economics and trade. New targets should include incentives to both actively tackle diseases, but also take a preventative approach to disease. The group agreed that a core framework, including central principles should be created on a global level, but that it would be more appropriate to develop specific targets on a more regional scale. There was a suggestion that stronger accountability structures should be put into place, although there was recognition that this may be challenging. It was agreed that the United Nations was an appropriate authority to build international consensus, however in developing new targets a ‘bottom-up’ approach would be more valuable to address the needs of populations who receive development assistance and international aid funding. There was also discussion around the fact that the funding streams for MDG work are deeply complex and wasteful. These problems should be addressed through strong global health governance. The group strongly agreed that ultimate outcomes should be measured in relation to population health, even if any targets set are not specific health interventions.

2. Whose responsibility should it is to monitor progress towards any new targets?

The group agreed that the United Nations provides the most appropriate forum to build international consensus and monitor progress towards any new targets, due to both its unique position and its successes with the current set of MDGs. It was noted, however, that there was limited scope to monitor progression towards the targets on a regional or national level, and there may be significant value in improving local accountability systems. In any future system there should be a shared responsibility towards reaching any MDG replacements, from local community and NGO to governmental and international levels. A bottom-up approach to setting and meeting targets accompanied by a top-down system for developing a core framework, as well as monitoring progress and accountability, would be most effective. Any global governance structure must ensure that progress towards any future goals is not skewed by national political interests, and should purely serve the goal of improving population health.

3. How can civil society in the global North and South engage to drive progress in meeting these goals?

There was consensus that in any new framework there must be stronger arrangements for setting up true partnerships between civil society organisations, governments, communities and universities in order to share experience and expertise. These partnerships must be equal, with exchange of ideas and resources in both directions. Partnerships should involve exchange of information as well as human and financial resources. The power of public pressure to ensure progress towards targets was discussed, and a new framework should have the empowerment of communities and civil society at its heart. The group noted that the current MDGs have some public awareness, but not enough to ensure that the public holds governments to account in countries where this is most needed. There is a risk, however, that this kind of approach may leave the door open to vocal special interest groups to hijack target setting or MDG work. The group agreed that this must be avoided by having a core framework to guide local target setting, as well as solid accountability structures to ensure that local target setting is in the best interest of the population as a whole.

Conclusions

In light of this article, we would like to welcome the recent paper by Waage et al [2] published in the Lancet discussing the principles for goal setting post-2015, the conclusions of which broadly match those of the group. Of the options presented in Summer’s 2009 paper (3) on the future of development policy post-2015, the group supported the third option: that a core set of principles should be decided on an international level combined with locally defined targets. Is the most appropriate structure for any MDG replacements, and that the principles described in Waage et al’s paper are an excellent starting point.

These are very preliminary ideas as discussed by a small but dedicated group of individuals, and more work is required in this area. However, the workshop group agreed that it would be of great value to involve future global health professionals in the dialogue and debate regarding MDG replacements, in order to provide invaluable experience as well as create a sense of ownership for the next generation of advocates. For this reason, we would like to announce the founding of the MDG15 Young Professionals Forum to produce an evidence-based consensus on the future of the MDGs. The Forum will take a collaborative multidisciplinary approach, involving students and young professionals from the sciences, medicine and humanities, with the key principle of engaging individuals and groups from both the global north and south. Current students and junior professionals are likely to be the ones who see the work of any MDG replacement through to the conclusion, and inclusion in the process would provide invaluable experience as well as creating a sense of ownership for the next generation of advocates. We would like to highlight this to the IFMSA and encourage other NMOs to get in touch, if they feel they would like to be part of the MDG15-YPF project.

References


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Health Under Siege
BY OMAR ABDEL-MANNAN, UK

Palestinian health has never been in a worse state... and it continues to deteriorate. Why and how can we use our resources here in the UK to support medical professionals in the West Bank and Gaza?

On the December 27th 2008, the Israeli Defence Force (IDF) launched Operation Cast Lead, a three week military assault on Gaza. 1366 Palestinians were killed, 313 of whom were children. International doctors, Mads Gilbert and Erike Fosse, witnessed at first hand, “the most horrific war injuries in men, women and children in all ages in numbers almost too large to comprehend” [1]. White phosphorous munitions were fired upon civilian areas in Gaza, leading to widespread severe chemical burns [2].

However, what we tend to forget is that the 18 month sea and land blockade on Gaza, prior to the IDF operation and the siege which continues to this day precipitated the collapse of Gaza’s healthcare infrastructure. This is evident by the lack of basic medical equipment, such as patient trolleys, ventilators and electronic monitors for vital signs in hospitals like Al-Shifa, where Mads and Erik worked. Infant mortality and growth stunting rates in children (representing reliable indicators of health status) have either stagnated or increased between 2000-2006 [3]. A WHO survey on quality of life in 2005 found it to be lower in the occupied Palestinian territory (oPt) than all other countries studied.

Further, malnutrition, unemployment, public curfews and restrictions on movement are daily realities. The separation wall, constructed between Israel and the West Bank and declared illegal by the International Courts of Justice, continues to impede movement of Palestinians during everyday activities, and divides neighbourhoods and households [4]. Reports of patients needing life-saving operations and critical care being denied access and women giving birth at checkpoints are commonplace [5]. The need for travel permits delays access to hospitals for patients, medical students and health workers, with commuting times increasing from 30 minutes to more than 2.5 hours on a regular basis.

Chronic exposure to violence, humiliation and insecurity has bred pervasive demoralization and despair amongst Palestinians. Yet, within this context, Palestinians have cultivated a collective social resilience to civilian areas in the face of daily struggles [6].

This sad state of affairs for the health of Palestinians is couched within a larger context of disjointed and inadequate public health provision and health infrastructure that developed over generations of different regimes. A Palestinian Ministry of Health, established after the Oslo accords in 1994 (along with the

Above: The Erez Checkpoint in Gaza

Palestinian National Authority), inherited a neglected health service from the Israeli military after decades of degradation. Current services remain inadequate for the health needs of the people, due to continuing neglect, poor management and corruption. Israeli restrictions since 1993 on the free movement of Palestinian goods and labour across borders between the West Bank and Gaza have certainly made matters much worse. The lack of any control by the Palestinian National Authority over water, land, and the environment within the oPt has made building an effective health system virtually impossible. To compound this further, the reliance on financial assistance from a multiplicity of donors, complete with their different agendas has also resulted in programme fragmentation [7].

So what is the solution? Building an effective healthcare system requires command over resources, self-determination, sovereignty and free movement of people, all absent in the Palestinian territories, particularly in Gaza. This is

Omar Abdel-Mannan is currently a final year medical student at Oxford University, about to embark on an academic foundation job in Paediatrics at University College London. He has a special interest in the challenges and obstacles to healthcare and medical education in the Occupied Palestinian Territory. In his spare time, he enjoys playing tennis, cycling and globe-trotting!
the argument put forward by a number of world renowned academics, doctors and surgeons in a conference organized recently by myself and a number of students at Oxford University: ‘Healthcare under siege: supporting medical education in the occupied Palestinian territories’. In this gathering the expert speakers drew on their decades of personal experiences in the OPT to expose the devastating effect of crippling economic blockades and military attacks on civilian health and access to medical care, especially in Gaza. Who are these ‘experts’? Sir Iain Chalmers – A co-founder of the UK Cochrane Collaboration, Sir Terence English – the first surgeon to perform a heart transplant in the UK in 1979, Dr. Richard Horton – Editor-in-Chief of The Lancet, to name but a few.

Earlier this year in February, Dr Horton and Sir Iain Chalmers visited Gaza, gaining access with the help of the charity Medical Aid for Palestinians. In his ten-minute talk, Dr Horton vividly portrayed the image of a disintegrating healthcare system and a humiliated people: “Going through checkpoints is like going through cattle gate”. One of the pressing needs, as he argued, is to systematically train medical researchers and postgraduate students to build a solid foundation of medical professionals for the future. Supporting the universities, he added, is crucial to better understand the Palestinian case, to understand their needs, and to focus on supporting human rights.

Meanwhile, Prof Colin Green from University College London (and UNESCO Chair of Cryobiology with the Ukraine Academy of Sciences) was a key player in the extraordinary construction of a medical school from scratch based at Abu Dis in the West Bank in 1994 (with an original intake of 34 students), which today has grown to over 800 students in four campuses. As he highlights, family practice in the area is very poor and it seems that all doctors end up in the hospitals: “We need champions of primary care,” enthused Prof Green. More specialists are also needed in the region, with only 1 pathologist and 2 cardiologists in the whole of the West Bank and a clear lack of psychiatrists.

So why should we care about this region? I personally believe, as do all the speakers, that the UK has a special responsibility towards the people of Gaza and the West Bank, due in no part to our historical ties. The Balfour declaration of 1917, which involved Britain giving away a country that didn’t belong to us, to two different national movements, was always bound to end in tears. It is thus our politicians’ responsibility today to clean up this mess, and to uphold the promise made in that same declaration that ‘nothing would be done to harm the civil and religious and human rights of existing non-Jewish communities in Palestine’.

By discussing the wider role and moral responsibility of the UK towards the Palestinian people in Gaza and the West Bank, I am confident that we will develop and implement innovative strategies to make a positive on-the-ground difference to civilian health, access to medical services and medical education there. Oxford Brookes University’s historic decision in March to establish a scholarship programme for Gazan students (set up with the help of Dr Iain Steadman, Director of Development and one of the attendees at the conference) is one such example of the tangible difference that can be made through academia. In fact, within hours of the conference ending, a number of enthusiastic medical and humanities students from the university had already formed a student movement aiming to push through a number of short and long term proposals; including the facilitation of twinning Al Quds University medical school (based in Abu Dis) to Oxford University medical school. I very much hope that this will promote elective exchanges, the sharing of ideas and teaching materials, and act as a catalyst for similar programmes at other UK medical schools.

I could not help but to think during the conference: Why have such distinguished members of the medical elite, with hugely successful careers in their respective fields, invested so much energy in this cause - sometimes putting their jobs on the line as a result? These are people with no political, religious or cultural affiliation to the Palestinian issue, fighting for a cause that is thousands of miles from their doorstep. The simple answer is that at the end of the day, doctors and surgeons work in the business of helping people – the original Hippocratic Oath clearly states: “I will keep them (the sick) from harm and injustice”. That is undoubtedly a political statement. All medics should be championing human rights and tackling injustice across the world, wherever it rears its ugly head.

While a political solution remains distant, ordinary Palestinians in Gaza and the West Bank continue to suffer. The physical, psychological and social well-being of Gazans will remain poor, whilst the structural impediments and barriers to development remain in place. As the Commission on Social Determinants of Health of the WHO states:

“The conditions in which people live and work can help to create or destroy their health”.

The situation is grave, but it is not impossible. Within all the darkness, beacons of light remain shining white phosphorous in attacks on Gaza. The Times, 24th Jan 2009

Rita Giacaman, Rana Khatib, Luay Shaban, Asad Ramlawi, Belgacem Sabri, Guido Sabatinelli, Prof Marwan Khawaja, Tony Laurence, Health status and health services in the occupied Palestinian territory. The Lancet 2009; 373: 837-849

Above: The Separation Wall in West Bank

something to help: by supporting medical education, by visiting the region to see at first hand the challenges of daily Palestinian life, and by advocating for justice and human rights, we can make a difference.

For me the heartfelt passion and commitment of the speakers resonated with my core values as a future doctor and reminded me of why I chose medicine in the first place. Inspired by this event, I am taking the first steps on a journey that will take me to a land of challenges and resilience. I truly believe that every medic should go to the occupied territories and see with their own eyes the health of ordinary, innocent people under siege.

3. Rita Giacaman, Rana Khatib, Luay Shaban, Asad Ramlawi, Belgacem Sabri, Guido Sabatinelli, Prof Marwan Khawaja, Tony Laurence, Health status and health services in the occupied Palestinian territory. The Lancet 2009; 373: 837-849

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Healthcare In a Resource-Rich Community
The Case of Prestea Huni-Valley District in Ghana
BY RALPH KWAME AKYEA, GHANA

There I was, in a dilemma after my End-of-Senior Clerkship Examinations on Wednesday, with my Final MBChB Part 1 Examinations scheduled to take place in four weeks time and the district tours of the Annual Health Week Programme beginning that very Saturday. Many of my colleagues had opted to stay behind to revise and prepare for the new district examinations. The day prior to departure for the district tours, the decision was finally made and Prestea Huni-Valley District was the destination.

The National Health Week Programme is an annual Public Health Campaign on a pertinent public health concern. It is a project organised by the Federation of Ghana Medical Students’ Associations (FGMSA). An average of four students, from a member Medical Students’ Association, is sent to a district for a week. The theme for this year’s campaign – Caring for the Lungs: Breath is Life.

Africa is a rich continent endowed with vast natural resources which when properly managed will improve the health and overall well-being of Africans. The major problem confronting the African continent is that of quality human resources against medical resources. Equitable distribution of wealth would ensure that inhabitants in either the rural or urban setting have access to quality healthcare since optimal distribution of wealth would ensure that resources against medical resources. Equitable distribution of wealth would ensure that inhabitants in either the rural or urban setting have access to quality healthcare since optimal healthcare is a right not a privilege. This fact became so real in a region that made airwaves.

The Western Region is probably the richest area in Ghana so far as mineral deposits are concerned. Minerals found in the region include gold (Prestea/Bogoso), diamond, manganese, bauxite, limestone, iron ore and glass sand. The region produces an average of 42% of Ghana’s timber used and exported annually. The soil types are suitable for a wide range of crops—mainly cocoa, coffee, rubber, oil palm, coconut, black pepper and rice. The region is one of the 3 most industrialized regions in the country.

Prestea Huni-Valley District is situated in the central part of the Western Region of Ghana, it is one of the new districts created in 2008. The district covers a land size of about 1,832 sq. km and has an estimated population of 165,804 as of 2010 (projected from the 2000 census). The district is divided into seven operational sub-districts for effective healthcare delivery—Bogoso, Inusisiding, Awudua, Himan, Prestea, Huni-Valley and Aboso.

There are a total of 123 communities within the sub-districts. The under 1 year old population of about 32,133 and Women in the Fertility Age (WIFA) population of 36,952.

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The rapid population expansion in the district due to migration has brought with it attendant environmental and sanitation problems and challenges. Most parts of the rich forest has been reduced to secondary forest through increased human activities such as excessive open cast mining, farming activities and indiscriminate lumbering. Parts of the district are suffering from “environmental stress”. A number of rivers and farmlands have been polluted and lost due to the spillage of cyanide and mercury from the mining activities.

In spite of this, the district faces serious challenges especially when it comes to accessing advanced and specialized healthcare from the only general hospital as the referral center located at Prestea. Due to this, specialized services are accessed from the Tarkwa-Nsuaem Municipal Hospital with an operating theatre. Photo: Anny Huang, Australia
The poor state of roads from the remote communities makes accessibility to health facilities within sub-districts a challenge. This also affects regular routine outreach activities by community health officers.

With a total Out-Patient Department (OPD) attendance of 75,649 the district has an nurse to patient ratio of 1:850 and a doctor to patient ratio of 1:18,912 according to the 2009 Annual Health Report of the district.

There has been a total of 40,973 OPD cases between January and June, 2010. Most of the disease condition presented at the various health centers are preventable.

The top three disease conditions (malaria, acute respiratory infections and diarrheal diseases) are major contributing conditions for the high Under Five Mortality Rates in developing countries. With appropriate environmental and sanitation measures together with good nutrition and safe drinking water, most of the disease conditions presented at the OPD would be prevented.

The major concerns of the health directorate are:
- Providing health infrastructure
- Improving the human resource management
- Increasing access to quality care
- Reducing maternal mortality
- Improving the availability of resources
- Control of tuberculosis and malaria.

For a young health directorate grappling with a weak health sector infrastructure and inadequate financial resources, to have such accurate, reliable and easily accessible data is laudable.

In a region endowed with so much natural resources the healthcare level is nothing close to optimal. The inhabitants do deserve a much better healthcare system. The million dollar question still remains – whose responsibility is it to provide the needed optimal healthcare these residents deserve?

The above is a report by a medical student assessing the healthcare level of the Prestea-Huni-Valley District during the 43rd Annual Health Week Programme of FGMSA from 19th – 24th September, 2010.

Figures quoted were obtained from the Ghana Health Service website and the 2009 Annual Health Sector Report of the Prestea Huni-Valley Health Directorate.
When considering the human rights of Lesbian, Gay, Bisexual, Transgender/Transsexual, Queer, Intersex (LGBTQI) individuals as medical students, the question that might come to our minds is: Do they have adequate access to health care services? This article provides some facts and ideas that may be useful in answering this question or in giving some insight into the matter. Recently, a study implemented this topic, these results are not surprising at all.

Much research confirms that attitudes that stigmatize any non-heterosexual form of behaviour, identity, relationship or community play an obstractive role in adequate assessment, treatment and prevention of LGBTQI health problems. Discrimination and marginalization are the major hindering determinants of health in LGBTQI communities, especially in the field of sexual and reproductive health. One of the sources of stigma captured by these studies is the attitude of healthcare providers, who often demonstrate prejudiced manner towards LGBTQI individuals. Given the fact that most of them lack knowledge about LGBTQI health since there is not enough education and training in this topic, these results are not surprising at all. This attitude of healthcare providers, enclosed within the systemic marginalization, often subject LGBTQI individuals to bias, discrimination and substandard care. For instance, medical forms and interviews are frequently exclusive of gender and sexually diverse experiences, which may discourage the disclosure of gender identity, sexual orientation, and health-related behavior. Consequently, LGBTQI people may avoid or delay care (e.g. screening for various health problems) or suspend expressing their health concerns. Thus, health problems may be undiagnosed, misdiagnosed, and/or left untreated until they progress to severe conditions.

According to the literature, LGBTQI issues are addressed by 0.1% of all medical articles, which are mainly disease-specific (mainly HIV, sexually transmitted diseases or mental health related) and omit the reference to race and ethnicity. Additionally, it is interesting to see how most of the research involves lesbian and gay individuals solely, whereas bisexual and especially transgender individuals are neglected, causing marginalization among the marginalized populations. Thus, this data clearly show how public health research underestimates LGBTQI-health related problems.

What are the attitudes of medical students on this matter? Recently, a study implemented amongst medical students in a metropolitan school in the USA shows that those with more clinical experience of caring for LGBTQI patients tend to perform more comprehensive history taking, hold more positive attitudes towards LGBTQI patients, and possess greater knowledge of LGBTQI health care concerns than students with limited or no clinical exposure.

To conclude, immediate action needs to be taken in order to sensitize medical students on this reality, which mainly concerns the public health from human rights perspective. Comprehensive health coverage cannot be achieved without recognizing the health of the so-called marginalized populations. Medical students, let us be the face of change: advocate for more comprehensive medical curriculum that acknowledges LGBTQI health care needs in order to provide at least basic health service to LGBTQI individuals.

10. NCLUSION Project: Towards a Healthier LGBT Scotland Glasgow: Stonewall Scotland and the Scottish Executive Health Department (NHS Scotland); 2003.
“Without a measure of solidarity, no society can be truly stable. It is not realistic to think that some people can go on deriving great benefits from globalization while billions of others are left in, or thrown into, abject poverty.”

Rwanda: In search For Food
Poverty gives a big contribution in creating country’s health problem. Eradicating poverty is every country’s commitment as stated in the Millennium Development Goals (MDGs). Fulfilling that commitment gives the new lease on life to thousands.
Photo: Megan Kizuik, McMaster University, Hamilton, Ontario, Canada

Guatemala: Women doing laundry
Water is a huge source of infection and spread of disease, but many people simply don’t have a choice. Laundry is spread out on rocks, drying under a hot sun, and women in the water are washing clothes for their families. Children swim in the background.
Photo: Megan Kizuik, McMaster University, Hamilton, Ontario, Canada

Thailand: Unequal quality of life, inequality in health
Health inequality arises within and between communities. Social and economic conditions and their affects on people’s lives determine their risk of illness.
Photo: Pawin Panijayanond, Thawalsak Ratanasiri, Faculty of Medicine, Vajira Hospital, Bangkok, Thailand

Nigeria: When There Are No Automobiles
This picture can be mistakenly dated two decades backward, especially in the light of the sophisticated machineries and diagnostics populated massively in the urban and semi-urban settings in hospitals in Nigeria. Taken two years ago in one of the rural settlements, this picture shows how far apart health inequality could be within and between communities.
Photo: Adeyemi Oluwaseun John, Nigeria
San Blas Islands, Panama: Bathroom These waters are part of everyday life for the Kuna People of the San Blas Islands. Children swim and play, women do their laundry, and people take care of their bathroom needs in close proximity... there are implications on health as a consequence. Photo: Megan Kizuik, McMaster University, Hamilton, Ontario, Canada

To travel is better than to arrive The gap can be bridged. The large divide can become imaginary. All that is needed is commitment. A young boy walks home, down a dusty path lined by other similar houses. The contrast between nature and man-made is striking; the boy is looking in the direction of beautiful hills. Photo: Megan Kizuik, McMaster University, Hamilton, Ontario, Canada
Test of Survival
(In)accessible Diagnostics in an Inequitable World
BY RAMON LORENZO LUIS R. GUINTO, PHILIPPINES

“Tatay (Father) Berting, we need to get a blood sample of Nanay (Mother) Tinay immediately,” I told the old man in Tagalog with a tone of both urgency and compassion. “But unfortunately, our hospital cannot perform the test to check her blood tonight. We need to send the sample to a private laboratory outside the hospital ASAP.”

To say “to check her blood” is actually too general and vague – I felt it was a breach of my patient’s, or at least her bantay’s (caregiver’s), right to complete information about her medical management. But Nanay Tinay is already in a coma, the clock is ticking fast, and we badly need to measure the blood levels of one particular chemical element – potassium.

High school students will recognize potassium as number 19 in the periodic table, but for doctors, it is an ion essential in the functioning of nerves and muscles and in maintaining fluid balance in cells. A scarcity of potassium can lead to symptoms as tolerable as fatigue to as severe as paralysis of the lungs. An excess, on the other hand, may knock out the heart quickly.

Actually, testing for potassium, along with other chemicals in the blood like sodium and creatinine, is free of charge for charity patients in our hospital, which is government-funded and public service-oriented. Unfortunately, on that fateful night, the laboratory had run out of reagents needed to measure these chemicals, and so we needed to send the samples to private laboratories across the street.

Ironically, a week before this happened, this government hospital had just inaugurated its new private laboratory facility, which offers the same services as the public laboratory but charges higher fees, since it is targeted to the paying middle to upper class patients. The hospital administrators claim that the private lab will help augment the meager funding the hospital receives from the government. On the other hand, the health workers’ union says this is the first step towards the gradual privatization and commercialization of the hospital. Nonetheless, that night, the new lab had not opened in full blast yet, and only one private hospital, located a few blocks away, could run the serum potassium test at a charge of 300 pesos.

From zero to 300 pesos. A quantum leap in cost, and a test of survival for Tatay Berting and Nanay Tinay.

Being in a hospital does not equate to diagnosis and treatment. Ideally, we perform tests like blood exams and chest x-rays to check the status of the patient, search for any cause of disease, and monitor the response to treatment. But for the majority of Filipinos today – and I am sure elsewhere too – these tests are more than just clinical tests – they are literally tests of survival. Even families are tested for their capacity to pay for a CT scan or genetic test that could mean life or death of their loved one.

Honestly, even doctors face the litmus test. At times we are tempted to blindly treat diseases that we still haven’t detected yet, or to look for financial resources to, on our patients’ behalf, pay for expensive tests that reveal the definitive diagnosis, an example of which is a bone marrow aspiration for hematologic diseases.

Studies from the Philippine National Institutes of Health show that, despite our rapid advances in medicine and public health both locally and globally, six out of ten Filipinos who get sick still die without ever seeing a doctor [1]. Sadly, the statistics don’t end here, and I’m sure I might be guessing now, since there’s no evidence yet regarding access to diagnostics and treatment among the lucky four Filipinos who get to meet doctors to seek medical advice.

Or are they really lucky for having seen a doctor? How sure are we that they get the right treatment, or at least the right diagnosis? Nanay Tinay had the opportunity to get admitted in the hospital, but every day, Tatay Berting begs for help from relatives and neighbors so he can pay for laboratory tests needed for regular monitoring. Their story is just one of myriads more.

Nowadays, being seen by a doctor or stepping inside the hospital premises does not automatically lead to the cure of disease and restoration of health, especially without appropriate diagnosis and effective treatment due to the lack of access to medical resources. Nanay Tinay’s story signals us not just to continue caring about the six Filipinos without access to health care anymore – her experience calls us to become concerned about the health of the four others who reach the health facilities too --- every Filipino, every person.

Cheaper medicines only? Cheaper diagnostics too!
In recent years, we tried to tackle the issue of access to essential medicines – in the Philippines, the Congress passed a Cheaper Medicines Act, and the previous president and health secretary attempted to come up with a list of drugs with their maximum retail prices so that pharmaceutical companies and distributors would not be able to charge fees beyond the ceiling. But we know that drugs are not just what we need to get cured from illnesses.

Now is also the time to take a look into access...
Below: A screen in Zhongshan hospital, Shanghai, China, shows the prices that patients must pay for diagnostics. These range from 10 yuan (approximately 2 USD) for urinalysis to 650 yuan for an MRI. Photo: Anny Huang, Australia

to essential diagnostics, which include blood tests to determine cell counts and electrolyte status. Even if there is still little evidence on this issue (and hence the need for more research in this area), our day-to-day experience in the hospital and the community tells us that this indeed is an equally important but immensely ignored public health concern. How can we treat our patients with medicines if we cannot diagnose them correctly, just because the laboratory does not have the required reagent, or the patient cannot afford a syringe and a vial, or worse, the health care facility does not have a laboratory at all? In my school, I am not alone in the practice of buying, using a portion of my weekly allowance, a stash of syringes and vials, ready to be shelled out to patients in dire need.

In the popular American TV series, Dr. House always gets what he wants – an MRI, a biopsy, an antinuclear antibody (ANA) test for lupus, even a DNA analysis of the long arm of chromosome 22! At times, I feel envious of Dr. House. In a public hospital here in the Philippines such as the one where I currently work as a clerk, when the consultant asks the residents during ward rounds, “Where’s the CT scan result?” an unusual reply would be “The caregiver is still requesting for funds from the mayor, or from PCSO (Philippine Charity Sweepstakes Office).” By the time the CT scan result is out, the tumor would have already impinged on a larger area of the brain, or obstructed another vessel, or worst, murdered another life.

Health – a fundamental right and our collective wealth

Sadly today, over 50 percent of our national health expenditures are still paid out-of-pocket [2], and perhaps the amount is bigger in poorer countries. At first, I couldn’t imagine how poor Filipinos can pay for basic health services if they do not have pockets at all, but my daily experiences in the wards tell me that one doesn’t need imagination to understand the gravity of this problem.

One of my classmates once had a patient who was admitted for encephalopathy due to chronic liver disease. He eventually got treated, but unfortunately couldn’t be discharged from the hospital due to an outstanding debt. He eventually died, not because of his liver disease, but from hospital-acquired pneumonia! He died of poverty, literally.

From a larger point of view, this is a question of access to quality, essential, primary health care to competent doctors and other health professionals, to essential medicines, and even to basic and critical diagnostic procedures. More importantly, this is an issue of health as a basic human right. As a country, and perhaps as a global family striving to protect the rights of our people, we must address this issue immediate-ly. More Nanay Tinays’ will suffer as we further delay the dialogue, and more importantly, the course of action.

The issue of public health is our collective test of survival. Once we begin to realize that people’s health is our nation’s and our world’s real wealth, we cannot afford not to act upon this challenge with a sense of urgency.

Her story can save more lives

Going back to Nanay Tinay, after four hours, Tatay Berting returned to the ICU, carrying a sheet of paper containing her blood potassium level. It was 4.5, which is normal. The latest result would indeed be helpful in documenting her potassium status on the chart.

But for a lifeless body such as that of Nanay Tinay, potassium levels are of no use. The latest result proved to us that she did not die of potassium excess or loss, and given her deteriorating condition, we know that she was also fighting against a constellation of diseases – disseminated infection, respiratory failure, and many others. Ultimately, she battled against poverty, social injustice, and society’s lack of regard for her right to health.

A small infusion of potassium chloride cannot anymore restore her life, but a young medical student like me can share her story, hoping that it will effect positive social change and save more lives.

Notes

* The real names of “Tatay Berting” and “Nanay Tinay” are altered for confidentiality.

† Both the Universal Declaration on Human Rights (Article 25) and the 1978 Alma Ata Declaration on Primary Health Care affirmed health as a basic human right.


3. Republic Act No. 9502 or the “Universally Accessible Cheaper and Quality Medicines Act of 2008,” fondly called “Cheaper Medicines Act,” aimed to enhance access to generic drugs that will provide cheaper but quality medicines to Filipinos. It was signed into law by former Philippine president Gloria Macapagal Arroyo last June 6, 2008. http://en.wikipilipinas.org/index.php?title=Republic_Act_No._9502

4. Both the Universal Declaration on Human Rights (Article 25) and the 1978 Alma Ata Declaration on Primary Health Care affirmed health as a basic human right.
Advocating for Insurance

BY ADEYEMI OLUWASEUN JOHN, NIGERIA

Abstract
A good health insurance scheme still remains the most viable opportunity to a better health for most people-groups in Africa and it can be most effective if run by the government and complemented by private health management organizations. Challenges abound in making this possible and it will take a purposeful and corrupt-free government to achieve this.

Free Dialysis for the World
Belding Scribner is not a popular name in the region of the world where I live. The reason is due to the unpopular but heroic path that the "father of bioethics"[1], took regarding renal dialysis. For a disease whose diagnosis is equivalent of a death sentence, Scribner generously gave the solution free to the world. It is however, not the disregard of patency in his discovery that is of interest to me but his ideology. He believed strongly that dialysis should be done primarily in a setting outside the hospital, should never be done for profit, and should be universally available. Scribner did this for a discovery that could have put his name in the mouth of every doctor around the world and a solution that could have flooded his bank accounts. Sadly, he could not stop the world from making money off him.

On June 13, 2003, Belding Scribner passed away but his philosophy remains. He might not have been able to achieve free dialysis for the world but he showed that his belief of free dialysis is possible. As far back as 1962, together with Dr. James Havilland, then President of the King County Medical Society, Dr. Scribner developed the first nonprofit, outpatient dialysis facility in the United States, the Seattle Artificial Kidney Center, which has since grown into the still-nonprofit Northwest Kidney Centers. But the dialysis done here is not for all and sundry. It is for those whom the anonymous lay committee believes need the scarce resource the most. Of course, ethical issues arose from this structure of "free dialysis" but Dr. Scribner and his team had their way around it.

Belding H. Scribner was survived by seven children, six grandchildren, and millions of patients around the world whose lives, or those of their loved ones, were saved or made better by his life’s contributions.

All for One, One for All
People die in Africa. And sadly, those that are privileged to still be alive live only to allot blames. They blame the doctor for not staying by the patients’ bedside long enough, the nurse for not taking vital signs at every whim of ache, the other relatives for not supporting them with money, the government for not making health free and God, for taking their beloved away at such a tender age of 70! Truly, some cases are hopeless but a lot more could have been salvaged. In the part of the world where I live, the most common hindrance is funds. I have never been a proponent of free health. In fact, I believe there is nothing called free health. Someone inevitably pays for it directly or indirectly. In societies and countries where health appears free, the secret lies in a strong health insurance policy.

I like defining insurance with the phrase “all for one, one for all”. This statement somehow sums up the whole concept of insurance while undermining its more dominant legal framework. Insurance is a legal contract that protects people from the financial costs that result from loss of life, loss of health, lawsuits, or property damage. It provides a means for individuals and societies to cope with some of the risks faced in everyday life. And in relation to health, it protects people from financial loss caused by the high cost of medical care.

By combining or pooling the risks of many people into a single group, insurance can make the financial risks associated with healthcare more manageable. Through insurance, each person who buys coverage agrees to pay a share of the group’s total losses in exchange for a promise that the group will pay when he or she needs services. Essentially, individuals make regular payments to the plan rather than having to pay especially large sums at any one time in the event of sudden illness or injury. In this way, the group as a whole funds expensive treatments for those few who need them.

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Most developed countries provide universal healthcare. Coverage is guaranteed from birth until death. In these countries, most hospital, physician, and pharmacy care is covered throughout a person’s life. Patients receive care according to their needs, not their ability to pay. From simple immunizations to serious operations such as bone marrow transplants, everyone has access to whatever care is required.

The Nigerian Story

I live in a country where good health is a luxury and not a privilege. This is due to the high cost of healthcare and the solemn fact that few of the population is gainfully employed. Luckily, Nigerian leaders understand the place of health insurance in protecting the lives of their people but the structure is not well grounded. The health insurance scheme in Nigeria is a blend of the private-run health management organization and the government-run national health insurance scheme (NHIS).

Several crises have rocked the health insurance scheme in Nigeria. Some of which include the debate of whether or not the government should take over the health insurance of its people. Also, there has been strong contentions between the federal and state-run NHIS based on the opinion that the NHIS should purely be a federal run programme. Questions abound in the hearts of most Nigerians as regards to how efficient that would be in lieu of the other failed national insurance policy schemes. There are also questions regarding integrity issues as past insurance schemes have failed because of fraud.

These crises are not isolated problems of Nigeria. They are common indices found in some other African countries. And as long as these countries do not find lasting solution to these problems, they still remain in the Dark Age. Ghana is a good example of a country that rose up to the challenge and surmounted the hurdles of attaining an efficient health insurance scheme. Ghana’s national health insurance scheme is believed to be one of the richest dividends of democracy that the then President, John Kuffour handed over to his people. Of course, there might still be slight structural and implementation issues but that would be perfected with time. Nigeria is also on the track of change and will get there soon – hopefully.

Making Things Work

Can the health care system work in Africa? Yes it can; at least, evidenced by the current happening in Ghana. What Africans need is a healthcare system that guarantees access to qualitative healthcare at an affordable price. And the answer lies in a strong and efficient
national health insurance scheme. A national health insurance scheme can never solve all the health problems in an African country but it can take off a large chunk of the burden. Through insurance, a sizeable and strategic segment of the population would be captured. And the rest would be settled with a strong primary health care system.

For countries that run a federal system of government, the states and federal NHIS programmes can both coexist. It will allow for variety and diversity rather than over-centralization. HMOs can then operate independently at various levels and they need not be under the control of the federal government. In fact, universal coverage will be better achieved through decentralisation and greater investment in primary health care targeted at the poor. Sure, there are countries in the world where health-care insurance is completely public sector driven as part of an overall reform framework, but it is a model that is suitable to African countries only if there is credibility, transparency and accountability in leadership. Sadly, based on past records, this is not the case.

Also, health workers need to be motivated to take their jobs more seriously and be interested in serving their countries, and not foreign lands with promises of better conditions. Governments at all levels must assign more funds to the growth of the health sector with international standards in mind. Special attention must be paid to colleges of medicine, teaching hospitals and health related institutions to ensure quality training of medical personnel. A lot more energy should also be devoted to public enlightenment and the creation of social safety nets. People need to know what health insurance is all about: are they entitled to discounts? Is there a linkage between lifestyle choices and health insurance packages? Can they make choices and if so, what kind of choices?

In Conclusion

Some dreams are born while others remain still-births. What gives life to a dream is commitment. Belding Scribner had a dream that renal dialysis would be free and then spent his life achieving this dream. His name is written in the annals of history as the man who saved millions of lives. I wish African leaders would take a cue from this man and dedicate their service in making health insurance work in their countries.


“By combining or pooling the risks of many people into a single group, insurance can make the financial risks associated with healthcare more manageable. Through insurance, each person who buys coverage agrees to pay a share of the group’s total losses in exchange for a promise that the group will pay when he or she needs services.”
What can we do to reduce health disparity?
A brief reflection on the flood
BY YEN-HAO CHU and MAO-HSUAN HUANG, TAIWAN

On October 21, 2010, the periphery of Typhoon Megi swept past Taiwan, bringing an unforgettable nightmare to the residents of Su-ao, a small town located in north-eastern Taiwan. Unprecedented heavy rain pelted the flat plain, accumulating a total of 939 millimetres within a single day. After Typhoon Megi left, Su-ao was flooded by mudslides and left temporarily paralyzed. Many victims of the flood were displaced from their homes and had to take refuge in local aid centres, including those provided by the government and various NGOs. Though free from imminent danger, many who witnessed the flood would re-experience the horrors through vivid flashbacks of the terrifying events, which still haunt their days.

In early November, the Federation of Medical Students - Taiwan (FMS-Taiwan) joined the Taiwan E-well Society in setting up a free clinic for the disaster that struck Su-ao. Preliminary assessments of the damage wreaked by the typhoon were done prior to setting up the clinic. Members of FMS-Taiwan worked with other medical professionals in preparing for the pro-bono clinic. A post traumatic stress disorder (PTSD) screening questionnaire was specifically prepared for this relief effort, with the primary goal of prevention of PTSD. The psychological well-being of the residents of Su-ao would be assessed, and proper counselling recommended for those severely affected emotionally by the flood.

During the event, physicians provided free physical examinations and health guidance for 63 residents, while medical students helped record the past medical history of the patients, carried out the PTSD survey and taught basic health education. Other than providing free medical services, bed quilts and other basic necessities were provided to the disaster stricken residents in need. As part of an effort in providing relief aid to the landslide affected areas, FMS-Taiwan and charity groups went door-to-door to distribute the quilts. More importantly, through household visits, medical students were able to provide emotional support for the local villagers.

The National Health Insurance has been established for fifteen years in Taiwan, but health disparity still exists. This is especially apparent after disasters such as the typhoon mentioned above, with the gap being exacerbated and unveiled. According to the statistics from the Abridged Life Table in Taiwan 2009, the life expectancy of those living in rural eastern Taiwan...
in 2009 is the same as that of those living in the country’s capital, Taipei, in 1995. This is a fifteen year gap in life expectancy, despite the two locations being merely 80 kilometres apart.

[1] Why is there such a difference in life expectancy? While uneven allocation of medical resources plays a role, socioeconomic factors should also be taken into consideration. Many residents living in rural areas are of a lower social status, and are offered fewer educational resources, public health services, and social support networks. These fields often lack adequate government funding, in addition to lack of proper health education. The community as a whole is placed at risk of suffering from chronic diseases such as diabetes and cardiovascular disease, frequently due to excessive consumption of alcohol, betel nuts, and cigarettes. These hidden socioeconomic factors rarely catch public attention the same way as the aftermath of destructive typhoons. Despite steady economic growth, the establishment of the National Health Insurance, and accessible utilities and services, health disparity still persists in Taiwan’s society. Disasters, more often than not, add insult to injury.

As medical students, how can we improve health equity? The following are the possible approaches [2]:

Fund disease prevention rather than disease treatment

The government, NGOs, and students should reach a consensus in constructing a multi-disciplinary communication network. The aforementioned free clinic is an pertinent example of such a coordinated effort. First, FMS-Taiwan and NGOs teamed up to investigate residents’ mental health status and the conditions of the local surroundings, hoping to nip psychological conditions such as PTSD at its root. Later, the collected data was analysed, and the statistics reported to the Public Health Bureau. Finally, the concerned parties, mainly the government authorities, can then make an effort towards policy-making and implementation as well as emphasize public health infrastructure.

Strengthen communities

Community is an important determinant of health disparity. For example, community stressors such as structural processes, environmental pollutants, and lack of neighbourhood resources may lead to individual stress; therefore residents may become more vulnerable to illness when exposed to environmental stress.

[3] We can design individualized long-term programs that are of the most concern to the community, such as holding annual symposiums on community empowerment, educating members on focusing on minority groups, using positive deviation theory to foster a self-organizing sustainable community, and even establishing intercommunity communication in order to stimulate improvement through the ripple effect. A knowledgeable community is essential in implementation of health policies, and through education and training, they can become independent and self-sustaining.

Make voices heard through the Internet and media

By utilizing media and social networks such as the Internet, newspaper editorials, and workshops held by the various committees of IFMSA, not only can more medical students learn and recognize the importance of socioeconomic factors affecting health inequality, but the general public can also become aware of both the causes and effects of such a social issue. With advertisements and campaigns strewn across the Internet, essential health education can be conveyed to the audience with several clicks of a finger. With proper management, the media can easily be utilized to its full potential.

Concluding statement

According to the Adelaide Statement on Health in All Policies, “A healthy population is a key requirement for the achievement of society’s goals. Reducing inequalities and the social gradient improves health and well-being for everyone.” [4] Although the status quo of health equity is a much-desired thought, if we are willing to contribute our voice, time, and dedication to this cause, together we can bring about reform in policies and attitudes towards socioeconomic factors. Together we can bring change to our treasured communities.

1. Taiwan Ministry of Interior, Abridged Life Table In Taiwan; 2009
Social Factors in Relation to HIV Diagnosis

BY NICOLAS Xu, CANADA

Background
A social determinant of health framework contributes to our understanding of health by examining the social context of HIV/AIDS. The influence of social conditions, especially structural positions, on the health and well-being of persons living with HIV/AIDS is an important area of HIV research. Social conditions may be the social positions that people hold (both achieved and ascribed) such as race/ethnicity, gender orientation, socioeconomic status (education, occupation, income, employment status) and age; but also process or resource variables such as social support, resiliency factors such as sense of personal control, and social capital [1]. The intent of this paper is to review whether and how social and demographic factors are associated with time of HIV diagnosis.

Current antiretroviral therapeutic guidelines support that the early initiation of treatment for HIV is associated with virological, immunological, and clinical benefits. However, many people with HIV are diagnosed relatively late in the course of their infection. Even when individuals suspect that they may have been exposed to HIV, they often delay seeking testing. In the United States, it was estimated that a third of HIV-positive people might be unaware that they were infected [2]. In Europe, a large proportion of HIV infections were undiagnosed before the onset of AIDS [3]. Further, timely testing for HIV does not guarantee prompt entry into treatment. A range of one to five years between knowing a positive test result and seeking primary HIV care has been reported [4, 5]. In addition to the benefits to individuals, early diagnosis and HIV treatment provides significant public health benefits. Factors associated with the time of diagnosis have been presented; however, the associations of demographic and social factors with early diagnosis are either not well studied or inconsistent. Hence, research to understand the association between social factors and estimated time between infection and diagnosis could be beneficial for timely HIV diagnosis and treatment.

Age
Limited studies have investigated the association of age and time of HIV diagnosis in the literature and this association is not clear. One study showed that late testing was more likely among people less than 20 years of age or more than 55 years of age, heterosexual people, people without a reported risk, people with private insurance, people born outside of the United States and people whose initial AIDS diagnosis was an opportunistic infection [6].

Gender
In the United States, an annual national probability survey revealed that from 1991 to 1993, the proportion of women aged 18 to 44 years who had ever been tested for HIV increased from 19 to 32% [7]. Trends suggest that the proportion of women being tested for HIV in the United States is increasing but there still remain high-risk and infected women who are unaware of their serostatus. Studies have shown that a large proportion of women at risk of HIV infection have either not been tested or delayed seeking testing or have failed to obtain results after HIV testing [4, 8, 9, 10, 11, 12]. However, Miller et al. found that 64% of 470 Hispanic and African-American women attending an inner-city US family planning clinic accepted HIV testing, and that most of the women tested (87%) returned for their results [13]. In a cross-sectional study of HIV testing patterns among 131 low-income African-American mothers, 41% of the women reported that they had been tested for HIV and 18% more than once [14]. Women who had been tested were more likely to report a greater number of sexual partners within the past 5 years, and not having used a condom during their last episode of intercourse [14]. Further, Heckman et al. found that women who were more likely to have been tested for HIV were younger, perceived themselves to be at risk of HIV infection, reported more conversations with peers about AIDS concerns, and had condoms readily available [15].

Race and ethnicity
Studies on the associations between race/ethnicity and HIV testing mainly focused on African-American and Hispanic populations. In the United States, national surveys in the late 1980s and early–mid 1990s showed that African-Americans and Hispanics were more likely to report having been tested for HIV compared with Whites [8, 16, 17, 18]. However, in a population-based sample in Los Angeles County, Sorvillo et al. found that compared to White clients, African-Americans and Latinos were less likely to detect their HIV infection early [11]. Similarly, a study in the United Kingdom showed that among 4127 adults diagnosed with AIDS, people who were non-white (race/ethnicity not specified) were more likely than others to be unaware of their HIV infection before they were diagnosed with AIDS [19].

A survey of 2717 heterosexual African-American adults conducted between 1990 and 1991...
revealed that whereas 22% reported some risk of HIV infection, of those, only 24% had been tested for HIV [20]. Among attendees of US clinics for the treatment of sexually transmitted diseases, African-Americans have been reported to be more likely to refuse HIV testing, to report not having been tested in the past [21], and to fail to return for their test results if they are tested [21, 22, 24, 25], when compared with white clients. Test refusal and failure to return for results have been associated with a number of factors, including previous testing episodes, fear of learning positive results, and perceptions of low risk [21, 22]. In a study of 592 clients voluntarily entering public alcohol treatment centers in San Francisco, African-American and Hispanic clients were significantly less likely to report previous HIV testing when compared with whites [26]. Taken in aggregate, these data suggest that whereas some racial/ethnic minority populations report more frequent testing than whites, there is also evidence that a substantial number of all racial/ethnic minorities have not yet been tested for HIV, or test late, after the presentation of symptoms.

Income
Several studies have shown inverse associations of HIV testing with income in the United States, i.e. people of lower income are more likely to have been tested for HIV [17, 18, 27]. However, the association between higher income and educational levels and earlier HIV diagnosis or earlier detection of seropositivity is found among gay communities of 30 years before the diagnosis of AIDS has also been reported [11].

Men who have sex with men
Among gay and bisexual men at risk of HIV infection, 22% reported some risk of HIV infection before diagnosis. This is important to people living with HIV and their families. As well findings of this area will inform research on the social determinants of HIV/AIDS and disease progression. It is anticipated that future research is needed to examine the relationship between social factors, and health and well-being among people living with HIV will be of benefit to them.

Summary
Further understanding of the impact that demographic and social factors have on time from HIV infection to diagnosis is important to people living with HIV and their families. As well findings of this area will inform research on the social determinants of HIV/AIDS and disease progression. It is anticipated that future research is needed to examine the relationship between social factors, and health and well-being among people living with HIV will be of benefit to them.


The Cost of Life: So Easy, Yet So Difficult
BY OMAR Mukhtar, EGYPT

“Health is not mainly a matter of doctors, social services and hospitals, but an issue of social justice.” (K. Park – Indian scholar)

The most significant determinant of an individual’s access to healthcare among other factors is their socioeconomic status governing inequality of access to healthcare globally. Consequently, the discriminated distribution of wealth and poverty account for the most hazardous inequalities underprivileged populations face. It should be considered that a slight shift in the global economic attitude can turn this situation around.

Out of the six billion people that inhabit our world, five billion live in low and middle income countries. These five billion suffer from 93% of the global burden of disease but only have access to 11% of global healthcare resources. More than 40% of the world’s healthcare resources are spent in the United States. In 2001, 14.1% of the United State's budget was allocated to healthcare meaning an average of over $5000 per person. This is some 500 times more than the amount spent in the poorest countries of the world.

The entire international health collaboration only accounts for six billion dollars (10% of global funding) which leads us to the fact that the greatest share of spending comes from individuals and countries themselves. This is alarming considering the socioeconomic hardships such countries most probably encounter.

Accordingly, it is definitely an issue of social injustice that over eight million children under the age of five die from malnutrition and mostly preventable diseases annually, and that pneumococcal diseases became the number one vaccine-preventable cause of death worldwide with an annual mortality of 1.6 million people. It is an impending situation which is further exacerbated by poor social policies, bad politics and unfair economics.

To address these health issues, the World Health Organization’s Commission on the Social Determinants of Health suggested 3 principles of action to face this imbalance in healthcare services:

1. Improve the conditions of daily life—the circumstances in which people are born, grow, live, work, and age
2. Tackle the inequitable distribution of power, money, and resources—the structural drivers of those conditions of daily life—globally, nationally, and locally.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

As an independent medical students’ body engaged in the efforts of civil society to tackle healthcare inequality, these principles are feasible for adoption to fully orient the public and direct decision-makers to responsibly allocate national resources to the sectors of population with low socioeconomic standards both globally and nationally.

Empowering our communities to take action against healthcare inequality using any means possible is essential to facilitate healthcare reforms which are already taking place especially in developing countries aspiring to an undiscriminating and prosperous future.


Omar Mukhtar is a third year medical student currently studying at the University of Alexandria, Egypt.
Below: The illustration is meant to depict the inequality that exists with respect to the administration of health care in the United States between the wealthy and the poor. The sick, homeless gentleman (in the forefront) sleeps outside, across the street from a family doctor’s office that is currently accepting new patients. He must go without treatment due to inability to pay, leading to unnecessary pain and suffering. Picture: Michael Corbo, Canada
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