The International Federation of Medical Students' Associations (IFMSA) is a non-profit, non-governmental and non-partisan organization representing associations of medical students internationally. IFMSA was founded in 1951 and currently maintains 106 National Member organizations from about 100 countries across six continents with over 1,2 million students represented worldwide. IFMSA is recognized as a non-governmental organization within the United Nations' system and the World Health Organization and as well, it is a student chapter of the World Medical Association. For more than 60 years, IFMSA has existed to bring together the global medical students community at the local, national and international level on social and health issues.

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.

Objectives:
• To expose all medical students to humanitarian and health issues, providing them with the opportunity to education themselves and their peers;
• To facilitate partnerships between the physician in training community and international organization working on health, education and social issues;
• To give all medical students the opportunity to take part in clinical and research exchange around the world;
• To provide a network that links active medical students across the globe, including student leaders, project managers and activists, so that they can learn from and be motivated by each other;
• To provide an international framework in which medical student projects can be realized;
• To empower and train medical students to become advocates in leading social change.
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Dear reader,

MSI26 is focusing on the issue of Universal Health Care, a subject of increasing interest worldwide in the last few years.

In the recent 65th World Health Assembly in Geneva, Switzerland, Dr. Margaret Chan, the Director-General of the World Health Organization, expressed her unwavering confidence in universal health coverage, not just once but twice. In her opening speech, she called it as “the single most powerful concept that public health has to offer”[1]. Later during the week, she said in her acceptance speech, after her re-election for a second term, that “universal coverage is the ultimate expression of fairness”[2].

As future Physicians and Health Care leaders, it is essential for us to embrace the importance of this concept that is considered as one of the four key pillars of primary health care and services[3] to be able to contribute to the reaching it.

MSI26 will reflect various medical students’ opinions, experiences, thoughts and analyses on this topic of increasing importance.

As future Physicians it’s our mission to develop our skills and our understanding of the world, to be able to contribute to the welfare of all human beings.

Finally I want to thank my whole team for their efforts for making this happening.

Enjoy reading!
Omar Safa, Editor in Chief

References
Dear friends,

We live in a world that is constantly evolving. The health issues we face today are becoming increasingly complex. The global public health issues are different from what they were 20 years ago. No longer are the limits to health the lack of knowledge and understanding about disease processes and treatment. More and more is health becoming interconnected with human development as a whole.

The transformation has begun. The days of health care being isolated from the community it serves have come to an end. The role of health care is increasingly being defined in terms of how good it can adapt to solving public health problems and facilitate the development of the communities they serve.

As doctors in training and as health activists, we are at the forefront of these evolving global public health issues. We need to continue to be active contributors and initiators of this change – both locally and globally. The duty we perform, not only acts as a model for leading social change, but also prepares us as future health professionals to embark upon a lifelong quest of learning and applying. This is our assurance of being able to provide our future patients and communities with the best quality care they need – not only today but also 40 years from now.

This is exactly why our August Meeting 2012 is held under the theme “Universal Health Care”, we are coming together from all over the world to meet in magnificent India to maximize the opportunities we have in affecting Health Care world wide and to set one more milestone in IFMSA’s continued quest to make the world a better, healthier place to live in.

Finally, I hope that you enjoy this intense intercultural experience and that you take the best out of this exceptional event; that you learn more about yourself and that you are empowered to return home to organise your own local actions and inspire other members of our federation.
Degrading health services offered to refugees in Canada

Yassen Tcholakov

The Canadian health care system is described as a public health care system where patients are provided care without point of service charges. Around 70% of the funding of this system comes from public funds and the remaining 30% is funded privately\(^1\). In 2010, the costs generated by the health care system represented 11.7% of Growth Domestic Product (GDP) or 5,614 Canadian Dollars (CAD) per capita\(^2\).

The current medical system was implemented in 1968 by the Medical Care Act, which was later updated in 1984 by the Canada Health Act. It is organized around six guiding principles\(^3\):

- **Comprehensiveness**: coverage of all services (with some exceptions)
- **Universality**: coverage of all citizens
- **Accessibility**: equitable access regardless of socio-economic status and geographic location
- **Public administration**: single payer system
- **Portability**: ability for citizens to use services across the country

Medical services, as described in those federal laws, are paid for by both provincial and federal governments; however, the federal contribution, which was 50% of healthcare costs in 1968, has constantly been decreasing since the introduction of the Federal-Provincial Fiscal Arrangements and Established Programs Financing Regulations\(^4\) in 1977. This trend of decreasing federal contribution to health care is now being expressed through a new piece of legislation; Bill C-31, “An Act to amend the Immigration and Refugee Protection Act, the Balanced Refugee Reform Act, the Marine Transportation Security Act and the Department of Citizenship and Immigration Act”.

Until now, health care costs generated by refugees in Canada have been covered by the federal government through the “Interim Federal Health Program”. This program offered refugees health care coverage similar to that offered to the poorest Canadians on welfare\(^5\). These health benefits included basic health care services and supplemental benefits, such as medication coverage, dental care, vision care, ambulance services and devices to assist with mobility\(^6\). On June 30th 2012, Bill C-31 will come into effect, greatly decreasing the health care services offered, where refugees will only have health coverage only for urgent and essential conditions and diseases that are a risk to public health or public safety.

The refugee population, which represents an extremely vulnerable group, will certainly be greatly affected by these legislative measures. Already, many medical associations and non-activist medical professional groups have expressed their concern regarding these changes to the “Interim Federal Health Program,” including the Canadian Medical Association, Royal College of Physicians and Surgeons of Canada, College of Family Physicians of Canada, Canadian Nurses Association, Canadian Dental Association, Canadian Pharmacists Association, Canadian Association of Optometrists, Canadian Association of Social Workers\(^7\). These associations have warned the government about the public health and economic consequences of placing these costs on a provincial budget rather than real nationwide savings, increasing costs providing future curative care for degenerated chronic conditions increasing utilization of emergency departments for non-emergency needs and the danger to public health (although public health concerns are covered within the changes framework, it is hard to understand how patient will be diagnosed for such conditions given that regular healthcare visits would not be covered).

Since that big united contest, many other organizations have joined their voices to denounce these changes to the Canadian health system, which...
The Canadian health care system is described as a public health care system where patients are provided care without point of service charges. Around 70% of the funding of this system comes from public funds and the remaining 30% is funded privately.[1]

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would make preventative care for newly arriving immigrants very difficult according to current evidence based guidelines.[8] The Citizenship and Immigration Canada[9] present two case examples: 1) We learn that because diabetes is not a risk to public health, patients diagnosed with diabetes would not have their medication covered by the plan; 2) Although preventative medication for stable angina is not covered, if that patient has a acute myocardial infarct, all expenses (emergency room assessment, surgery and hospital care) are covered. These two examples describe the changes associated with reducing preventative care while maintaining emergency care.

In short, it is discouraging to see that the Canadian public health care system has reduced health care coverage for the population without full review of the considerations mentioned in many evidence-based reports. These political changes will most likely result in one of the most vulnerable population groups in Canada having decreased access to health Care. Even if the provinces pick up the charge that the federal government is dropping on them, this situation will only create a patchwork of fixes throughout the country and an uneven distribution of services, based on the geographical location of the newcomers. Over the upcoming year, the social repercussions of these changes will be observed and studied by business, economic and health professionals who specialize in health policy and systems.

References
Can Low-Income Nations Achieve Comprehensive Healthcare?

Ismail El-Kharbotly

Money. It all comes down to one simple word: Money. The currency; the root of all evil; the manifestation of every form of human greed and every way we can destroy our world for short-term gains, is money. It is also a most vital element in the world of healthcare – an unfortunate fact. Healthcare provision is costly. This point manifests itself most clearly in how much time and effort is spent trying to reform systems and reallocate fiscal resources to ensure fair provision of healthcare services in most nations. Due to the immense significance of money in the process of healthcare provision, health economics has been developed as a field, and is now a respectable and recognized offspring of the merger of the financial, economic and managerial arms of healthcare provision. Health economics is composed of many things: agents, markets, policies and services, but many in the field agree that economics, in a nutshell, is the proper allocation of scarce resources to try and reach target goals with maximum efficiency. Money and fiscal resources are not an exception to this rule. On the contrary, the importance of funding and the fact that there are not enough funds to fulfill intended goals and outcomes gives birth to Health Finance as a topic of debate and research. It is an attempt to reintroduce equity in healthcare systems that lack it, and to widen the serviced areas in underdeveloped, and underfinanced countries.

Developing countries, also known as low-income countries, are particularly restricted in their ability to provide universal health coverage to its citizens. Universal healthcare means the provision of pre-specified health service packages, provided to protect against financial risk, to improve access to health services and improve health outcomes citizens. Lack of financial means is a detrimental factor in how these countries are able to manage their health policies, often in the midst of turmoil and political unrest. This lack of financial funds is responsible for the inability shown by a number of countries to fulfill the Millennium Development Goals (MDGs). Perhaps the question to be asked is: Are low-income countries able to fulfill their MDGs and achieve universal healthcare with their low financial capabilities and high out-of-pocket spending rates?

The World Health Organization, also known as the WHO, is keen on the promotion of equitable healthcare worldwide. Alongside the General Assembly of the United Nations, the WHO has initiated the MDGs at the turn of the century to be achievable targets that all countries aim to achieve to improve general health worldwide. The WHO has supported the provision of universal healthcare services as a means to help achieve the MDGs as well as a vital issue on its own. In its 2011 Resolution (WHA64.9), the World Health Assembly recognised in the preamble that universal and fair health coverage is among the charted human rights. It also underlined the effectiveness of fair and sustainable financial structures in achieving MDGs and accepted that equitable prepayment and pooling of finances, and avoiding direct payment at points of service provision are basic principles in universal health coverage. In the same resolution it urges that direct payments are avoided; equitable and affordable healthcare coverage, aiming for universal coverage, should be encouraged; and to ensure that not only is the effect of external funding kept along the health priorities of the country, but also that government and private sectors should collaborate under government-inclusive stewardship.

While these points are a perfectly good general reference for general policy improvements, a number of regional WHO reports provide data that could be more unsettling. For example, out-of-pocket direct payments have been found to make up to 65% of total health expenditure in Southeast Asia, while about 55% of the expenditure of the African region was nongovernmental (private insurance and out-of-pocket and 25% came from external sources in 17 African countries). Other figures were not any more encouraging; in 2007, 65% of the Asia-Pacific countries spent less than 7% of their GDP on the total health expenditures. Numbers were not better in Africa (a third of African countries spent less than 4.5% of their GDP on health and in most countries, government expenditure per person per year was less than a meager US$ 10. Sadly, only 3 countries achieved the target African leaders agreed upon in 2001 and spent 15% of their national annual budget on health (as of 2002)); or the Eastern Mediterranean Region (EMR) where 44.2% of spending was out-of-pocket. These reports offer strategies on how to improve the situation, all revolving around the focal points of revenue collection, pooling and resource allocation, and streamlining the processes through a number of general measures. The EMR regional report is perhaps the most detailed, offering a small analysis of the alternative
health funding strategies and the advantages and disadvantages of each. Unfortunately, the disadvantages in common with government programs (targeting selected groups or comprehensive national/provincial public health plans), and private initiatives (social or community based or otherwise) is the direct relationship between the available funding and the establishment and inclusivity of the programme. Can low-income countries and their citizens afford comprehensive and equitable health coverage?

Experts would say: the answer to this question would depend on how one calculates the cost of such comprehensive and equitable health coverage. According to some authors, there is no settled estimation technique that can estimate the cost with perfect accuracy: some rely on the UN Millennium Project (MP) model (which calculates average unit cost per capita); others use the UNICEF Marginal Budgeting for Bottlenecks (MBB) model (which calculates additional resources required to remove health system bottlenecks); and even others rely on the elasticity estimates developed by the World Bank (this calculates expenditure per capita, with certain assumptions taken into consideration). Without delving into the finer technicalities of these estimation methods, they all show that the costs, per capita, necessary to achieve the MDGs and comprehensive healthcare are high – higher than the values that would easily satisfy even with reallocation of large portions of the GDP to healthcare. Some models even predict that for some countries, the portion of GDP allocated to healthcare should rise to values ranging from 8% to as high as 30% by 2015 to meet needs, which could reach values that supersede the total tax revenue-to-GDP ratio in some countries. These deficits are most obvious in the poorest of countries, naturally, and they are the states with the largest financial gaps; the largest discrepancies between the resources available and those required. Satisfying those needs can therefore be unrealistic in some instances without external funding and donor grants which are fraught with difficulties themselves.

Among the elements restricting the usefulness of external aid are fiscal sustainability, predictability, fungibility and absorptive capacity. Fiscal sustainability is the ability of the managing party to generate enough service costs and repay external debts. Time is an elementary factor when it comes to fiscal sustainability, and ensuring fiscal sustainability within a reasonable amount of time would depend on the grants themselves and their policies. Predictability is the faith a low-income country shows when it depends on the promise of continuing aid to fund long-term projects. The volatility of such grants and loans, however, are a barrier to the success of many such projects which delays overall progress in achievement of targets and provision of comprehensive care. The fungibility of aid can be best summarised as the diversion of funds to public expenditures other than those for which aid is intended. While this might achieve project-level targets, it shows poor responses on a larger scale, which is why many providers are increasingly suspicious of the effectiveness of aid in reaching its intended target groups. Absorptive capacity is the ability of a country to fully “absorb” and incorporate large sums of aid into their budgets and system, which might have physical or human resources as limiting factors instead. As a result, a country may therefore choose to allocate the scarce limiting resources from other uses that could be of better use for the country, to the supported project to satisfy donors’ needs for results – effectively creating bottlenecks in several processes. With large financial gaps and external financial aid riddled with difficulties, do low income countries still have hope in their ability to achieve the MDGs in time and in turn help achieve comprehensive healthcare? The road to achieving comprehensive healthcare in the poorest of nations is a rocky one. While the MDGs are just one step in the right direction, let us agree that nation development and general health promotion are both important contributing factors toward the achievement of that ultimate goal. And while external funding is a powerful tool that can help save people if channelled correctly, let us not forget that it is still a volatile method. And without collective donor commitments, strategically-calculated and adjusted grant conditions and transparent reporting, they are still short of their full potential. It can be argued that grants ought to be directed to fill governmental poverty gaps before focusing on more specific outcomes in a particular field or another. But on the other hand, perhaps more change should come from the countries and their policymakers. It is difficult to maintain comprehensive healthcare in countries plagued by wars and strife, as most low-income countries unfortunately are. In the words of Abraham Lincoln: “A nation that continues year after year to spend more money on military defense than on programs of social uplift is approaching spiritual doom”. Only time may answer the questions that have been raised here, but it is for the sake of the lives lost every day that we try, and try again, to make ends meet.

References


Medical Student International

medical students worldwide

9
The Emergency Room in the Dominican Republic

A right or a privilege?

Cristine Santiago

Our medical education integrates ethics as a key component for critical analysis and decision-making roles as future physicians. While we debate various controversial topics, my interest remains with the discussion of the public utilization of health care services: Is it a right or a privilege? The constitution of the World Health Organization (WHO) states that “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being…” However, as health care costs are escalating across the globe, does the utilization of health care services become a privilege? The following scenario describes my encounter with an elderly individual with co-morbidities who cannot afford basic health care services.

One afternoon, as I was walking with two friends to my university, we found my elderly neighbour, Doña Maria, sitting alone on a chair. She had just fainted, showing visible bruises and bleeding scrapes. As medical students, we provided first aid and asked her several questions for more details regarding the incident. Doña Maria mentioned that her family was not in the building and that her fainting episode was probably due to fasting during the religious holidays. Not compliant to her hypertension medications, she responded that her only “remedy” was home remedies recommended by friends. Since she was disoriented about time, we offered to take her immediately to the local hospital.

Maria responded: “For what? Since I have no health insurance, the doctors will not see me and will leave me waiting to die. I cannot afford health insurance, especially during these difficult economic times.” Just as Doña Maria was refusing to see a physician for her recent fall, her son arrived and took her inside the house.

After this scenario, I could not stop thinking about Dona Maria and other individuals in related situations, reflecting on health as an “unnecessary expense”. Naively, I thought that when you are sick, you visit a medical centre; however, I never considered the failure to visit a medical centre due to economic resources. For this reason, I wanted to learn more about the public health system in the Dominican Republic.

In the Dominican Republic, the Law #42-01 states that “Every single person has the right to emergency care in any facility of the National Health Service… with respect for their personality, human dignity and privacy, and freedom from discrimination on grounds of ethnicity, age, religion, social, political, gender, legal, economic, physical, intellectual, sensory or any other…” The development of public hospitals permits citizens to have access to health care services at extremely reduced economic costs.

When did we start to believe that visiting an Emergency Room was a privilege and not a right? In times of economic recession in developed and developing countries, we must become more aware about our national health policies that confirm health care services as a basic human right. As future primary health care physicians, we should educate our peers and community citizens that every individual has the right to receive medical attention. Remember, health is the best investment on the market!

References


International Dental Research Program [IDRP] 2012

an investment in the future of the dental research field

Pavel Scarlat

The Standing Committee on Research and Education within the International Association of Dental Students is proud to assure the successful continuity of the International Dental Research Program in 2012. It is the first worldwide dental research exchange network which aims to transfer and foster dental research knowledge to the ones who desire to make a difference within their dental communities.

The Program has achieved substantial development during the year of 2012, obtaining the support of overseas Universities which have agreed to receive international dental students to participate in a research project. The dental research projects offered as internships to dental students, cover the majority of the dental research fields. The Program got to the “doors” of International Association for Dental Research, asking for the honor of receiving the patronage over the Program. The Leaders of the IDRP dental research network have made presentations of it during the IADR South East Asia and Continental European Division Annual Meetings.

On an international scale, it is the first time to be honored of having as University partners from United States of America, Hungary, Poland, India and Turkey, along with the other countries (Universities) to which we are grateful for supporting the cause of initiating talented students into dental research.

The team which works on an international and national level over the development of the Program has extended. The Standing Committee on Research and Education is proud of consisting of new IADS National Scientific Officers from Portugal, Finland, Tunisia, United Arab Emirates, Iran, Slovakia and Italy, along with the already existing team to which we own the success and development of the Program.

“In my opinion the purpose of the International Dental Research Program is simply to make the impossible, possible. Many of our students through the world dream of scientific work abroad, but sometimes getting into the scientific research program is almost impossible. Here with our network we are able to collaborate, share our knowledge and within time I hope that in every IADS member country we will be able to conduct this program as it’s possibilities are bigger than we can now imagine.”

Magdalena Wilczak – IADS International Scientific Officer, Poland

“I think IDRP is an exchange program with more focused purposes. Students can gain the same experience as those who participated in the normal exchange with additional benefits of getting access to how the research is being conducted in other universities and countries.

I would say that IDRP is growing at a very steady and healthy pace, mainly due to the Founder, ISO and other local officers’ relentless effort in pushing the program to a newer height. In the next few years, I think it is safe to say that there will be more and more universities from different countries and even continents to join.”

Goh Seong Ling – IADS Local Scientific Officer, Malaysia, APDSA Treasurer

The dental worldwide community will achieve progress and development in a strong correlation with dental research, and what would help more than trying to foster and involve talented dental students since early student ages, into dental research activities. The International Dental Research Program guarantees that the today’s dental students will become the tomorrow’s Doctors who will lead dentistry to innovative and more successful treatments.
According to The Lancet, “Climate change is the biggest global health threat of the 21st century”. Yet, we tend to forget climate change when we talk of global health challenges. We think about malaria, tuberculosis, displaced populations, access to essential medicines, social determinants of health, and drinkable water. We start projects, build up campaigns and raise awareness on these issues – but what if we could link almost everything to the environment people live in? What if we also focus on tackling climate change at the same time?

Climate change is already having profound effects on health, with the WHO estimating it to directly cause over 200,000 deaths annually (McMichael et al., 2004). If we continue along the same path, this will escalate dramatically fast. One of the scariest things about climate change is that it will affect the most vulnerable people, those living in the poorest countries. They, who are the least responsible for climate change, will bear a far larger burden than citizens from the richest countries. Inequalities in social and economic development, education, accessibility and quality of basic health care, infrastructures and public policy, will play a crucial part in determining the national impact of climate change. Once again, the poorest populations will be hit the hardest.

Climate change will affect health in many ways:

• **Extreme Weather Events:** First of all, it will increase the number of deaths from heat-related causes. Do you remember the heat wave in Europe in 2003? More than 35,000 people died that summer, mostly in France, a country with an excellent healthcare system. Experts say that human-induced climate change has doubled the risk of heat wave. Oceans will warm up and this could contribute to increasingly severe hurricanes and cyclones with stronger winds and heavier rains. Just think of Katrina in the USA in 2005, Pakistan floods in 2010, Southeast Asian floods in 2011. The frequency of extreme weather events has increased six-fold in the last decade, with an accompanying rise in severity!

• **Famine, Drought and Malnutrition:** Climate change will also threaten the food supply of millions; as we can expect more droughts in some areas and increased rainfalls in others, damaging agricultural systems. Malnutrition will increase; mostly in poor communities, causing mortality and damaging child growth and development.

• **Mass Migration:** Stemming from this, many people will have to leave their houses as the result of environmental damages, rising sea levels, increased poverty and dependence on international aid. Recent studies indicate that there will be over 200 million climate change refugees by 2050.

• **Infectious diseases,** especially those transmitted by mosquitoes: malaria, dengue fever, yellow fever, West Nile Virus (WNV), and a lot more. Those diseases (and in fact any infectious disease influenced by the climate) will increase in their current regions but will also spread to new territories. For example, the WNV appeared for the first time in the USA in 1999. Last year, more than 667 people were diagnosed with WNV in the USA only. That’s a lot, right? We can also expect more diarrheal diseases, (such as typhoid) due to an increase of polluted water supplies.

• **And pollution?** Did you know that last year, air pollution led to more than 2 million deaths? If the current trends continue, there will be an increase of 2°C by 2050. This could result in 220 million more people at risk from malaria, 12 million more people at risk of hunger and 224 million more people at risk of water shortage (Global Health Watch, 2005). Isn’t that scary?

Climate change is the most serious threat we have faced throughout human history and will put a major stress on every health system. Sadly, very few leaders are prepared and ready to tackle this issue. Governments will face the urge to implement new strategies to fill the increasing needs of their population. At the same time, health expenditures will escalate. Achieving universal health coverage isn’t an option anymore. Political leaders will need to protect their population from catastrophic health expenditures if they want their people to stay healthy, to contribute positively to their societies. An integrated and multidisciplinary approach to reduce the adverse health effects of climate change...
change requires an appropriate public health to be put into place. Also, universal health coverage is crucial to the reduction of poverty and inequities in health, which are both essential to the management of health effects on climate change.

We, as young people and as medical students, have no choice but to act. As the WHO Commission on Social Determinants of Health states, “We need to bring the two agendas of health equity and climate change together”. Doctors must not only act as health care specialists, but as responsible members and leaders of their communities. If our political leaders are not ready to tackle the roots of the problem, then we must! We, as future doctors, have to ask our politicians to implement strategies that will benefit the health of communities worldwide. We need to talk more about universal health care.

It’s time to start thinking beyond a 4 year political mandate. Let’s not forget that good medicine is not only clinical care: it includes comprehensive prevention and promotion. And as Dr. Eugenio Villar said in a key note speak in the last regional meeting of PAMSA (Lima, January 10th, 2012), “MD students, have a moral responsibility to understand, and to the extent possible act upon the causes of health inequity both within medicine, and in society at large”.

Whether you like it or not, climate change is linked to health… Climate equals health. And it’s not too late to stand up for a healthy environment for all. We are now more than 7 billion living on Earth and it’s not space we need; it is balance. If we fight to reduce the impacts of climate change, if we fight to implement universal health care in every single country, if we fight for sustainable policies, we could save thousand and every single country, if we fight for sustainable policies, we could save thousand and millions of lives around the world. Isn’t our role as doctors, to save lives?

References


Hygiene practices within the hospital

A right or a privilege?

Xelenia DePeña

Once upon a time using gloves and practicing good hygiene habits in the clinical settings were of low priority. As the medical discipline continued to evolve, a plethora of routine medical procedures, such as childbirth and common surgical interventions. During the late 1800s, Dr. William Halsted, an American surgeon noted for his strict aseptic techniques and usage of gloves, took a special interest in the area. He came after his sister almost died after childbirth from an infection, because midwives would use the same birthing towels from mother to mother. This unsanitary hygiene practice was one of the etiological factors that propagated the spread of infections, causing deaths to mothers as well as infants, during or immediately after childbirth.

Universal precautions in the medical field is defined as putting into practice the use of nonporous pieces, such as medical gloves, goggles, and face masks, to avoid contact with patients’ bodily fluids. Today, our clinical practice aims to maximize infection control by using universal precautions, including hand sanitizers, touch-free sinks and sensory motion hand dryers. However, in many developing countries, unhygienic practices still commonly occur, due to reduced awareness or low socioeconomic conditions.

The following clinical scenario describes a medical student performing a common procedure in a hospital in a developing country.

As a second-year medical student, Maria is being supervised by her professor to draw blood from Dona Juana. When she asks for latex gloves, her professor states that there are no available gloves. During the procedure, Maria’s hands were exposed to Dona Juana’s blood, and Maria is later informed that Dona Juana was infected with the Hepatitis C virus.

Let’s consider two reflections regarding optimal hygienic practices in the clinical setting:
1. Our patients deserve the most sanitary and hygienic practices while they are at our health center to have a minor or major surgical intervention.
2. As medical professionals, we are the example to promote universal precautions and maximize infection control between health providers, clinical instruments and patients within the health center.

Since the microbial world expands beyond what can be seen with the naked eye, our clinical protocol should prevent, protect and provide the most sanitary environment possible for all patients who seek medical attention as well as health providers who interact with these patients.

Although we can debate the motives for the failure of health centers to follow universal precautions, the answer remains the same: Universal precautions save lives! Medical professionals risk exposure to many communicable diseases, which can easily be transmitted from accidental exposure or lack of protocol to comply with the use of latex gloves or masks. As future physicians, we should be advocates within our classrooms and clinical rotations for the mandatory compliance of universal precautions for increased infection control and safety for health providers, patients and families.

References


Universal Health Care

Achieving Health Equity in the Philippines

Ramon Lorenzo Luis R. Guinto, MD

In the recent 65th World Health Assembly in Geneva, Switzerland, Dr. Margaret Chan, the Director-General of the World Health Organization, expressed her unwavering confidence in universal health coverage, not just once but twice. In her opening speech, she called it as “the single most powerful concept that public health has to offer”[10]. Later during the week, she said in her acceptance speech, after her re-election for a second term, that “universal coverage is the ultimate expression of fairness”[12].

With these messages of support hailing from Geneva itself, there is no doubt that universal coverage will remain central in the global health agenda in the coming years. In the recently-concluded United Nations Conference on Sustainable Development, fondly called Rio+20, the global health movement even boldly pushed for the inclusion of universal health coverage in the outcome document “The Future We Want”[9]. Today, a worldwide momentum in favor of universal coverage is building, with nearly a hundred countries experimenting on various models of health care financing and delivery[4] and learning from each other’s experiences through joint learning initiatives[3].

Health inequalities in the Philippines

The Philippines is one of the countries embarking on this global race to universal coverage. Now a country of 92 million, the Philippines has recently renewed its commitment to reduce health disparities that have been killing lives and lingering for decades.

The present statistics are dismal. Six of 10 Filipinos who succumb to illness die without seeing a health professional[8]. Inequities between geographic regions and income groups are equally glaring. For example, despite the national infant mortality rate being halved from 1990 to 2008, the disaggregated rate in rural areas remains almost double as that in urban areas[7]. The Philippine Department of Health also recently announced that the country will be less likely to meet Millennium Development Goal 5 on maternal health, as the maternal mortality rate even increased from 162 for every 100,000 live births in 2008 to 221 in 2011[8].

For decades, the Philippines has been struggling to realize the right to health of all Filipinos, which is guaranteed by the Constitution. Various models of health care financing and delivery have been tried out, but none of them succeeded in providing accessible and affordable health care to all Filipinos. At present, every citizen is required by law to be enrolled in the National Health Insurance Program administered by the Philippine Health Insurance Corporation (PhilHealth), the health financing agency attached to the Department of Health[9].

However, despite the presence of a mandatory social health insurance program, coverage has only been anywhere between 30-80% of the total population, the huge variation of which is highly dependent on the source of data[6,10]. Fifty-four percent of total health expenditures come from out-of-pocket sources, while PhilHealth only contributes 9%(11). Due to catastrophic expenditures during an illness, an estimated 250,000 families eventually sink below the poverty line each year[11].

The Aquino Health Agenda

This grueling situation welcomed President Benigno Aquino III when he was elected in 2010. Hence, his administration placed health high in his political agenda, something that has not been seen in the previous administrations for decades. In his first State of the Nation Address, the president even committed to achieve universal PhilHealth coverage by 2013[13].

The “Aquino Health Agenda” that was launched during the election campaign later metamorphosed into the current Department of Health’s Kalusugang Pangkalahatan, the Filipino phrase for “universal health care.”

The government adopted the comprehensive definition of universal health care developed by the Universal Health Care study group based in the University of the Philippines: “the provision to every Filipino of the highest possible quality of health care that is accessible, efficient, equitably distributed, adequately funded, fairly financed, and appropriately used by an informed and empowered public”[14].

The current administration’s version of universal health care is summarized into three overarching thrusts: expansion of PhilHealth coverage in terms of both enrollment and benefits; enhancement of hospitals and primary health care centers through public-private partnerships; and attainment of health-related Millennium Development Goals (MDGs) by targeting public health interventions onto disadvantaged
families [15].

**Current progress**

At present, the Philippine government, particularly PhilHealth, is gradually implementing the insurance expansion plan, aiming to sponsor the membership of the poorest 11 million families by 2016. Early this year, it also began to implement a “no balance billing” scheme which prevents the sponsored families to spend out of pocket at the point of care[16]. Other reforms, including the addition of outpatient benefits in response to increase in the prevalence of non-communicable diseases, are now being explored by the social health insurance agency.

On the other hand, while private sector partners have already been tapped to invest in the improvement of some public hospitals in Manila, the move has been criticized by some civil society groups as paving the way to privatization of health care[17]. And while there remains a slim chance to reach the target reduction for maternal mortality, the Philippines is positive that it will reach the other health-related Millennium Development Goals like reduction in child mortality and cases of HIV-AIDS, tuberculosis, and malaria[18].

**Universal health coverage versus universal health care**

One can note that the Aquino administration adopted the term “universal health care” instead of the more popular term “universal health coverage,” which is used in most literature on health financing reform. The term “universal health coverage” was defined by the World Health Assembly in 2005 as “access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost”[19].

On the other hand, universal health care connotes that the restructuring of health systems is more than just an issue of health financing (implied by the word “coverage”). Instead, universal health care requires major reforms in all six “building blocks” of the health system as enumerated by WHO, namely [20]:

1. **Leadership and governance** marked by effective oversight, coalition building, provision of appropriate regulations and incentives, attention to system-design, and accountability;
2. **Service delivery** of effective, safe, quality personal and non-personal health interventions to those who need them;
3. **Health workforce** which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances;
4. **Medical products and technologies** of assured quality, safety, efficacy, cost-effectiveness, and availability;
5. **Health information** that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status, and;
6. **Financing** system that raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them.

The two terms are not mutually exclusive – universal coverage can be even seen as a key component of the greater goal of universal health care. Ultimately, being covered by a health financing scheme does not automatically mean receiving the care when in need. The miserable level of health indicators such as infant and maternal mortality is one manifestation of the inability to translate insurance coverage into positive health outcomes.

Hence, the Philippines must go beyond its current three-pronged approach (that exerts intense focus on health financing), and instead adopt a holistic health systems framework covering all the vital elements towards the realization of universal health care.

**Action on social determinants of health**

What the Philippine government and all governments should also not forget is that efforts geared towards achieving universal health care will only be successful if placed in the context of action on social determinants of health – the conditions in which people are born, grow, live, work, and age.

In 2008, the WHO Commission on Social Determinants of Health released the landmark report entitled “Closing the Gap in a Generation” – the very objective of universal health care[21]. In fact, the Commission identified universal access to health care as...
an important determinant of health that needs to be addressed.

However, the Commission did not stop there – it called on governments to act on more “upstream” determinants of health inequalities such as social policies, economic arrangements, and ultimately the inequitable distribution of power, money, and resources within societies and at the global level.

Certainly, acting on the social determinants will reinforce the equalizing power of universal health coverage. Healthy urbanization protects people from road injuries and pollution-related diseases, thereby reducing the disease burden on the health system and saving more money for more health. Expanding access to education and developing life skills in early childhood lead to productive citizens that can grow economies in order to increase investments for health promotion and disease management. Adopting health impact assessments in trade negotiations improve access to essential medicines and other healthy products especially those coming from other countries.[22]

Countries on the road to universal health care such as the Philippines are still yet to enshrine and implement these “whole-of-government” and “beyond-the-health-sector” measures, an example of which is the “Health in All Policies” being implemented in South Australia and other countries.[22]

The way forward

Presently, the Philippines is also implementing a conditional cash transfer (CCT) program which was modeled after similar programs in Brazil and Mexico[23,24]. The CCT aims to provide cash assistance to the poorest families to alleviate their immediate need and ultimately to break the intergenerational cycle of poverty through investments in human capital.[25]

Although administered by another government agency – the Department of Social Welfare and Development, the program works in tandem with the Universal Health Care agenda, since the families enrolled in PhilHealth under the sponsored program are also the ones receiving cash assistance. In addition, recipients have to fulfill certain conditions related to health and education, such as regular preventive health check-ups for children 0 to 5 years old, prenatal check-ups for pregnant mothers, and attendance of children in elementary schools.

However, the impact of CCT on poverty alleviation and ultimately human development are still yet to be measured in the coming years. Furthermore, addressing the social determinants of health does not only mean designing interventions targeted to the least advantaged, but also acting on the factors affecting the entire social ladder.

The Philippines still has a long way towards achieving universal health care – not just the goal defined by numbers, but the highest state of well-being, security, and satisfaction that every Filipino family deserves and must achieve. A government can make false claims and academics may attempt to quantitatively measure the current status, but it is the people that can truly judge if we as a society have succeeded in making the humanitarian vision of universal health care a reality.

References


Towards better health care

Jihad Abdelgadir Imam

The public continues to view doctors as the most trusted of professionals, and the key values of professionalism continue to underpin the daily life of medical practitioners. However, significant changes in the society, medicine, and health service delivery have occurred over the years, where some of these changes (e.g., patients’ expectations) have inevitably influenced the roles and responsibilities of doctors along with the knowledge and skills needed to fulfill these roles. Physicians find it increasingly difficult to meet these responsibilities to patients and society. This reaffirms that the fundamental and universal principles and values of the medical profession are increasingly important.

Medical advancement should always be coupled to professionalism; the fundamental stone in the doctor-patient relationship. The practice of medicine in the modern era is beset with unprecedented challenges in virtually all cultures and societies. These challenges center on increasing disparities among the legitimate needs of patients, the available resources to meet those needs, the increasing dependence on the market to transform health care systems, and the temptation for physicians to forsake their traditional commitment to the primacy of patients’ interests. To maintain the fidelity of medicine’s social contract during this turbulent time, physicians must reaffirm their active dedication to the principles of professionalism, which entails not only their personal commitment to the welfare of their patients, but also their collective efforts to improve the health care system for the welfare of society.

For many, medical professionalism is the “heart and soul of medicine.” More than just medical ethics, it is the daily expression of what originally attracted them to the field of medicine—a desire to help people and society as a whole by providing quality health care. However, today, many physicians experience profound obstacles to fulfill the ideals of medical professionalism in practice.

Medical profession everywhere is embedded in diverse cultures and national traditions, but its members share the role of healer and understand the complicated political, legal and economic forces. Moreover, there are wide variations in medical delivery and practice, through which these general principles may be expressed in both complex and subtle ways.

Since the 1980s, many people and organizations have increasingly emphasized the role of medical ethics and professionalism in the education and training of physicians. In response, many medical schools have developed programs to teach these topics to new physicians. Ethics training has shown to have a significant influence on the professionalism and moral qualities of medical professionals. Various methodologies have attempted to promote ethical conduct in health professionals, using strategies, such as lectures, small-group seminars, role-playing exercises, directed reading, and one-on-one observation and counseling. Despite these efforts, both the public and health leaders have been concerned about recent reports of unethical and unprofessional behavior by resident physicians.

We ask: Where does the problem of unethical and unprofessional behavior come from? Is professionalism in the medical curricula sufficient? Do we have ineffective teaching methodologies? Do health workers sense the low priority of professionalism?

The overwhelming truth is that medicine has become so specialized that doctors have become incapable of viewing a patient holistically. According to their specialty, they are only able to consider the particular organ or body system, relying on technology, rather than the patient’s words or physical examination. As the patient’s mental and emotional state, lifestyle habits, age, and need to rest are often overlooked, the patient’s welfare is often sacrificed for physician convenience. However, physicians do not understand that by shortening the physical examination and ordering numerous tests, they fail to listen to the patient and tend to overlook simple diagnoses. They lose the power of the human hand to touch, to comfort, to diagnose and to bring about treatment. Is it too much for patients to expect physicians to sit down, relax, calm them, listen and explain the issues in terms they should be capable of understanding? The obvious answer is no, but the reality is far different!

As future physicians, we should all remember that patients are human beings before everything, and appreciate the practice of the history and physical examination, which represents the corner stone of the doctor-patient relationship. Remember, healthcare is not only about the right diagnosis or access to medicine; it is also about the human touch of the physician.
Female Genital Mutilation (FGM) is any procedure involving the partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons. There are four main types of FGM according to the World Health Organization classification, Type I being the mildest form and Type IV being the most severe.

FGM is a traditional custom since antiquity that is practiced mainly in Africa and in some parts of the Middle East and Asia. Amnesty International estimates that over 130 million women worldwide have been affected by some form of FGM, with over 3 million girls at risk of undergoing FGM every year.

The exact origin of Female Genital Mutilation is not quite clear, but many believe that it dates back to the Pharaonic rule in Egypt. Story has it that one night the Pharaoh had a dream that a man would be born among the Jews who would bring his throne to the ground. In order to ensure that no male would be born without his knowledge he circumcised all the women and that way a midwife would have to be there during the time of birth and thus will kill all the boys born.

Others also believe that it originated in the time of the Pharaohs but for a different reason. Pharaohs believed in the bisexuality of their gods and accordingly mortals (reflecting the traits of their gods) possessed both a male and female soul. The feminine soul of the man was located in the prepuce of the penis and the masculine soul of the woman was located in the clitoris. For healthy gender development, the female soul had to be excised from the man and the male soul from the woman and thus all mortals must be circumcised.

Ever since then there has been great controversy and debate regarding the legitimacy of such practice and people all over the world have been trying to pinpoint the main reasons behind the continuous practice FGM and basically narrowed it down to one of two reasons; religion or tradition.

TRADITION: Many of people in countries where FGM is common say that it is done because they are simply following the traditions of their forefathers. They believe FGM is essential for the preservation of the woman's virginity and that without it she is likely to go astray and become ineligible for marriage. There are even stories of women being married and then "returned" when found to be uncircumcised, either indefinitely or until she gets circumcised.

Some believe that a man gets more pleasure out of having sexual intercourse with a woman who is circumcised and since, in their point of view, a woman's main job is to satisfy her husband then she should accordingly be circumcised. They commonly perform Type III FGM which is also known as the Pharaonic type.

RELIGION: The majority of circumcised females are Muslims. Many Muslims believe that it is a Sunnah (one of the ways or saying of the Prophet, which Muslims use as a guide through their own lives). Most of the sources they resort to in this case are weak ones, with broken chains of transmission or poor in authenticity. The UNICEF reported that: "... Al-Azhar Supreme Council of Islamic Research, the highest religious authority in Egypt, issued a statement saying FGM/C has no basis in core Islamic law or any of its partial provisions and that it is harmful
and should not be practised.” A point that is often overlooked by Muslims who believe in FGM is that surely if the Prophet believed in circumcision then all his wives and daughters would be circumcised, but none of them are. Those who perform FGM for religious reasons usually perform Type I, which is also referred to as the “Sunni” type.

The complications of FGM are numerous and some even fatal. Because FGM is usually performed using unsterile items such as broken glass, scissors, razor blades and sharp edged rocks pelvic inflammatory disease (PID) and urinary tract infections (UTI) are common among circumcised women. Severe pain, shock, haemorrhage, urine retention, ulceration of genital region and injury to adjacent tissue Infection are but a few of the immediate complications of FGM. More long term complications include dermoid cyst and keloid formation, difficulties in menstruation and urination and the increase need for episiotomies or even C-sections for all deliveries. The above reasons and the psychological consequences of undergoing such a traumatic procedure at such a young age, usually under NO anaesthesia, are some the main reasons why FGM should not be performed under any circumstances.

The World Health Organization and the International Federation of Gynaecology and Obstetrics have opposed FGM as a medically unnecessary practice with serious, potentially life threatening complications. The American College of Obstetricians and Gynaecologists and the College of Physicians and Surgeons of Ontario, Canada, also opposed FGM and advised their members not to perform these procedures. In 1995 the Council on Scientific Affairs of the American Medical Association recommended that all physicians in the United States strongly denounce all medically unnecessary procedures to alter female genitalia, as well as promote culturally sensitive education about the physical consequences of FGM. The American Academy of Paediatrics believes that paediatricians and paediatric surgical specialists should be aware that this practice has serious, life-threatening health risks for children and women. The AAP opposes all forms of FGM, counsels its members not to perform such ritual procedures, and encourages the development of community educational programs for immigrant populations.

FGM has been characterized as a practice that violates the right of infants and children to good health and wellbeing, part of a universal standard of basic human rights and is now considered illegal in many countries all over the world. Though people are subject to criminal prosecution FGM is still being performed!

In conclusion, whether it’s under the guise of religion, tradition or for no reason at all FGM is a harmful unnecessary violation of human rights which has absolutely no benefits or legitimate reason for it. People all over the world should stand together as one in the moral battle against FGM, by not only increasing the severity of the punishment against those who perform FGM but also increasing the awareness of people in communities where FGM is still being performed.
Universal Access to Healthcare

NIGERIA’S FAILURES AND TRIUMPHS

NJOKU KINGSLEY KALU

Nigeria has 36 states plus the Federal Capital Territory, comprising 774 Local Government Areas (LGAs). There is considerable political and fiscal decentralization, and health is a concurrent responsibility of all three tiers of government—federal, state, and local[1]. The federal government of Nigeria pays 100% for traditional vaccines as well as the Hepatitis B vaccine, and co-pays for newer Global Alliance for Vaccines and Immunisation (GAVI)-supported vaccines. Through the National Primary Health Care Development Agency (NPHCDA), the federal government provides vaccines, immunization guidelines and technical support to the states and LGAs. State and local governments are responsible for funding and implementing immunization programs at the sub-national level. The journey of Nigeria to ensure universal health care has been an interesting story that reflects the determination of a country struggling to reposition itself in the league of Nations.

In a strict sense, the concept of universal health care may not be applicable or understood in Nigeria. The efforts of the Nigerian governments at immunization universal coverage alludes to our determination to gradually aim toward the concept of universal access to health, starting from birth.

On September 12, 1978, following a joint conference on Primary health care sponsored by the World Health Organization (WHO) and the United Nations (UN) in Alma-ata, Russia, Nigeria clearly recognized the importance to align the direction of achieving a state of physical, mental and social-wellbeing for all citizens.

Efforts were made to follow the policy guidelines from the conference, leading to the establishment of the Basic Health Service Scheme (BHSS)[2]. Several basic health units, each comprising of one compre-
prehensive health center, four primary health centers, 20 health centers and five mobile units), were organized in each state. The goal was to ensure that there was universal access to health care. Although the BHSS was initially successful, it failed toward the end of the planned period.

With the launching of the National Health Policy in 1988, a national primary health care system was adopted, using the district health system approach to ensure a self-reliant health care delivery to the entire population. This further demonstrated the willingness of the Nigerian governments to achieve universal access to health care.

As effective as all these programs appear, it fails to guarantee health care for each Nigerian citizen. Infant and maternal mortality as well as all mortality indexes have soared[3].

As resilient as their citizens, the Nigerian governments continued to look for ways to further ensure affordable health care for all. Health leaders have continued to review existing policies for more effective policy frameworks.

In 1999, Nigeria took a bold step toward ensuring health for all. Under the decree of the Federal Military Government, the National Health Insurance Scheme (NHIS) was born! It marked a great milestone in the country's quest for affordable health care for all citizens, cutting across all social strata. Although the list continues to expand, incorporating further segments of society, some packages under the NHIS[4] included: Formal Sector Social Health Insurance Program, Urban Self-employed Social Health Insurance Program, Rural Community Social Health Insurance Program, Children Under-Five Social Health Insurance Program, Permanently Disabled Persons Social Health Insurance Program, Prison Inmates Social Health Insurance Program, Tertiary Institutions and Voluntary Participants Social Health Insurance Program, Armed Forces, Police and other Uniformed Services.

We realize that we may not achieve the statistics of North Europe or the United States, but we have demonstrated a desire to work hard to achieve universal access to health care. With the conclusion of the Rio+20, Nigeria hopes to further adapt to ensure universal access to healthcare for all citizens.

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An Omnipotent Card of Taiwan

How a small card achieves the top universal health care system in the world?

Po-Liang Chen

What can a gardener do when his fingers are cut off by a weeder accidentally? What can a young woman do when she is declared that she gets a malignant tumor? Should they check with their insurance companies to make sure that their insurance cover the accidental injury or cancer beforehand? Do they have to make sure how much money the insurance companies will actually give them first before they get any medication or surgery? In some countries, the answer is absolutely YES. However, in Taiwan, they can just go to hospitals and get quality medical services immediately.

How can people in Taiwan obtain medical care without checking their insurance? How can they afford the high quality medical services? Well, that is because most people in Taiwan have been forced to join a health insurance, called National Health Insurance (NHI), which was founded by Taiwan government, since the day they were born. Since the government implemented the National Health Insurance Act in 1995, the medical condition has been tremendously changed since then.

How does the NHI system work? According to the National Health Insurance Act 1995, amended in 2011, all the qualified citizens in Taiwan are arranged into six different insured categories first—according to their occupations and fixed incomes (children are ordered into their guardians’ category). The Bureau of National Health Insurance calculates how much the insureds of each category shall pay then. And the insureds and the group insurance applicants shall pay for the premiums together every month- based on the insurance contribution rates calculated by the authority. For example, insureds of the first category, including civil servants, teachers, etc shall pay 30 percent of the premium, and the other 70 percent is paid by the group insurance applicants.

After paying the premium, all the insureds will be issued “insurance IC cards” then. And the insureds can enjoy the medical services by registrating with their cards and paying the cheap copayment each time after a medical service is accessed. And the major part of money will be paid by the Bureau of Health Insurance and the premiums from insureds and group insurance applicants.

Patients in Taiwan no longer have to pay large amount of money to get medical services owing to this amazing insurance policy.

With this system, both of the finger-cut gardener and the young woman with cancer mentioned above, can bring their insurance IC cards to every hospitals in Taiwan, and register in hospitals directly and instantly. Most of time, they can get examinations or treatments within hours.

Thanks to the NHI system, it has elevated the accessibility of medical services in Taiwan. Thanks to the NHI system, people can get the highest quality medical services with relatively lower prices. Thanks to the NHI system, people can go to hospitals anytime and register to whatever division in hospitals with their insurance IC cards. Thanks to the NHI system, patients can register to many divisions and get various medical services at once.

And thanks to this socialistic policy, the medical system in Taiwan seems to be driven toward to an irreversible end in the predictable future.

When people can access most of medical services by bearing very small amount of medical expenses, the
government has limited hospitals and medical practition-ers’ incomes by a novel system called globle budget payment system[1] to balance the income and expenses.

Under this system, the government gives a fixed amount of budget for most medical services every year. Which means that medical practitioner cannot get fair remunerations by what they have done. On the contrary, the more patients they treated, the less remunerations they can get from each case due to the the fixed budget. Moreover, the global budget payment system cut prices of medical services down because of the limited budget. For example, it would cost thousands of U.S. dollars to have a caesarean section in other countries; however, Hospitals and doctors are paid 300 U.S. dollars by the Bureau of National Health Insurance only. And to the expect-ant mother, she just has to bear a few money for this surgery by herself.

When medical services become cheap and easily accessible, more and more patients do not go to clinics first, but directly go to medical centers—even if their symptoms and diseases can be treated in local clinics; More and more pseudo-patients gather in hospitals to have unnecessary medical services. This is all because people who are in the insurance system bearing very small part of both registration fees and medical expenses. As time passes by, more and more citizens in Taiwan take all the benefits they have for granted, and have become even more greedy and irrational recently.

Medical resources are wasted in numerous unnec-esary medical services, and the people in need cannot get immediate and well medical care owing to the fact that many patients come to hospitals and medical centers because of the cheap copayments, while they can easily solve their problems in local clinics.

When patients gather in hospitals without any limitation, medical practitioners are often overloaded and overwhelmed. The more patients one doctor should take care of, the less time that he/she can spend in one patient; the more hours doctors should work, the higher risk they would make mistakes during the entire procedure. Under such condition, there are more and more doctors sued for making mistakes because of overtime working in Taiwan.

Without rational working conditions and remu-nerations, many of them choose not to practice medi-cine in some high-risk departments, such as surgery, internal medicine, etc. Worse still, more and more doctors choose to leave to other countries or change their careers forever.

To address such problems, some medical-issue-concerned and medical-practitioner-related organiza-tions have started to review this social welfare policy recently. They also question whether the NHI system is suitable for Taiwan, and whether the copayment rates and globle budget payment system are actually fair or not. Furthermore, does this insurance system make medical practitioners be overloaded and over-whelmed indirectly? And, does it lead to the shortage of doctors, nurses, pharmacists in hospitals?

A small card has changed Taiwan into a fairer and healthier country, a small card make citizens enjoy the convenience to access medical services wherever, whenever, and whatever people are needed. To this point, people cannot live without this national health insurance system anymore. Hence, all problems above are now urged to be solved in this country to make this policy be sustainable.

Today, the authorities are seeking for a modified NHI policy to correct those problems and to try to improve the working environment for medical pract-itioners. As medical students in Taiwan, we are look-ing forward to see a better and fairer working condi-tions, and a mature and career-respecting society in the future.

References
Health systems
Can you be an active member of the health system without knowing about them?

Marien Báez Jiménez, Irene Díaz Vásquez and Adriel Guzmán

Health systems have existed for more than a century, ever since citizens have tried to protect their health and treat disease. This article aims to review the concept of health systems, including the definition, function and historical development as well as following the World Health Organization (WHO) recommendation that these systems should improve their function within society.

Historical context
For thousands of years, ancient civilizations, like the Egyptian, Hebrew, Chinese, Greek and Roman, employed lifestyle changes for aesthetic, curative and preventive purposes, and spiritual activities to promote physical and mental health. Modern health systems arose from basic designs created in the 19th century, influenced by the Industrial Revolution and the Social Security laws implemented in Germany, the United States, Japan and Denmark[1]. Each country recognized the high costs produced by illness and death, whether by conflict, wars or international collaborations (e.g. Panama Canal).

Since the late 19th and early 20th centuries, three models were identified to better care for citizens. The first model intended to cover all, or the majority, of the citizens through compulsory payments by the employer and employee to insurance or sickness funds, while the services were supplied by both public and private providers. The second model centralized planning and funding and depended primarily on income tax and the provision of services by the public sector, where resources were allocated through budgets by the number of residents, workers and health facilities. The third model included substantial, but limited, federal involvement, where coverage was given to certain population groups, while the remaining citizens depended heavily on the private sector, which provided funds, paid services and owned the facilities. Overall, the structure applied that best facilitates the performance of the health system function is key, rather than the exact model type.

Definitions
The World Health Organization (WHO) described a health system as a set of all organizations, institutions and resources that are devoted to maintain and improve health activities in a good and impartial way[2]. In this sense, a health system is considered good, if it responds well to the citizens’ expectations, and impartial, if it does not discriminate against any factor.

Role of the consumer
Although the main objective of health systems is to provide health services to improve population health, several challenges exist in our society. These include low salaries for health professionals, lack of qualified health care staff, and lack of pharmaceutical and medical supplies. In fact, the real issue lies in the lack of assignation of health care priorities and the respective organization of health care services.

In health systems, several individuals interact to facilitate the process. The patient can resemble the affected population or the consumer, seeking the need
for health care services. Through this method, the patient has a contributor relationship with the health care provider to fund the services. As suppliers, any individual can assume the patient role at any time point, which may complicate health care services offered because disease risks vary by age, population and other biological or environmental exposures.

**Selection of health services**

Although offering health services most needed by the population percentage and age is the most appropriate, it is not so simple. Each case requires review of the interventions, activities and equipment, toward the benefit of the patient and cost associated with the effective interventions and related patient outcomes through morbidity or mortality rates.

Proper selection of interventions, procedures and activities should be financed based on the available budget. Although the common strategy is to utilize interventions that are inexpensive toward reduced health care costs, our goal should be high-quality, cost-effective prevention strategies\(^3\). If our society can promote prevention strategies, the increased cost allotted for prevention may ultimately reduce future health care costs related to treatment.

**Financing of the health system**

Although modifying the health care focus to prevention will comply with the goal to improve population health, it does not necessarily impact the second health goal toward reduced inequality\(^1\). A health system should aim to achieve horizontal and vertical impartiality, where there is equal treatment to all persons with the need for health services, favoring those individuals with the greatest need. This does not mean that the healthy individuals should subsidize the sick individuals, but rather that the financing burden should be distributed fairly, which requires an expenditure of public funds for the poor\(^3\).

Health services can be organized in three fundamentally different ways: 1) hierarchical bureaucracies; 2) long-term contractual agreements subject to a degree of independent control of the market; and 3) short-term, market-based direct interactions between patients and service providers\(^2\). These methods can be combined as needed on the present demand and market interaction, and the configuration of services can be dispersed, concentrated (e.g. hospitals) or a combination.

The provision of health services requires that the various financial resources are distributed evenly, while available resources are assigned to both investments in maintenance of existing infrastructure and training in new fields, facilities and equipment. In practice, decisions should be based on reducing imbalances and providing policy guidance and clear incentives to buyers and service providers, so that they develop effective practices in response to the health services needs and expectations.

The financing of the health system is intended to ensure funds for access to effective public health services and individualized health care for all citizens.
To guarantee that all citizens have access to health services, three functions are essential: 1) Revenue collection, where the health system receives capital from families, organizations or donors; 2) Pooling of resources, which accumulates income in a common fund; and 3) Purchase of interventions, where providers are paid with funds allocated to provide a set of health interventions\(^4\). Both public and private financing are associated with advanced payments and large pools that maintain population health and fair allocation of services, allowing the visualization of high cost services as well as offering protection against out-of-pocket expenses.

**Challenges in the health system**

Currently, health care users have limited access to services once their personal funds are reduced. Some individuals, including the elderly or chronically ill, are considered high-risk and often denied access to services for their limited personal funds. One solution is that low-risk individuals (e.g., young, healthy) can make advanced payments over the lifespan, when those services are rarely needed, which would permit funds when those services would be required\(^1\). This method would allow cross-subsidies from healthy young individuals and elderly or chronically ill individuals, benefiting the latter without prejudice to the former.

Health systems attempt to disperse risk and subsidize the poor, through combinations of organizational and technical arrangements. They ensure that the interventions help improve the system responsiveness and financial equity through strategic purchasing. Since the best interventions, suppliers, methods, payment and treatment should be utilized, they should consider: Which interventions should be purchased? Who should we select as our supplier? What is the strategy for our purchase?

The citizens help sustain the health system with payments from personal funds obtained from the following organizations: Ministry of Health, Social Security agencies, community organizations or dependent pooling of providers, and health insurance private funds\(^2\). System performance should have good equity and efficiency, if the pooled resources are used wisely to purchase the best combination towards health achievement optimal expectations.

**The role of the government**

The role of a responsible government is to provide for the population’s welfare\(^4\). The Ministry of Health guides the development and implementation of health activities within the country. Unfortunately, the Ministries of Health of low- and middle-income countries are often poorly managed within the public sector, since they neglect the important goal of population health. Since the Ministries of Health may ignore any violated regulations, health policy must enforce the proper execution of laws, regulations, decrees and ordinances to establish short- and long-term parameters, describe priorities and inform the public. Regulations are the responsibility of the Ministries of Health and Social Security agencies, so that solid rules enforce proper function and management of the health systems.

Brazil is one of many low and middle-income countries that have adjusted financing systems so more people can access health services. [Emergency Unit, Manguinhos, Brazil.]
The leadership role

The leadership role in health systems is critical to maintain a solid vision that upholds the goals and appropriate decision-making at the highest level based on the scientific evidence. Effective leadership is a great challenge in many countries, misusing power and limiting the full potential to achieve the responsiveness and equity in financing. One solution for optimal organizational performance includes rectories within the government, for systems to manage health care service delivery, resource generation and financing[2].

Summary

In brief, the three basic goals of health systems are improving health, responding to the legitimate expectations of the population and fairness of financial contributions[2]. To achieve these purposes, four basic functions of health systems must be met, including service delivery, resource generation, financing and leadership. From the various fields within the domain of health, we acknowledge that without full knowledge of these respective goals and functions, no individual or group can work actively and effectively toward optimal performance within the health system. The worst part is that they cannot get to know where they can be affected to prevent damage in time. Just as a human body, where structure and function are critical to seek early medical advice or treatment based on any abnormal findings, a health system should be monitored to identify any errors that can be managed or fixed. After all, since prevention reduces costs and improves quality of life, the universal health system should care for all its citizens, address the population’s needs and ensure optimal function, toward benefit for all citizens.

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