Disuguaglianze di salute: politiche sanitarie e non sanitarie

30 maggio 2019

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e

ASviS – Alleanza Italiana per lo Sviluppo Sostenibile

CENTRO NAZIONALE PER LA **SALUTE GLOBALE**
ITALIAN CENTER FOR GLOBAL HEALTH


1920
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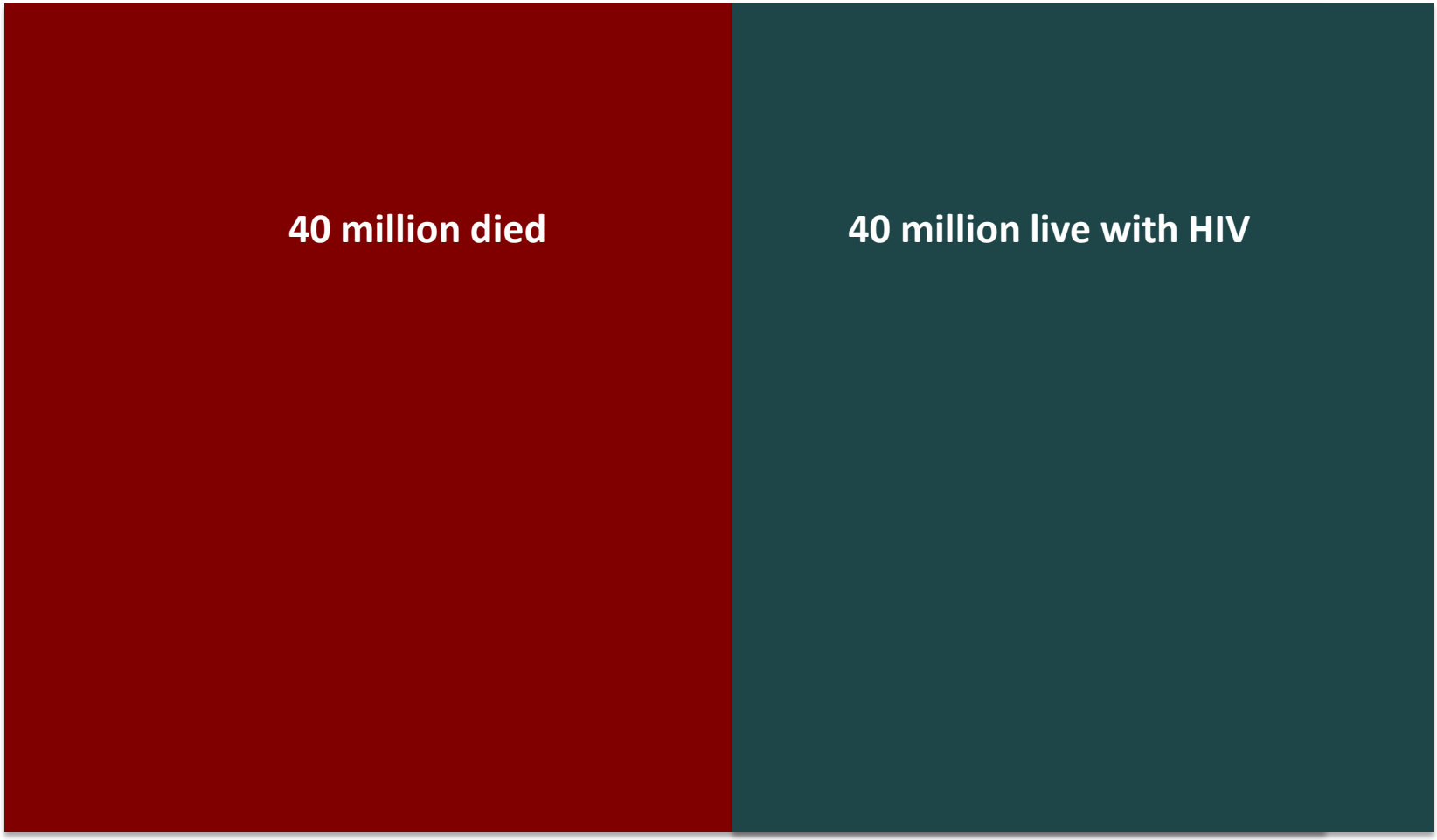
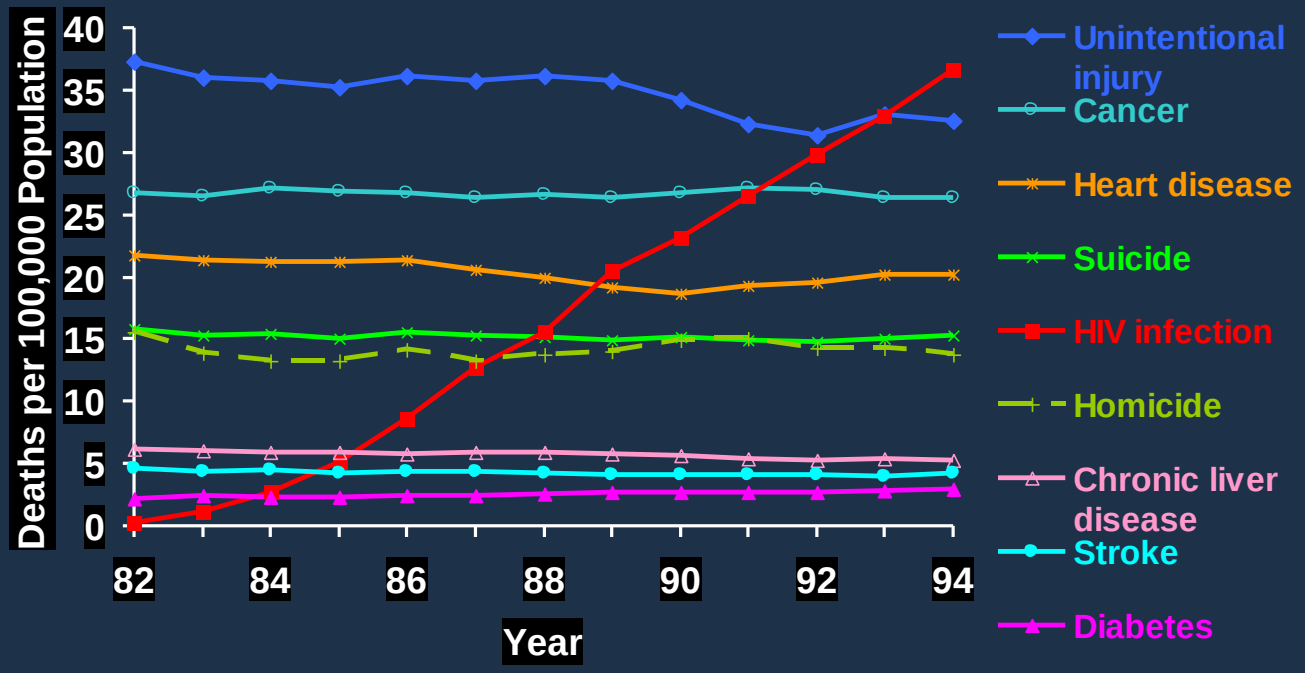
UN IMPATTO DEVASTANTE IN POCHI ANNI



Trends in Annual Rates of Death from Leading Causes of Death Among Persons 25-44 Years Old, USA



Antiretroviral Therapy for HIV Infection in 1996

Recommendations of an International Panel

Charles C. J. Carpenter, MD; Margaret A. Fischl, MD; Scott M. Hammer, MD; Martin S. Hirsch, MD; Donna M. Jacobsen; David A. Katzenstein, MD; Julio S. G. Montaner, MD; Douglas D. Richman, MD; Michael S. Saag, MD; Robert T. Schooley, MD; Melanie A. Thompson, MD; Stefano Vella, MD; Patrick G. Yeni, MD; Paul A. Volberding, MD; for the International AIDS Society–USA

Objective.—To provide clinical recommendations for antiretroviral therapy for human immunodeficiency virus (HIV) disease with currently (mid 1996) available drugs. When to start therapy, what to start with, when to change, and what to change to were addressed.

Participants.—A 13-member panel representing international expertise in antiretroviral research and HIV patient care was selected by the International AIDS Society–USA.

Evidence.—Available clinical and basic science data, including phase 3 controlled trials, clinical endpoint data, virologic and immunologic endpoint data, interim analyses, studies of HIV pathophysiology, and expert opinions of panel members were considered. Recommendations were limited to drugs available in mid 1996.

Process.—For each question posed, 1 or more member(s) reviewed and presented available data. Recommendations were determined by group consensus (January 1996); revisions as warranted by new data were incorporated by group consensus (February-May 1996).

Conclusions.—Recent data on HIV pathogenesis, methods to determine plasma HIV RNA, clinical trial data, and availability of new drugs point to the need for new approaches to treatment. Therapy is recommended based on $CD4^+$ cell count, plasma HIV RNA level, or clinical status. Preferred initial drug regimens include nucleoside combinations; at present protease inhibitors are probably best reserved for patients at higher progression risk. For treatment failure or drug intolerance, subsequent regimen considerations include reasons for changing therapy, available drug options, disease stage, underlying conditions, and concomitant medication(s). Therapy for primary (acute) infection, high-risk exposures to HIV, and maternal-to-fetal transmission are also addressed. Therapeutic approaches need to be updated as new data continue to emerge.

JAMA. 1996;276:146-154

From Brown University School of Medicine, Providence, RI (Dr Carpenter); the University of Miami (Fla) School of Medicine (Dr Fischl); Harvard Medical School, Boston, Mass (Drs Hammer and Hirsch); The International AIDS Society–USA, San Francisco, Calif (Ms Jacobsen); Stanford (Calif) University Medical Center (Dr Katzenstein); St Paul's Hospital, Vancouver, British Columbia (Dr Montaner); University of California San Diego, and San Diego Veterans Affairs Medical Center (Dr Richman); the University of Alabama at Birmingham (Dr Saag); the University of Colorado School of Medicine, Denver (Dr Schooley); AIDS Research Consortium of Atlanta (Ga) (Dr Thompson); Istituto Superiore di Sanità, Rome, Italy (Dr Vella); Hôpital Bichat-Claude Bernard, X. Bichat Medical School, Paris, France (Dr Yeni); and the University of California San Francisco (Dr Volberding).

Financial disclosures appear at the end of this article.

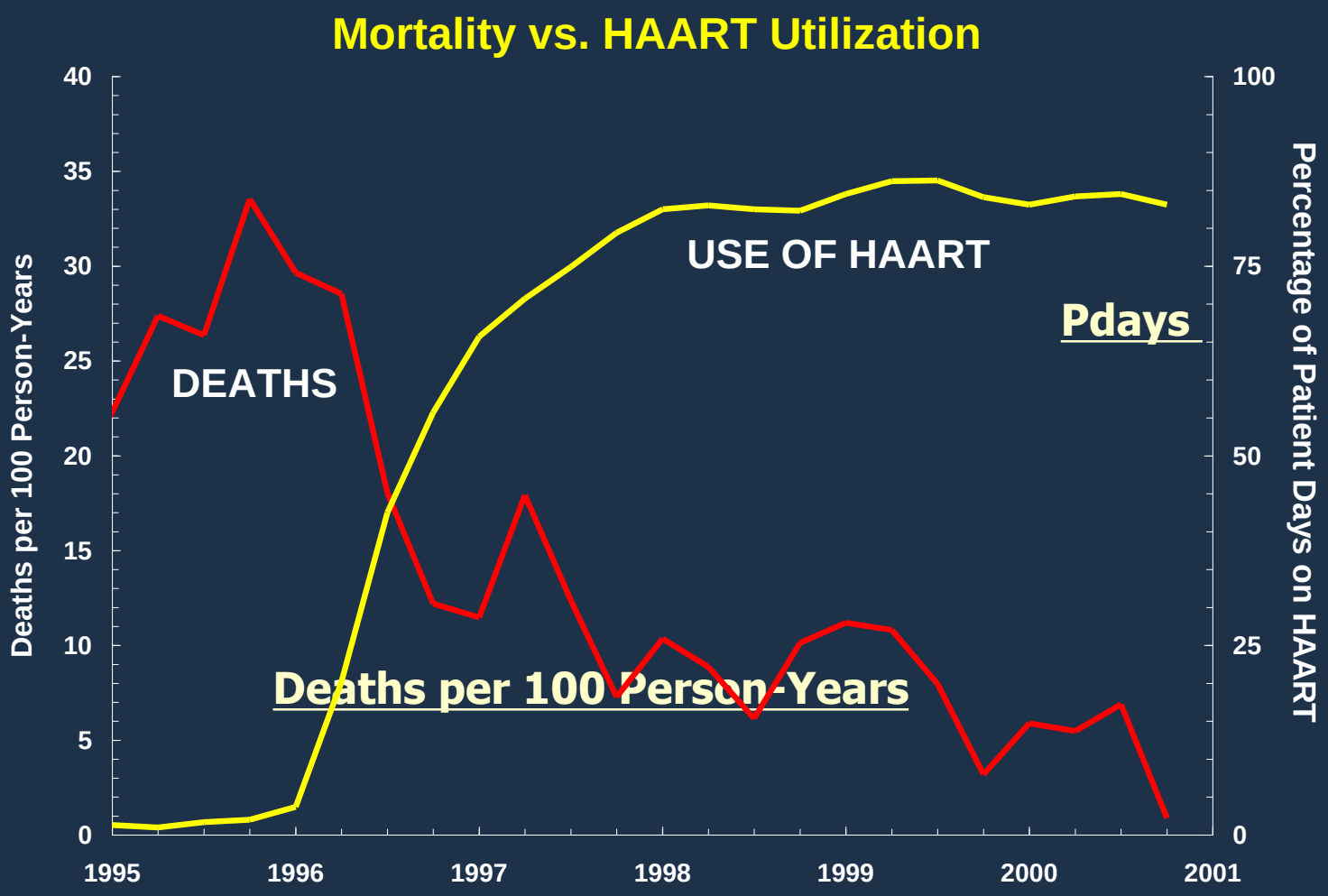
Reprints: International AIDS Society–USA, 353 Kearny St, San Francisco, CA 94108

IMPORTANT ADVANCES in understanding the biology and treatment of human immunodeficiency virus (HIV) infection have occurred during the past 18 months. As a result, new scientifically sound approaches to therapy have been developed that offer new options for persons with HIV infection. The relevant recent advances fall into 4 major categories: (1) a better understanding of the replication kinetics of HIV throughout all stages of disease; (2) the development of assays to determine the viral load in individual patients; (3) the availability of several new effective drugs; and (4) the demonstration that combination therapy is more effective than zidovudine monotherapy.

In light of these advances, the recommendations of earlier state-of-the-art guidelines[1,2] are no longer applicable to clinical decision making in 1996. Therefore, an international panel of clinical investigators experienced in HIV patient care was selected and convened by the International AIDS Society–USA to develop current recommendations for the clinical management of HIV-infected individuals.

The panel addressed 4 central questions about antiretroviral therapy: when to initiate therapy, which types of drugs to use, when to change therapy, and which types of drugs to use when a change in therapy is indicated. In addition, the treatment of primary HIV infection, prevention of vertical transmission, and postexposure prophylaxis were addressed. The recommendations are not solely based on the results of controlled clinical trials with well-defined clinical endpoints. Developing clinical guidelines in the HIV field at this time requires an approach firmly anchored in data from controlled, double-blind clinical trials when available, but must also include information from trials in progress and available virologic and immunologic endpoint data, as well as extrapolations from studies of the pathophysiology of HIV infection. Clinical decisions must be made for best use of up to 8 available antiretroviral drugs, at a time when long-term studies with clinical endpoints have been completed for only a few possible combinations.

The recommendations herein reflect the panel's agreement on the importance of plasma HIV RNA measurements for predicting risk of clinical progression as well as of the recent demonstration from clinical trials of combination therapies that reductions in plasma HIV RNA



Palella F et al, HOPS Study

Per Stefano Vella la prospettiva di cura è in un cocktail di farmaci dai costi elevatissimi

Ma la terapia sarà solo per pochi

GIANCARLO ANGELONI

È una bella o brutta notizia quella di Robert Gallo, secondo cui «entro dieci anni si curerà l'Aids»? È un'uscita elusiva e generica, che presta il fianco ad una certa informazione disinvolta, interessata solo a conoscere «date» e «linee di traguardo», oppure contiene intrinseche intenzioni autentiche dello scienziato? Certo, è strano che ad ogni anno che passa, ci si debba muovere a fare il gioco delle scommesse: e tanto più in questo 1995 che, anche a seguito della sospensione di tutte le sperimentazioni umane dei vaccini, ha fatto agli inizi pensare al peggio. Facciamo un sano passo indietro, hanno detto alcuni. Sì, per ricominciare e capire, hanno risposto altri: così, faremo due passi in avanti. E, in effetti, se le cose nuove nascono davvero dalle crisi, il ripensamento ha funzionato. Quasi inaspettatamente, due fatti, negli studi sulla patogenesi della malattia e sul fronte della terapia, hanno riportato un po' di sereno. «Ma non è ancora il cielo terso e azzurro – avverte Stefano Vella, direttore del reparto retrovirus nel laboratorio di virologia dell'Istituto superiore di sanità – perché non si devono scambiare i risultati ottenuti, pur importanti, con la cura dell'Aids: a dieci anni e più dall'inizio della pandemia, il ruolo dell'informazione squilibrata in questo campo è ancora un problema non risolto».

Nelle ultime settimane, Stefano Vella è stato invitato ad entrare, come uno dei tre membri per l'Europa, nell'organo di governo dello Ias, l'International Aids Society, che sovrintende alle conferenze internazionali, attualmente a cadenza biennale. Lo scorso anno ha tenuto, alla conferenza internazionale sull'Aids a Yokohama, la lettura inaugurale sulle terapie. E, di recente, al Congresso europeo di Copenaghen sull'Aids, ha discusso dei risultati dello studio europeo-australiano Delta, che ha impegnato, fin dal '92, lo stesso Istituto superiore di sanità, e che si è affiancato a un altro «trial» molto importante, l'Actg 175, condotto negli Stati Uniti dal National Institutes of Health. Ora, a distanza di un paio di mesi da quell'incontro di Copenaghen, Stefano Vella ricorda: «C'è stato un momento in sala, in cui tra i ricercatori è prevalsa l'emozione. Sì, proprio l'emozione che prova un medico quando si accorge di poter cambiare finalmente la vita del proprio paziente, di essere sulla strada giusta».

E qual è questa strada, dottor Vella?

Noi abbiamo diviso lo studio Delta in due parti: nella prima abbiamo sperimentato una terapia combinata, Azt e ddI o Azt e ddC, su pazienti mai trattati in precedenza con antiretrovirali; nella seconda abbiamo invece arruolato, sempre per la stessa terapia combinata, pazienti che avevano avuto un trattamento con Azt di almeno tre mesi precedente all'arruolamento. Bene, sia per la progressione verso l'Aids, sia per la sopravvivenza, i risultati nel primo gruppo sono stati molto più lusinghieri che nel secondo, tanto che nei pazienti mai trattati prima attraverso la monoterapia con Azt, la riduzione di mortalità, mediante l'uso della terapia di combinazione, è stata stimata intorno al 40 per cento. Il confronto, dunque, è stato tra monoterapia e terapia di combinazione, ma il risultato vero dello studio Delta è stato quello di aver ottenuto una risposta sul «come cominciare»: occorre iniziare subito, e a dose piena, con la terapia di combinazione, perché questa, al contrario della monoterapia, ha mostrato di poter modificare la storia naturale della malattia e ha stabilito, in un rapporto di causa ed effetto, che la replicazione del virus e la progressione della malattia sono legate tra di loro.

Ma, nella prospettiva, ci sono altre opzioni terapeutiche?

Certo. Lo studio Delta e quello americano hanno tenuto conto solo degli antiretrovirali già disponibili e non di quelli, sempre appartenenti alla famiglia dell'Azt, in via di approvazione da parte dell'Fda e delle stesse autorità europee, come il 3Tc e il D4t. Senza pensare, poi, che in «trial» molto avanzati ci sono gli inibitori delle proteasi, di diversa concezione e di potenza di gran lunga superiore agli analoghi dell'Azt; e che in futuro, forse, si potrà contare su altri inibitori, come quelli dell'integrasi. La prospettiva, dunque, è quella di usare tre o quattro farmaci contemporaneamente, e poi di cambiare le combinazioni, regolamentandole, però, secondo un uso mirato e non selvaggio. Purtroppo, c'è da dire che questa prospettiva riguarderà solo il 5 per cento di coloro che nel mondo sono infetti, perché per le moltitudini dei sieropositivi che vivono in Africa e in Asia nelle condizioni di miseria che sappiamo, i costi molto alti delle terapie di combinazione saranno semplicemente una cosa lunare.

E non c'è nessun altro intervento possibile?

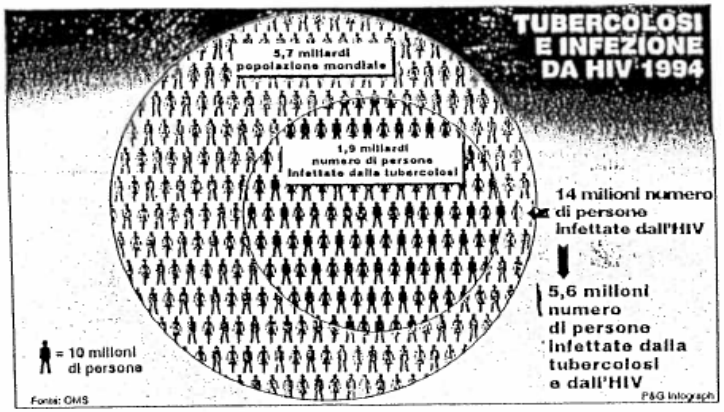
Allo stato dei fatti, l'unico intervento di tipo farmacologico è la prevenzione della trasmissione materno-fetale del virus, come sta cercando di verificare uno studio molto ampio, coordinato dall'Oms, in pratica, si vuol vedere se, somministrando farmaci antiretrovirali nelle fasi più vicine al parto, si riesce ad evitare la trasmissione dell'Hiv nel neonato. Il «trial» prevede una somministrazione che non superi i dieci giorni, perché questo è il limite che le disponibilità economiche pongono.

Diversa sarebbe la situazione se ci fosse un vaccino?

Sì, per i suoi bassi costi. Ma, allo stato attuale, non c'è davvero molto da sperare che il problema venga risolto, perché, nel caso dell'Hiv, il sistema immunitario, pur funzionando, non è in grado di contrastare il virus con una risposta efficace. E poi, un'ulteriore complicazione è costituita dalla via di trasmissione, che è generalmente sessuale. Si dovrebbe costituire, insomma, una protezione alla porta di ingresso del virus, cioè al livello delle mucose genitali. Ciò che oggi si pensa, in realtà, è che se un vaccino ci sarà, si tratterà di un «vaccino minore», che impedirà solo la progressione dell'infezione. In questo modo si rallenterebbe il corso della malattia, ma il paziente continuerebbe ad essere infettante.

Un ultimo punto: la patogenesi. Quali conoscenze nuove hanno portato i lavori pubblicati da «Nature» nel gennaio scorso, di cui si è tanto parlato?

Hanno riconvertito l'infezione Hiv in un quadro infettivo più classico, secondo un'immagine dinamica che è più vicina alla realtà patologica, e hanno dimostrato che non è vero che il sistema immunitario non funziona a dovere. Anzi, esso regge benissimo all'attacco del virus, e lo fa fino a quando, dopo anni, l'Hiv non riesce a sbaragliare le linee. Se non fosse così, la persona infetta, mediamente entro qualche mese in questo senso, il sistema immunitario va vinto come l'alleato essenziale della terapia.

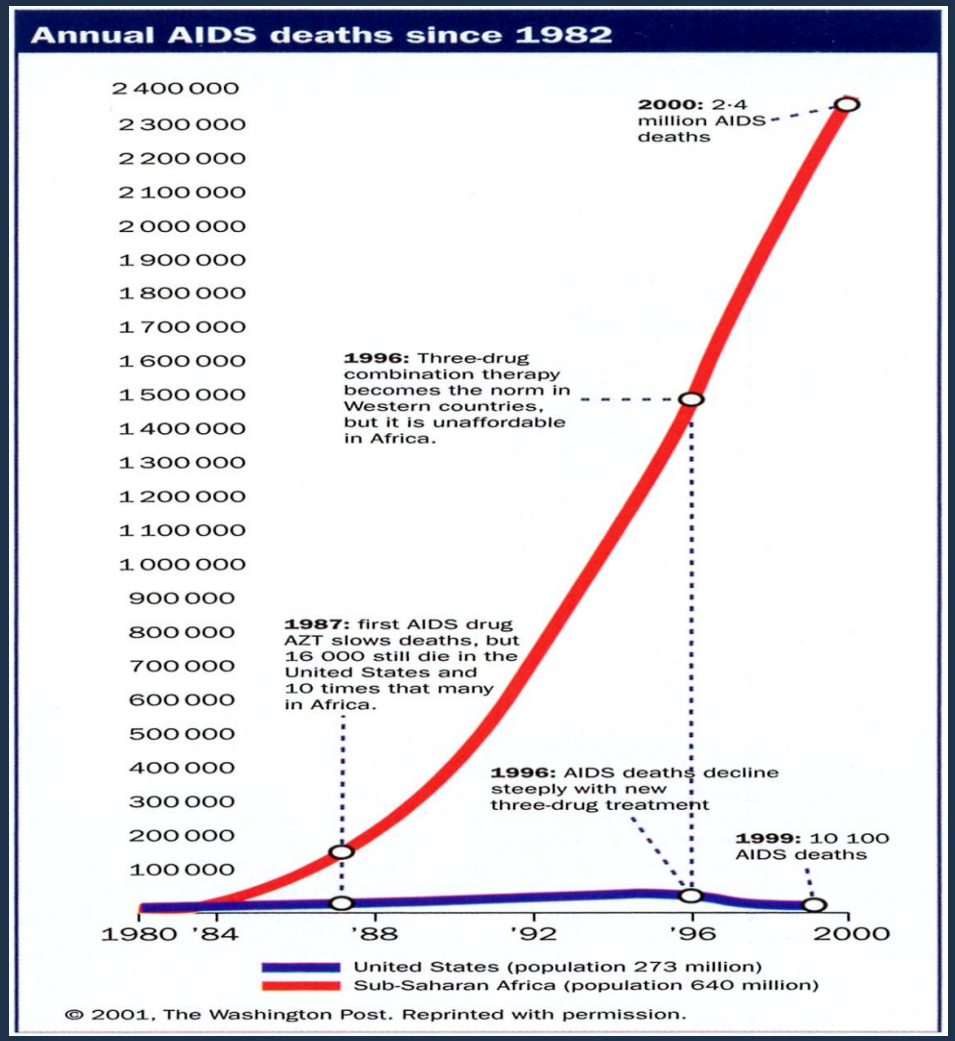


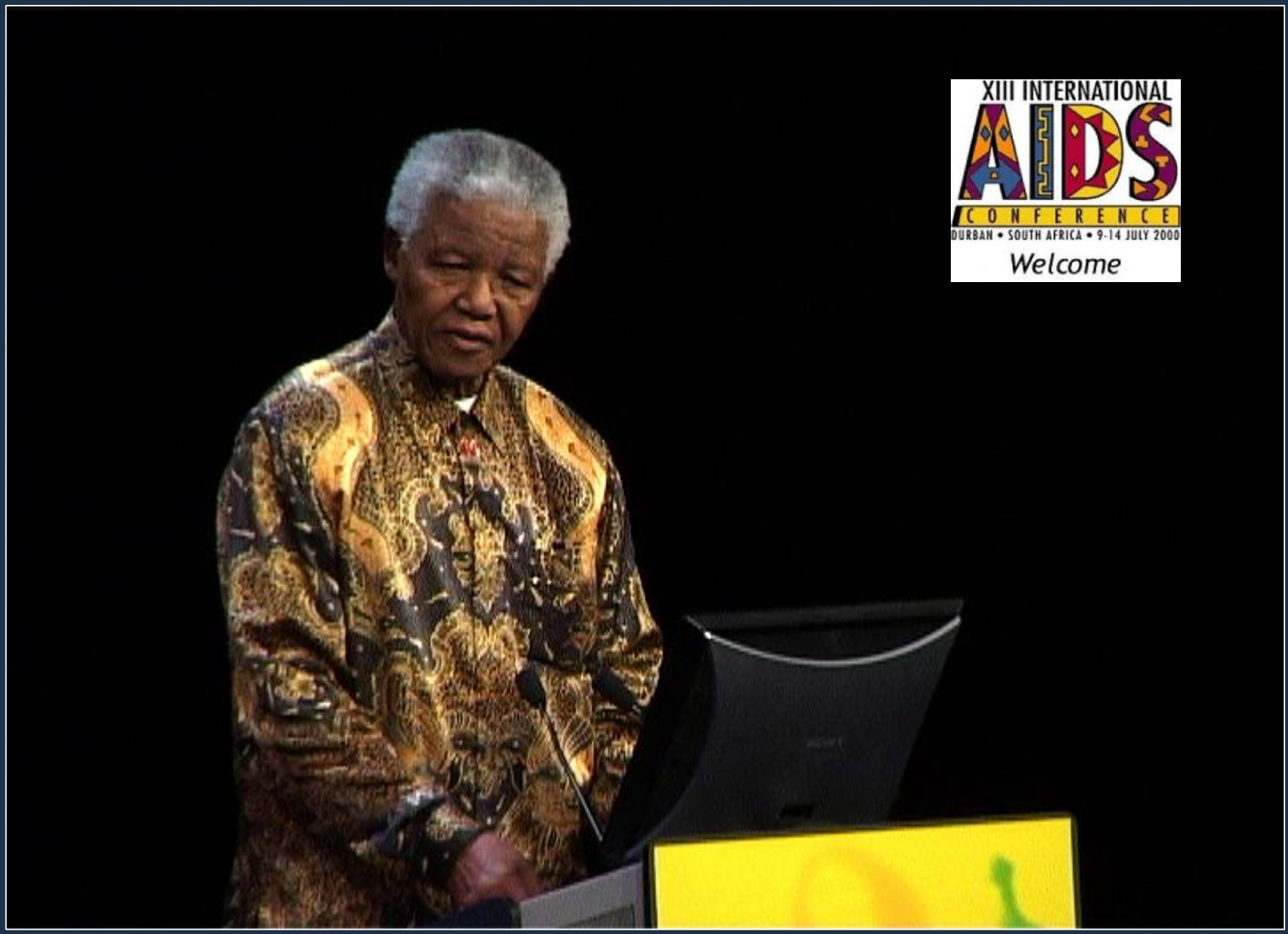
Tubercolosi più Hiv, il «doppio problema» di domani

È stata definita «the double trouble», il doppio problema. Sì, perché l'associazione «infezione da Hiv più infezione da tubercolosi» crea molti grattacapi alle autorità sanitarie. E ne creerà sempre di più.

L'infezione da tubercolosi è molto diffusa: colpisce nel mondo una persona al secondo e si stima che nei prossimi dieci anni ucciderà 30 milioni di persone. Ma solo il 10 % degli infettati ha il 10 % di probabilità di sviluppare la malattia nel corso della vita. Il rischio però aumenta enormemente se la persona è infettata dal virus dell'Aids. In quel caso le probabilità di ammalarsi aumenta fino al 5 % all'anno. E qui si innesta un circolo vizioso. Il contagio della tbc avviene tramite una persona ammalata, questo vuol dire che un aumento del numero di malati (tra i sieropositivi) comporta un aumento della circolazione della Tbc anche nella popolazione «sana». Negli Usa si è calcolato che l'aumento di Tbc verificatosi dall'85 è dovuto per il 30 % alla diffusione dell'Hiv (le altre cause sono l'aumento di povertà, quello dei senza tetto e il difficile accesso alla cura dei soggetti marginali). In alcuni paesi dell'Africa i casi di tubercolosi sono addirittura raddoppiati. In Italia, secondo uno studio condotto sul nostro territorio, questo fenomeno potrebbe portare a un aumento di circa 1000 casi l'anno.

YEAR 2000: difference in mortality between the rich north and the poor south




XIII INTERNATIONAL
AIDS
CONFERENCE
DURBAN • SOUTH AFRICA • 9-14 JULY 2000
Welcome

Durban 2000: Community mobilization

Durban 2000 – Activism from the South

Global March for access to HIV treatment
Treatment Access Campaign (and others)

EVERYONE HAS THE RIGHT TO HEALTH*!*

All people with HIV/AIDS have a right to access treatments in addition to health care, employment, education, clean water, adequate nutrition, and housing. Denying people with HIV/AIDS access to affordable medicines in order to protect profits or intellectual property rights, is tantamount to genocide.

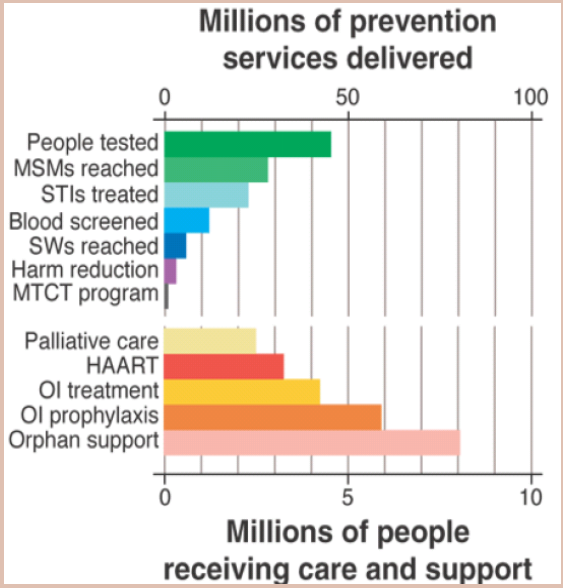
2001 – Global Commitment

Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Kofi Annan, UN Secretary General:

Call for 7 – 10 billion war chest against AIDS and the creation of the Global Fund (launched Jan 2002) *"… we must put care and treatment within everyone's reach".*

Resource Needs for HIV/AIDS



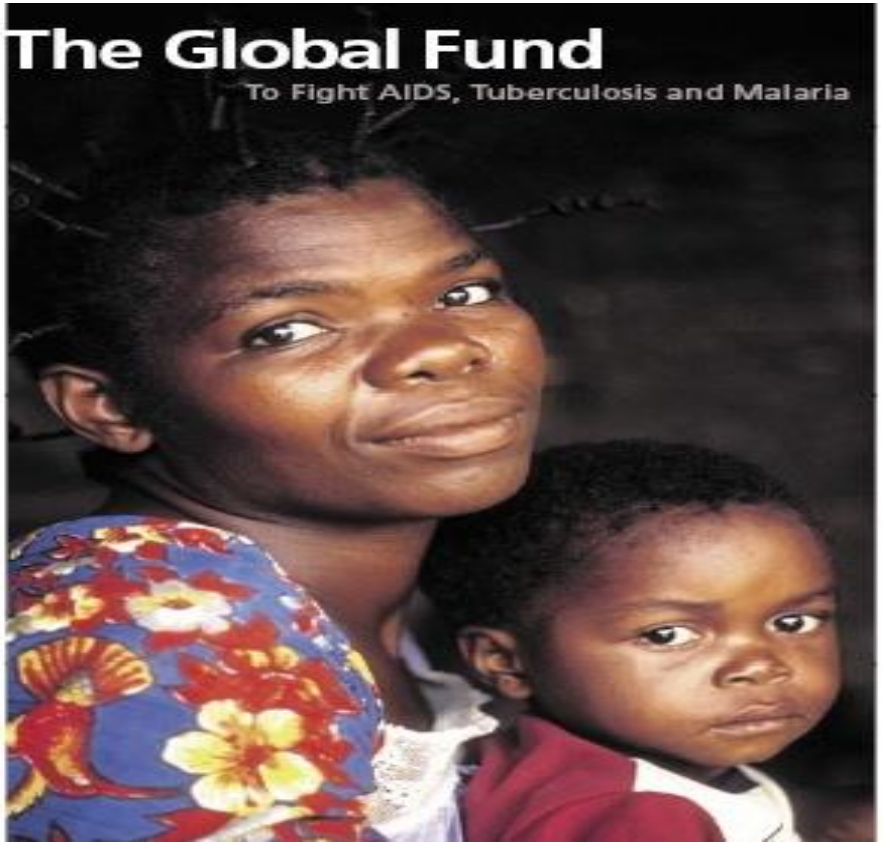
Schwartländer et al, Science, June 2001

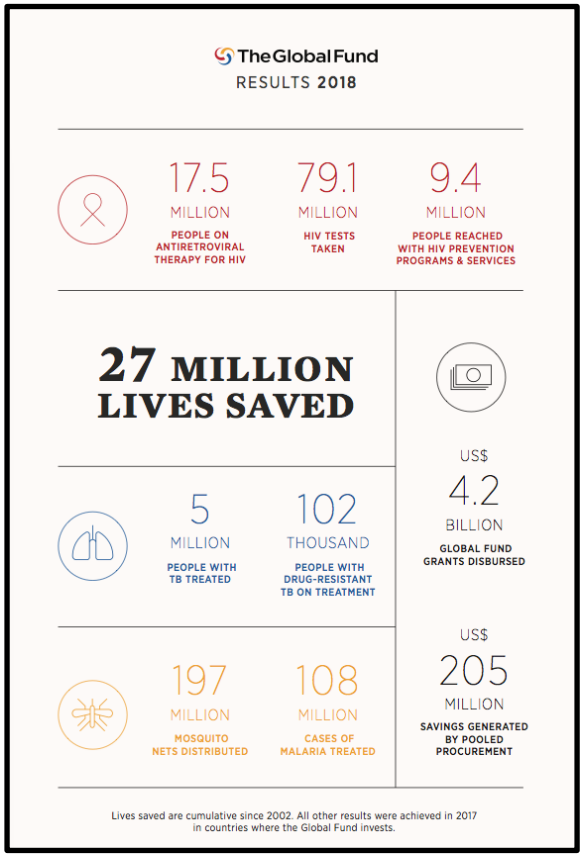
UNGASS AIDS, June 2001

Declaration of Commitment:

"… make every effort to provide … the highest attainable standard of treatment for HIV/AIDS, including … the effective use of quality-controlled anti-retroviral therapy …"

UNGASS 2001:
THE GLOBAL FUND WAS BORN





The Lancet *Vol 360, November 30, 2002*

Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Time to act: global apathy towards HIV/AIDS is a crime against humanity

Robert Hogg, Pedro Cahn, Elly Katabira, Joep Lange, NM
Samuel, Michael O'Shaughnessy,
Stefano Vella, Mark Wainberg, Julio Montaner

The NEW ENGLAND JOURNAL of MEDICINE

REVIEW ARTICLE

GLOBAL HEALTH

Response to the AIDS Pandemic — A Global Health Model

Peter Piot, M.D., Ph.D., and Thomas C. Quinn, M.D.

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N Engl J Med 2013;368:2210-8.
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JUST OVER THREE DECADES AGO, A NEW OUTBREAK OF OPPORTUNISTIC INfections and Kaposi's sarcoma was reported in a small number of homosexual men in California and New York.[1,2] This universally fatal disease, which was eventually called the acquired immunodeficiency syndrome (AIDS), was associated with a complete loss of CD4+ T cells. Within the first year of its description, the disease was also identified in patients with hemophilia, users of injection drugs, blood-transfusion recipients, and infants born to affected mothers. Soon thereafter, a heterosexual epidemic of AIDS was reported in Central Africa, preferentially affecting women.[3,4] Little did we know at the time that this small number of cases would eventually mushroom into tens of millions of cases, becoming one of the greatest pandemics of modern times.

Within 2 years after the initial reports of AIDS, a retrovirus, later called the human immunodeficiency virus (HIV), was identified as the cause of AIDS.[5] Diagnostic tests were developed to protect the blood supply and to identify those infected. Additional prevention measures were implemented, including risk-reduction programs, counseling and testing, condom distribution, and needle-exchange programs. However, HIV continued to spread, infecting 10 million persons within the first decade after its identification.

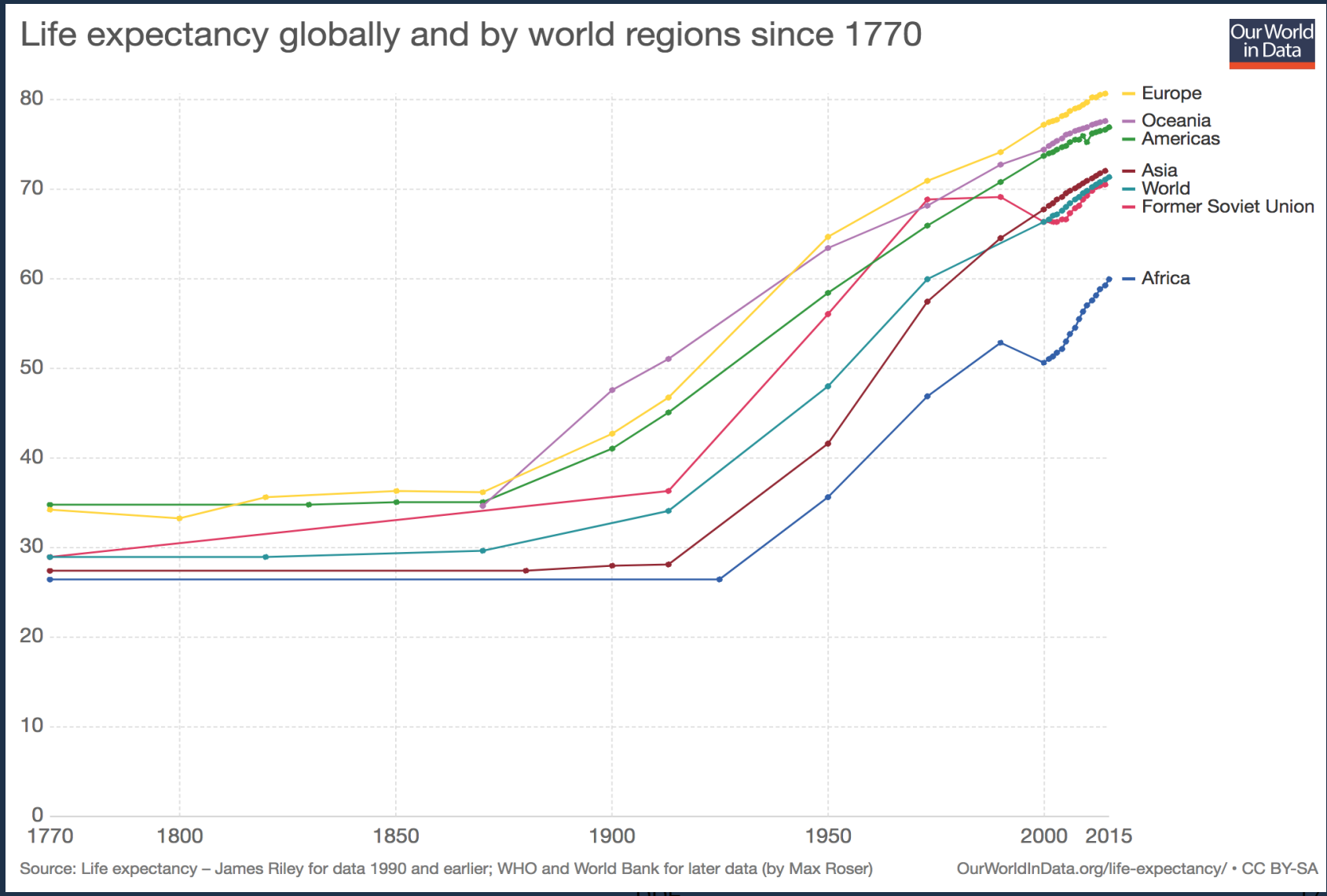
An interactive graphic including a prevalence map, a timeline, and details of HIV structure and life cycle is available at NEJM.org

The second decade of AIDS was marked by further intensification of the epidemic in other areas of the world, including the southern cone of Africa, which saw an explosive HIV epidemic. Asia and the countries of the former Soviet Union also reported a marked increase in the spread of HIV. However, by the mid-1990s, with the discovery of highly active antiretroviral therapy, rates of death in developed countries started to decline. The use of antiretroviral drugs during pregnancy also resulted in a substantial decline in mother-to-child transmission of HIV in high-income countries. However, without access to antiretroviral drugs in low- and middle-income countries, rates of death and mother-to-child transmission continued to increase, with 2.4 million deaths and more than 3 million new infections reported in 2001. Of these new infections, two thirds occurred in sub-Saharan Africa.[6]

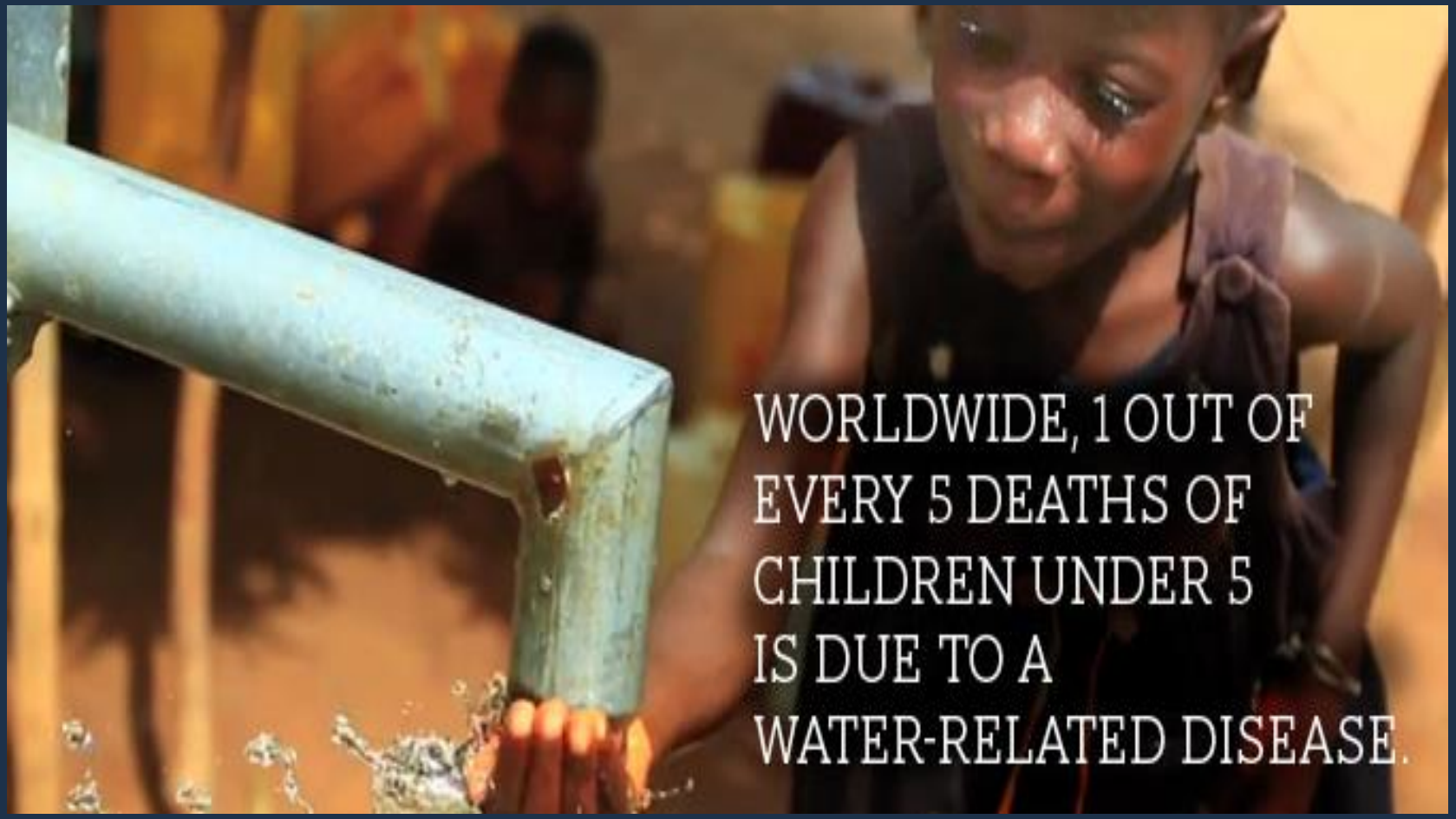
INTERNATIONAL RESPONSE TO AIDS — A GLOBAL HEALTH MODEL

It was not until the third decade of the epidemic that the world's public health officials, community leaders, and politicians united to combat AIDS. In 2001, the United Nations General Assembly endorsed a historic Declaration of Commitment on HIV/AIDS, a commitment that was renewed in 2011.[7] These actions resulted in the formation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, which was established to finance anti-AIDS activities in developing countries. In 2003, President George W. Bush announced the President's Emergency Plan for AIDS

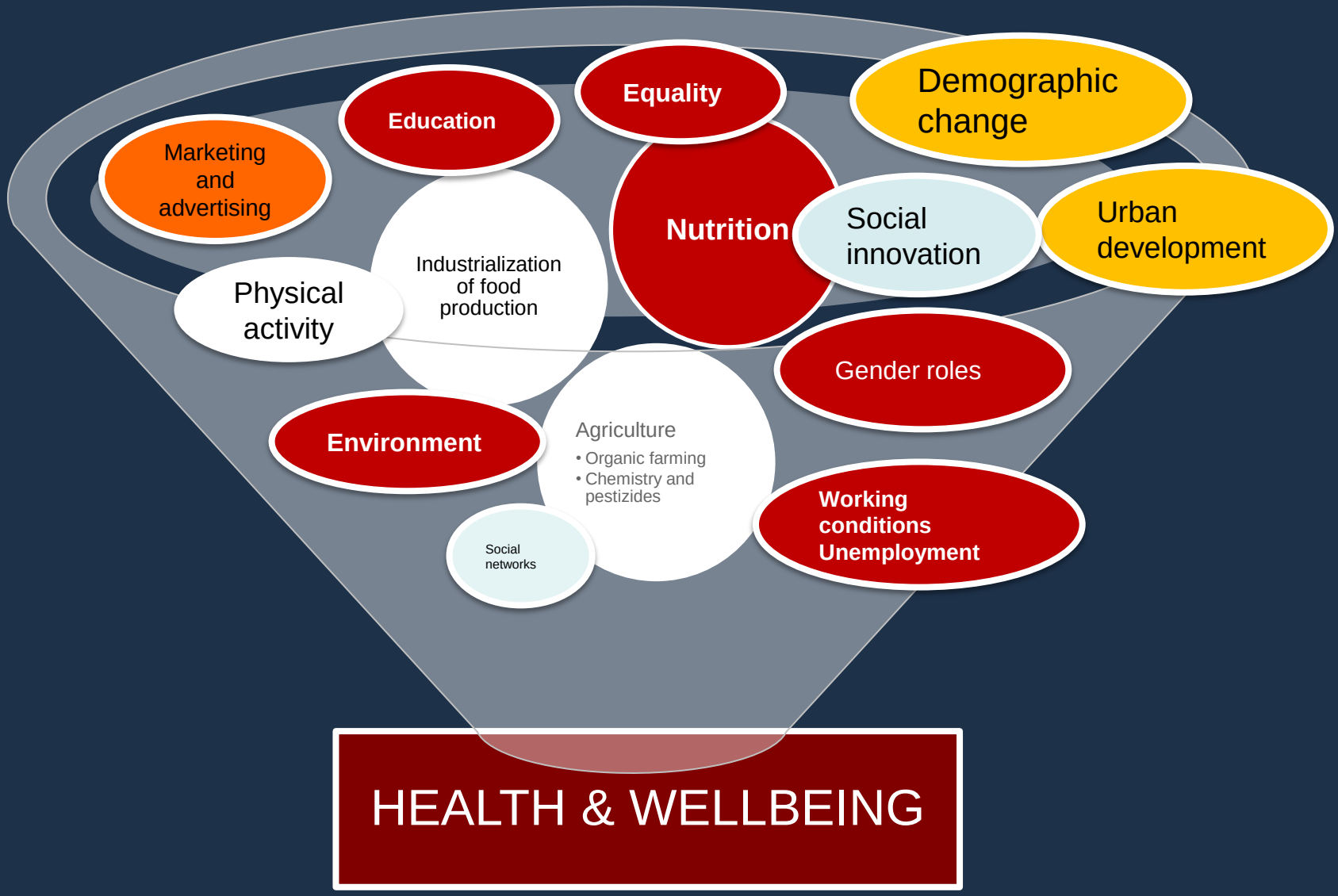
THE RISE OF LIFE EXPECTANCY



THE DRIVERS.....1. CLEAN WATER



THE DRIVERS.....**2. SOCIAL DETERMINANTS**



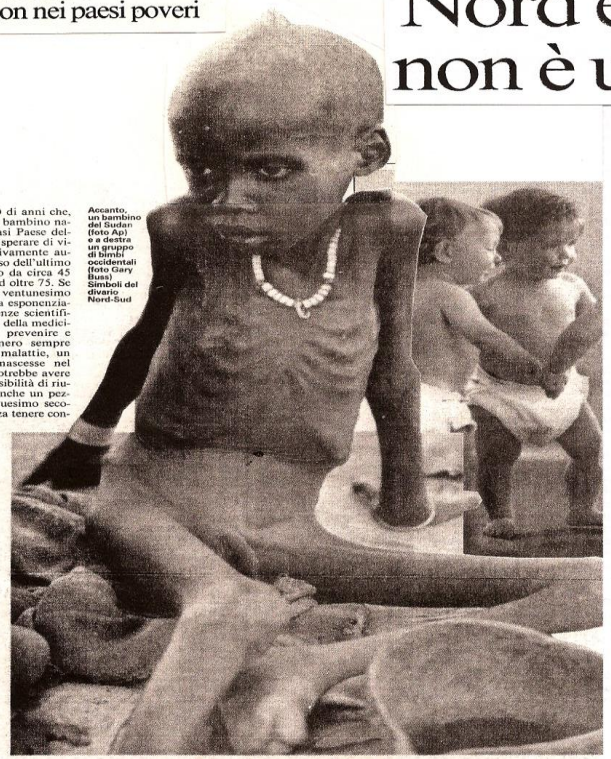
Addio Millennio
La medicina/Vaccini, antibiotici e soprattutto l'uso di acqua pulita: così il '900 ha allungato la durata della vita umana Ma non nei paesi poveri

Il Messaggero

CULTURA & SPETTACOLI

Nord e Sud, la salute non è uguale per tutti

di STEFANO VELLA



Accanto, un bambino del Sudan (foto Ap) e a destra un gruppo di bimbi occidentali (foto Gary Buss) Simboli del divario Nord-Sud

IL NUMERO di anni che, in media, un bambino nato in un qualsiasi Paese dell'Occidente può sperare di vivere è progressivamente aumentato nel corso dell'ultimo secolo, passando da circa 45 anni nel 1901 ad oltre 75. Se proiettiamo nel ventunesimo secolo la crescita esponenziale delle conoscenze scientifiche e la capacità della medicina moderna di prevenire e curare un numero sempre più grande di malattie, un bambino che nascesse nel 2000 in Italia potrebbe avere una discreta possibilità di riuscire a vedere anche un pezzetto del ventiduesimo secolo. E questo senza tenere conto della speranza di riuscire un giorno a manipolare i geni che fisiologicamente determinano l'invecchiamento delle nostre cellule.

Tuttavia, contrariamente a quanto saremmo portati a credere, l'aumento della vita media non è dovuto esclusivamente ai grandi progressi della medicina del ventesimo secolo, ma soprattutto all'abbattimento della mortalità perinatale e al miglioramento delle condizioni igieniche generali.

Il controllo delle malattie infettive

In un'ipotetica classifica delle più importanti conquiste della medicina, ai primi posti dovremmo inserire la scoperta del valore dell'acqua pulita per la prevenzione di tante malattie infettive. Lo avevano ben capito i Romani, che per primi hanno dotato le loro città di reti idriche e fognarie di grande efficienza, e anche gli operatori sanitari che lavorano in molti Paesi africani sanno bene che una falda di acqua pulita è in grado di arrestare il diffondersi di un'epidemia di colera molto più rapidamente che dieci "container" di farmaci.

Certo, senza la scoperta della vaccinazione e degli antibiotici, l'acqua corrente non sarebbe bastata per salvare l'umanità da tante altre malattie infettive che per secoli hanno rappresentato la principale caua di morte dell'uomo.

E se molti considerano come paradigma dei grandi progressi della medicina la capacità di sostituire organi malati, le tecniche cardiochirurgiche, i successi nella prevenzione e nella cura dei tumori (seppure ancora parziali), il controllo di malattie croniche come l'ipertensione e il diabete, il più grande risultato collettivo della medicina moderna è senz'altro costituito dalla battaglia vinta contro le malattie infettive, sebbene sia azzardato ritenere la partita come definitivamente chiusa, vista l'improvvisa comparsa dell'Aids e il ritorno della tubercolosi.

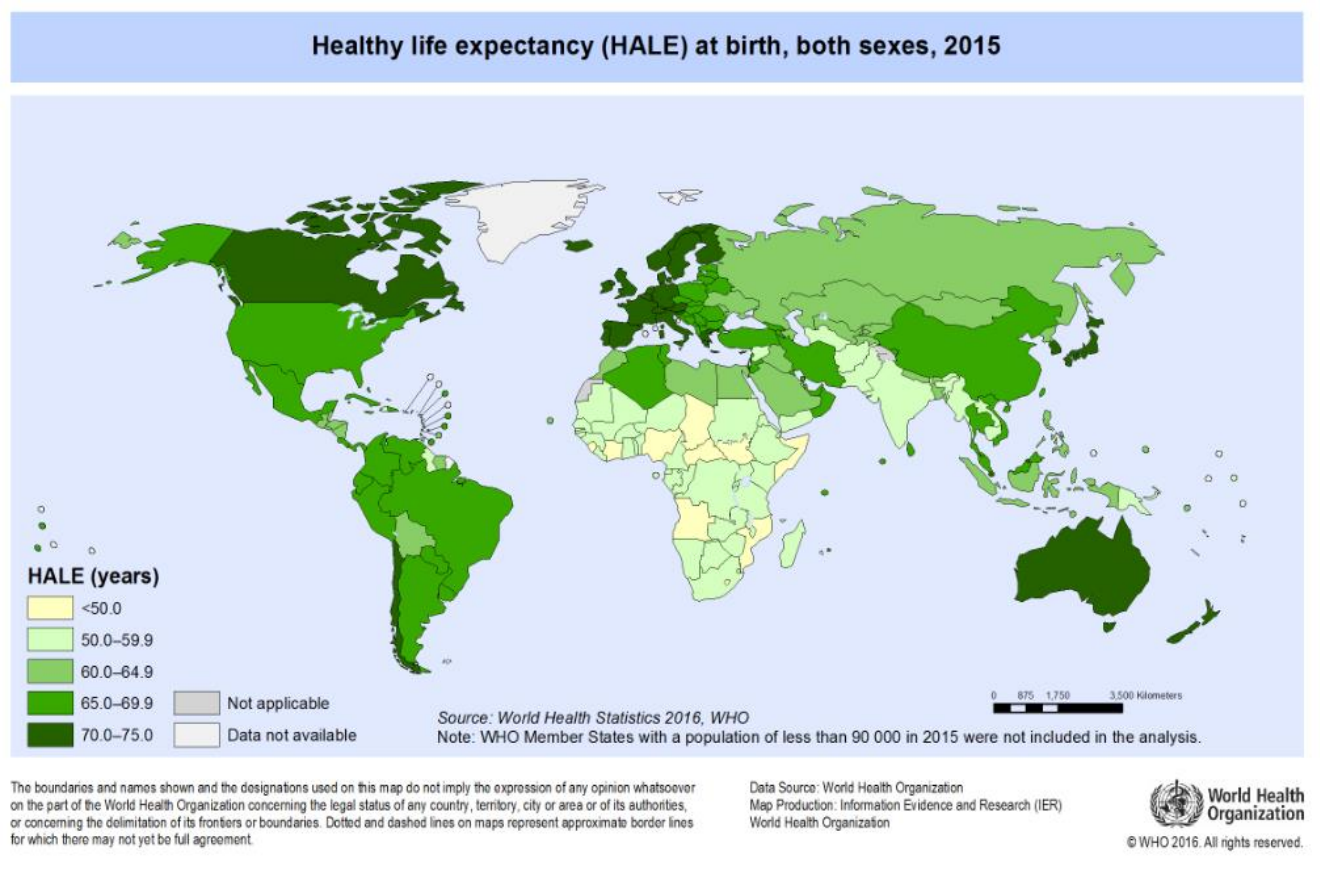
Da quando Jenner - era il 1796 - osservò che i mungitori delle vacche non contraevano il vaiolo, e pensò di inoculare il virus del vaiolo della mucca (il cosiddetto "vaccino") per prevenire il vaiolo nell'uomo, il diffondersi della pratica della vaccinazione ha salvato miliardi di individui da malattie infettive come la poliomielite, la difterite, la pertosse, il tetano, la febbre gialla, il morbillo e, più recentemente, l'epatite B. Nel 1997, grazie ad una campagna di vaccinazione durata alcuni decenni, il vaiolo, un flagello responsabile nei secoli passati di centinaia di milioni di morti, è stato dichiarato definitivamente scomparso dall'Organizzazione Mondiale della Sanità, e in molti considerano questo evento come il più grande successo della medicina moderna.

La nascita della genetica molecolare

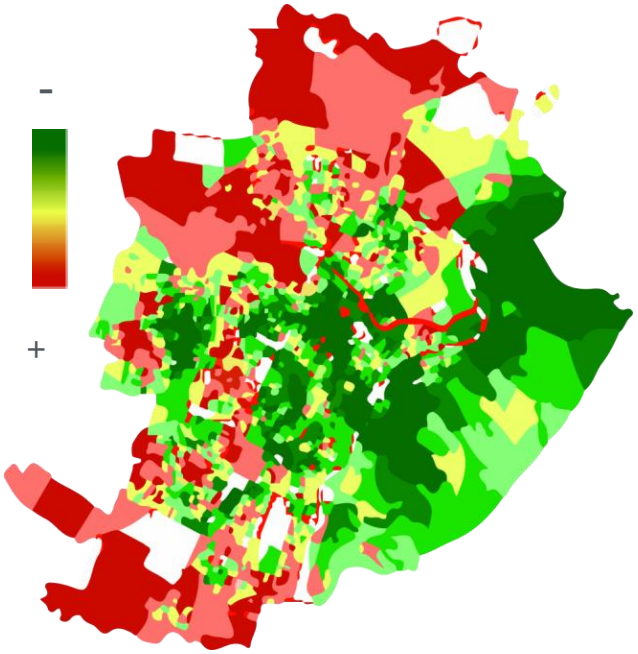
Certamente il grande protagonista della medicina del terzo millennio sarà la genetica molecolare. Per comprendere come questa branca della medicina abbia in sé la potenzialità di curare e guarire tante malattie dell'uomo, compreso il cancro, dobbiamo partire dal concetto nuovo e rivoluzionario dell'origine "genetica" della grande maggioranza delle malattie dell'uomo, almeno di quelle non dovute a microrganismi patogeni.

Grazie al *Progetto Genoma Umano*, un'impresa scientifica internazionale che sta disegnando la mappa completa del patrimonio genetico dell'uomo, è stato scoperto che non esistono soltanto le classiche malattie genetiche ereditarie, come l'emofilia o la distrofia muscolare: anche una parte rilevante delle comuni malattie croniche

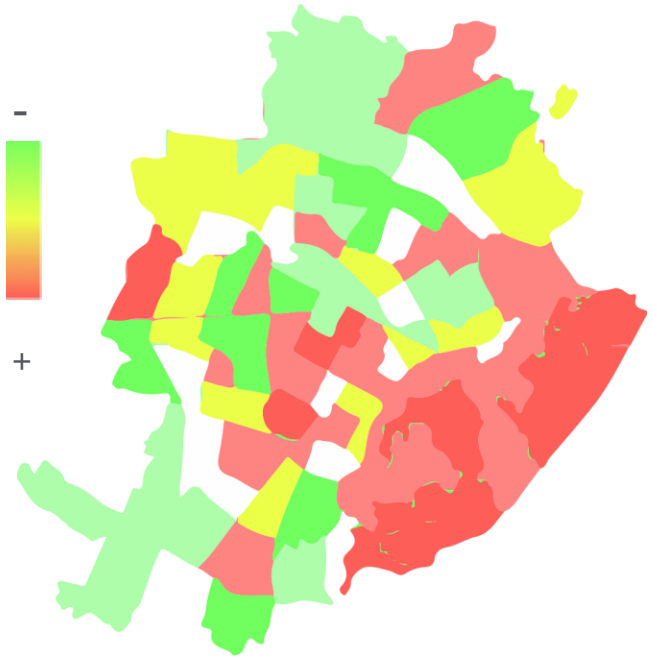
The unequal rise of «healthy» life expectancy



Acute myocardial infarction, 2009



Revascularization procedures, 2009



Giuseppe Costa

Fonte: FORASTIERE ET AL. 2011

-------- CORTE DEI CONTI --------

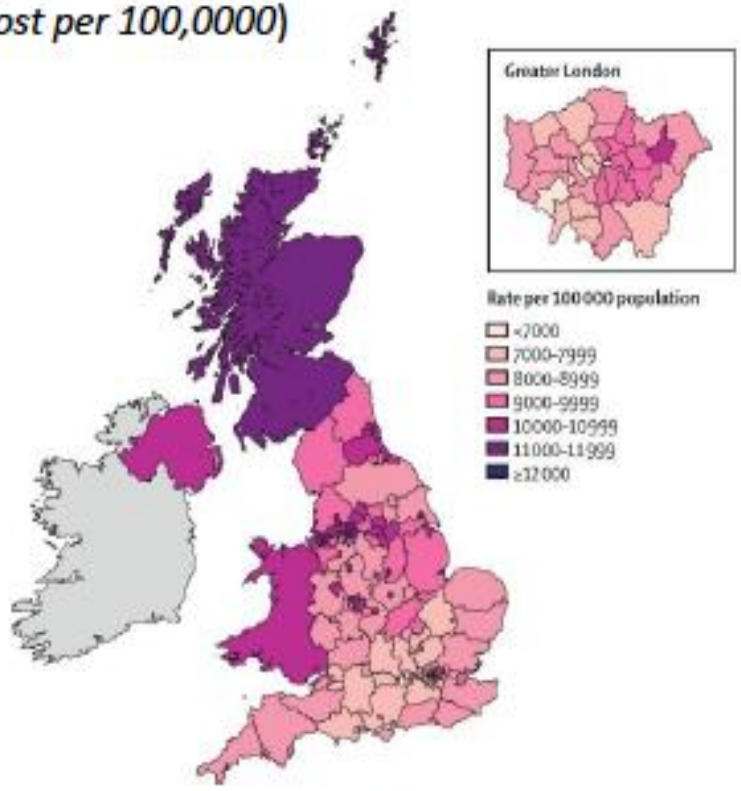
SEZIONI RIUNITE IN SEDE DI CONTROLLO

Rapporto 2019 sul coordinamento della finanza pubblica

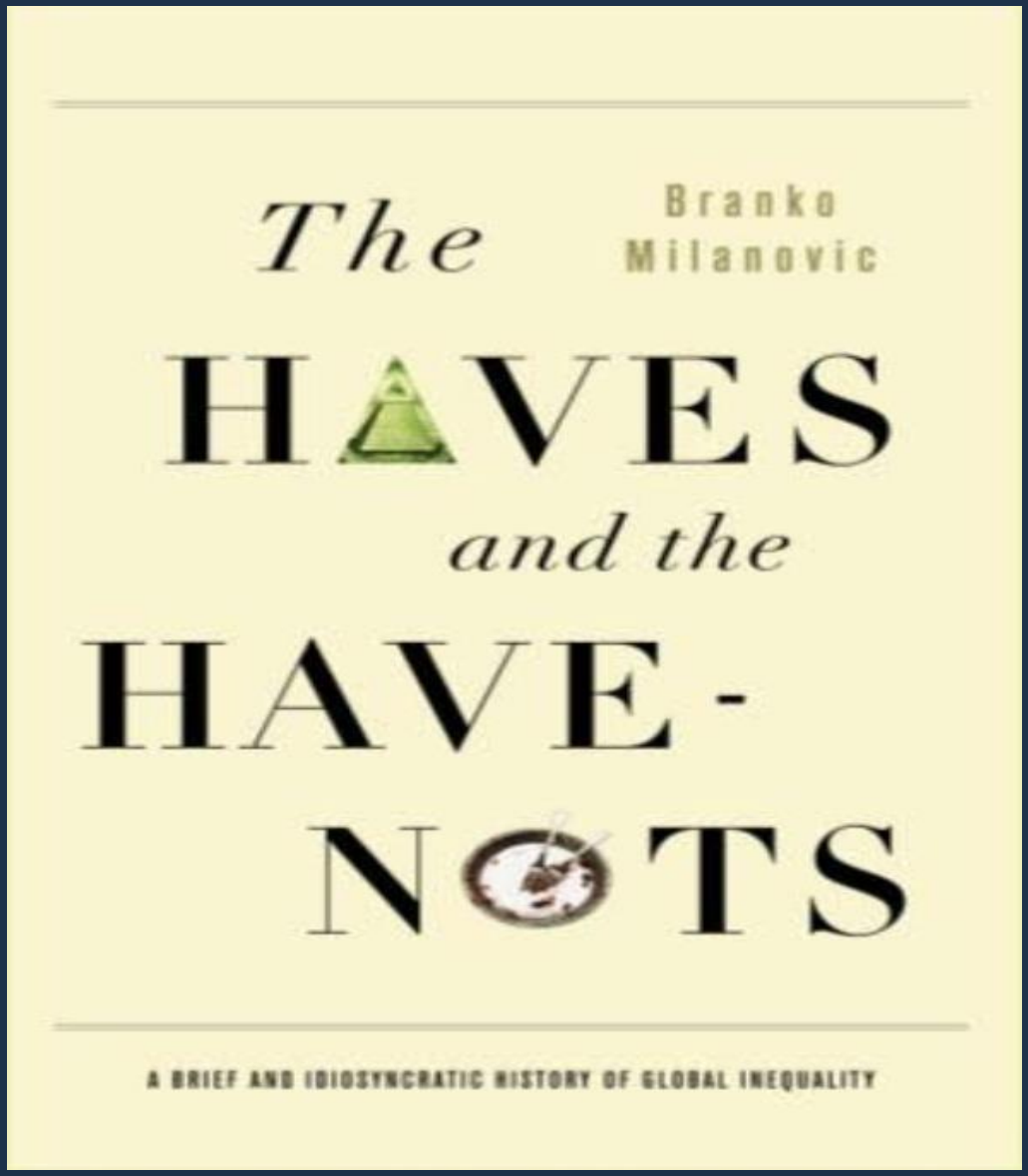
Corte dei conti: "Conti sanità sotto controllo ma crescono le disuguaglianze". Aumentano i

Premature mortality rates in 2016

(*as measured by years of life lost per 100,0000*)



Source: Steel et al. Changes in health in the countries of the UK and 150 English Local Authority areas 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. *The Lancet*. 2018; 392:10158.

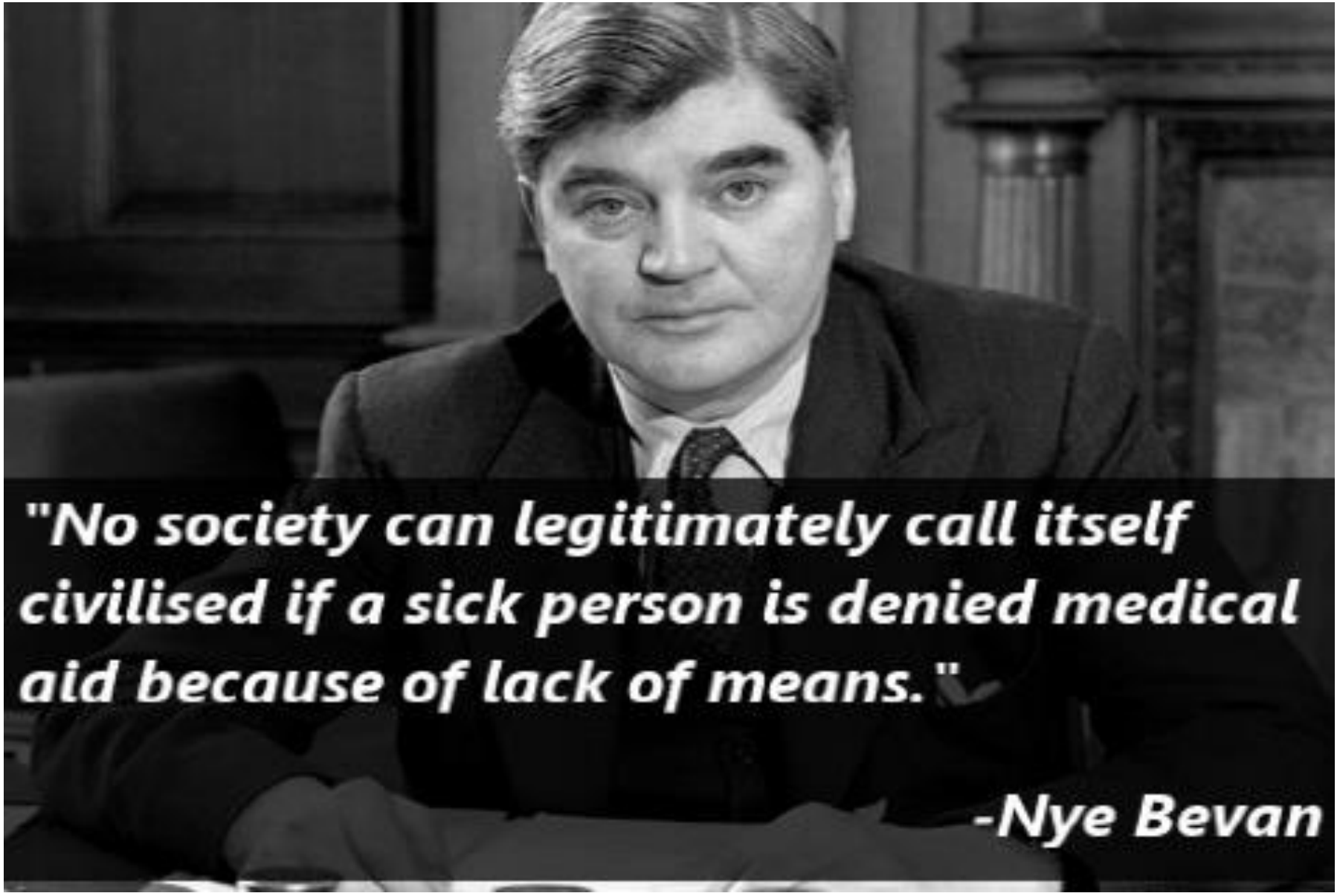

Branko Milanovic
The HAVES and the HAVE-NOTS
A BRIEF AND IDIOSYNCRATIC HISTORY OF GLOBAL INEQUALITY


SUSTAINABLE DEVELOPMENT GOALS
1 NO POVERTY
2 ZERO HUNGER
3 GOOD HEALTH AND WELL-BEING
4 QUALITY EDUCATION
5 GENDER EQUALITY
6 CLEAN WATER AND SANITATION
7 AFFORDABLE AND CLEAN ENERGY
8 DECENT WORK AND ECONOMIC GROWTH
9 INDUSTRY, INNOVATION AND INFRASTRUCTURE
10 REDUCED INEQUALITIES
11 SUSTAINABLE CITIES AND COMMUNITIES
12 RESPONSIBLE CONSUMPTION AND PRODUCTION
13 CLIMATE ACTION
14 LIFE BELOW WATER
15 LIFE ON LAND
16 PEACE, JUSTICE AND STRONG INSTITUTIONS
17 PARTNERSHIPS FOR THE GOALS
SUSTAINABLE DEVELOPMENT GOALS

The Sustainable Development Goals are interlinked

Universal Health Coverage (UHC)

means that **ALL PEOPLE** can obtain the quality health services they need without suffering financial hardship.


"No society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means."
-Nye Bevan

First get a recommendation from your family doctor that your eyes need testing. Then hand that recommendation to any doctor with special qualifications (lists will be available) or to any ophthalmic optician taking part in the new service. If you need glasses, these will be provided without charge. For re-testing you can go direct to any of the doctors with special qualifications, or to an ophthalmic optician.

The National Health Service will provide several kinds of spectacles of different types. For specially expensive types you will have to pay the extra cost.

Deafness Specialist ear clinics will be established as resources allow. At them you will get not only an expert opinion upon deafness but also, if necessary, a *new hearing aid* invented by a special committee of the Medical Research Council. Production of these aids is now going on, but will not meet all demands at once. They will be supplied free, when ready, together with a reasonable allowance of maintenance batteries.

Home Health Services Your local County or County Borough Council will, as soon as it can, make special provision for: (1) advice and care of expectant and nursing mothers and children under five (for particulars ask your doctor, health visitor, or Welfare Centre); (2) midwifery (ask your doctor or Welfare Centre); (3) home nursing where there is illness in the family (ask your doctor); (4) all necessary vaccination or immunisation (through your doctor or Welfare Centre); and (5) a health visitor service to deal with problems of illness in the home, especially tuberculosis.

Health Centres Special premises known as Health Centres may later be opened in your district. Doctors may be accommodated there instead of in their own surgeries, but you will still have "your own doctor" to give you personal and confidential treatment. He will still come to your home as necessary. At the Health Centre he will be able to use equipment supplied from public funds. These Centres may also offer dentistry and other services on the spot.

WHAT TO DO NOW

1. Choose your doctor.
2. Get application forms from him or from the Post Office, Public Library, or office of the local Executive Council.
3. Fill one in for each member of the family.
4. Hand them to the doctor.

ACT AT ONCE

PREPARED BY THE CENTRAL OFFICE OF INFORMATION FOR THE MINISTRY OF HEALTH

(8977) Wt. [illegible]

THE NEW

NATIONAL HEALTH SERVICE

*

Your new National Health Service begins on 5th July. What is it? How do you get it?

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.

to-reach
transferring innovation in health systems

TO REACH….

and the future of Health Systems and Services Research in Europe

This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 733274.

to-reach

transferring innovation in health systems

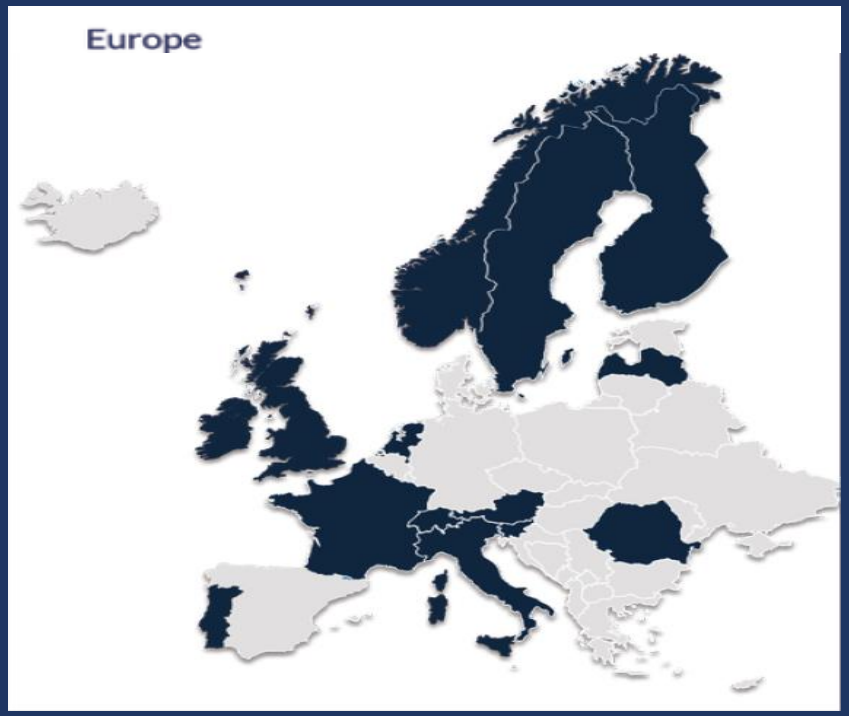
TO-REACH is a Coordination and Support Action funded by Horizon 2020 Societal Challenge 1 coordinated by
Istituto Superiore di Sanità (National Institute of Health), Italy.

Its goal is to pave the way to a joint European research programme aimed at producing research evidence to support healthcare services and systems so that they become more resilient, effective, equitable, accessible, sustainable and comprehensive in Europe and elsewhere.

to-reach
transferring innovation in health systems

This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 733274.

The consortium



28 partners
20 countries

to-reach
transferring innovation in health systems

This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 733274.

The TO-REACH consortium

Chaired by Prof Walter Ricciardi, President of the Istituto Superiore di Sanità), the EU-funded TO-REACH project consists of 27 partners, clustered around three main types:

- At the core are **Ministerial and funding bodies from 15 EU Member States and 5 non-EU countries**, all seeking to fund research that has the potential to change how care is being provided in the near or distant future.
    a. the Istituto Superiore di Sanità (the Italian National Institute of Health), coordinator,
    b. Ministero della Salute, Italy
    c. Agenas, national Agency for regional health services, Italy;
    d. ZonMw (Netherlands Organisation for Health Research & Development), the Netherlands;
    e. Austrian Public Health Institute (GÖG), Austria
    f. Academy of Finland, Finland;
    g. IReSP/ITMO santé publique, France;
    h. Health Research Board, Ireland;
    i. Latvian Council of Science, Latvia;
    j. Research Council of Norway, Norway;
    k. Foundation for Science and Technology (FCT) Portugal;
    l. National Institute of Public Health, Slovenia;
    m. Forte, Swedish Research Council for Health, Working Life and Welfare, Sweden;
    n. Federal Office of Public Health (FOPH), Switzerland;
    o. Health and Care Research Wales, UK;
    p. Regional Agency for Public Health and Social Well-being (PHA) HSCNI, Northern Ireland UK;
    q. CIHR Institute of HSPR, Canada;
    r. Israeli Ministry of Health, Israel;
    s. Agency for Healthcare Research and Quality (AHRQ), United States.
- **National research organisations**, able to identify methodological guidance for a future research programme and mapping shared priority areas between countries and stakeholders in those countries.
    a. NIVEL, Netherlands organisation for health services research, the Netherlands;
    b. National Institute for Health and Welfare (THL), Finland;
    c. University of Riga (RSU), Latvia;
    d. University of Malta (UoM), Malta;
    e. Babeș-Bolyai University (UBBCU), Romania;
    f. Catholic University of Sacred Heart (UCSC), Italy.
- **European level bodies**, able to contribute to part of the scientific preparations as well as well-positioned to identify fellow bodies and initiatives which require alignment.
    a. European Observatory on Health Systems and Policies;
    b. European Health Management Association (EHMA);
    c. European Public Health Association (EUPHA).

to-reach

Draft TO-REACH Strategic Research Agenda

May 2019

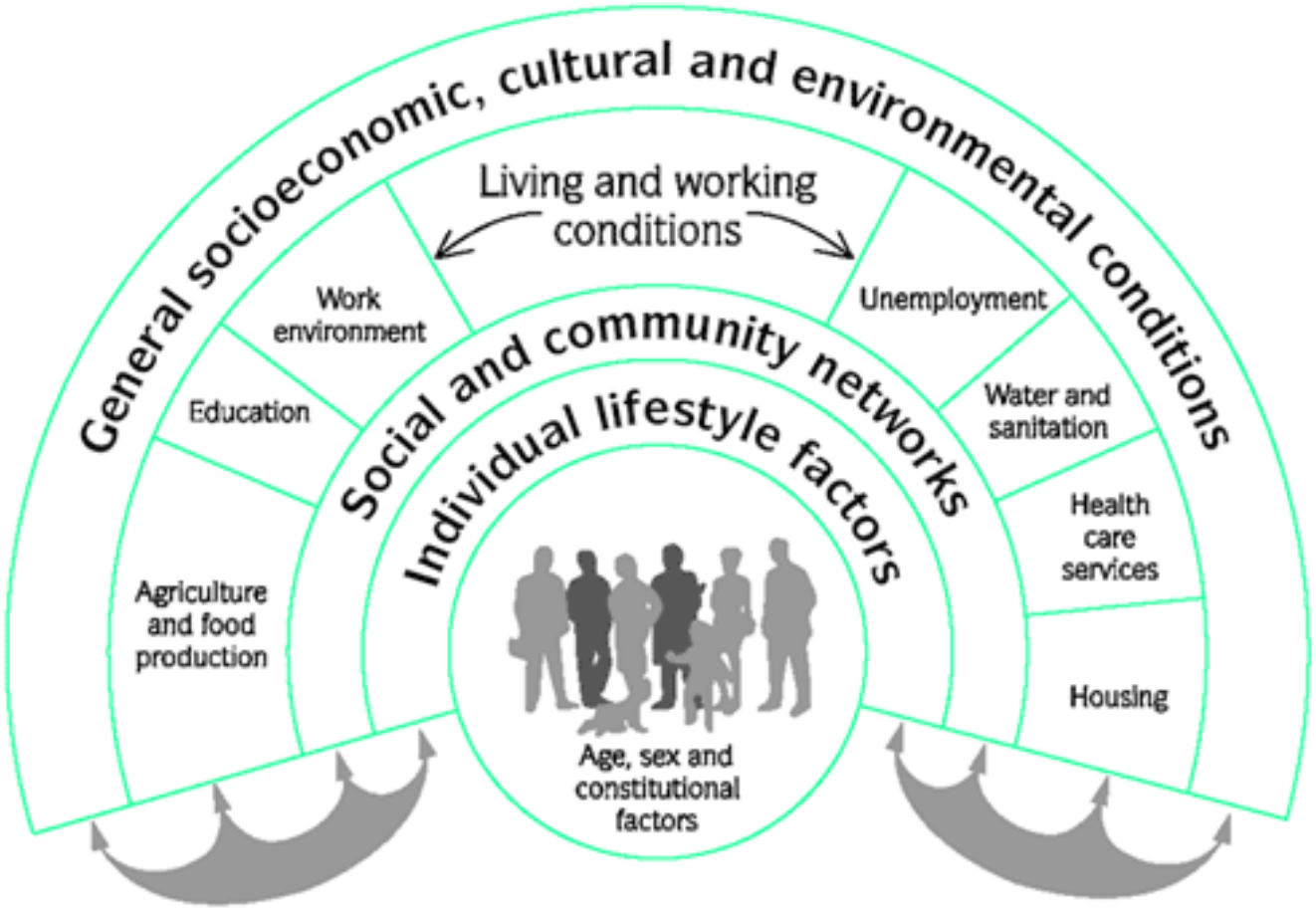
Preliminary list of candidates for European Partnerships in Pillar II, III and cross-pillar, and short description of what the partnership stands and aims for		Currently envisaged implementation mode(s)	Predecessors	Composition of partners	Relevance for clusters/ pillars
Health	**1. EU-Africa Global Health Partnership** Increase health security in sub-Saharan Africa and Europe, by accelerating the clinical development of effective, safe, accessible, suitable and affordable health technologies as well as health systems interventions for infectious diseases in partnership with Africa and international funders.	Article 185 or Article 187 or Co-programmed or co-funded	EDCTP2 (Art.185)	MS/AC and 3rd countries (i.e. sub-Saharan African countries) Foundations/industry on an ad-hoc basis	Cl.1
	2. Innovative Health Initiative A collaborative platform bringing the pharmaceuticals, diagnostics, medical devices, imaging and digital sectors together for precompetitive R&I in areas of unmet public health need, to accelerate the development and uptake of people-centred health care innovations.	Article 187 or Co-programmed	IMI2 (Art.187)	Industry, other organisations on an ad hoc basis	Cl.1
	3. European partnership for chemicals risk assessment Bring together the European risk assessment and regulatory agencies to implement a joint research agenda, to ensure their capacity to deal with persistent or emerging challenges. It will promote the uptake of new methods, tools, technologies and information in chemical hazard identification and risk assessment and as part of this, sustain the development and use of human biomonitoring capacities in Europe.	Co-funded	Human Bio-monitoring and a number of other actions	MS/AC, National agencies, tbd the role of the corresponding EU agencies	Cl.1, 4, 6
	4. Pre-clinical/clinical health research The partnerships aims for establishing and implementing a strategic research agenda and joint funding strategy between major European public funders in health research.	Co-funded	Around 10 previous and current ERA-NET actions	MS / AC / 3rd countries	Cl.1, 6
	5. Large-scale innovation and transformation of health systems in a digital and ageing society Improving health and care models in an ageing, data-driven and digital society, shifting to holistic health promotion and person-centred care approaches through health policy and health systems research.	Co-funded	AAL2 (Art.185), JPI 'More Years, Better Lives' and others	MS / AC Civil Society organisations	Cl.1
	6. Personalised Medicine To align national research strategies, promote excellence, reinforce the competitiveness of European players in Personalised Medicine and enhance the European collaboration with non-EU countries	Co-funded	ERA-PerMed and actions in support of ICPerMed	MS / AC	Cl.1
	7. Rare Diseases To improve the integration, the effectiveness, the production and the social impact of research on rare diseases through the development, demonstration and promotion of Europe/ world-wide production, sharing and exploitation of research and clinical data, materials, processes, knowledge and know-hows.	Co-funded	EJP Rare diseases (until 2023)	MS/AC /3rd countries, civil society organisations, EU research infrastructures	Cl.1

General Information	
Preliminary title of the European Partnerships	Large-scale innovation and transformation of health systems in a digital and ageing society: a European Partnership on Health and Care Systems Research and Innovation
Short description of the partnership	A partnership with health and care systems owners/organisers and research funders to boost research in policy, uptake and scale-up of innovations to accelerate transformation of national/regional health and care systems.
Services directly involved	RTD, SANTE, CNECT, ECFIN, ENV, REGIO, SRSS, JRC, EMPL, GROW, EAC, EUROSTAT.
Context and problem definition	Health and care systems in the EU are globally recognised for making quality care available to citizens, and are a key asset for economic strength in the EU. Healthcare is an important economic sector in Europe, employing 8.5% of the workforce, and counting for almost 10% of the GDP in the EU. Nonetheless, health and care systems face serious challenges due to ageing population, increasing number of people with multiple chronic conditions, higher demand for healthcare by citizens, expensive innovative products and solutions, and health workforce shortages. . Public spending on health and long-term care is steadily rising in the EU, which is expected to put additional pressure on the Member States given budgetary constraints and the need for fiscal sustainability. The key problem drivers are the following: - Lack of knowledge and good practice of how health and care systems research can support policy makers in management and design of health and care systems; - Lack of an operational platform that links researchers and innovators in the area of health and care systems with stakeholders from Member States and regional/local health authorities, technology and services providers, investors, patient/citizen and profession advocacy groups to define the unmet system needs and take collaborative R&I actions to address them; - Lack of communication channels between researchers and policymakers to take into account the research needs of policymakers, and ensure that solutions provided by researchers are uptaken into policy; - Underuse of local/regional stakeholder eco-systems that play a key role in communicating with and informing patients, in education and training for professionals, and in piloting and integrating innovative solutions in health and care services. The proposed partnership is being built with the support of a H2020-funded Coordination and Support Action (TO-REACH), which was created to prepare a Strategic Research Agenda towards a joint European research programme on Health Systems, and is composed of partners from 18 countries (IT, NL, FI, FR, IE, LV, MT, NO, PT, RO, SI, SE, UK, IL, AT, US, CH, CA). It has prepared the grounds for joint research activities and pooling of resources from EU and Member States within the European Partnership on Health and Care Systems Research and Innovation. This partnership will draw on specific aspects relevant to health and care systems research in FP7 and H2020 initiatives such as EIP AHA, AAL/AAL2 and MYBL, which are mainly focused on addressing challenges related to ageing population (detailed in the section on current active partnerships).
Objectives and expected impacts	The partnership has the following **objectives:** 1. Provide science-based evidence for health and care systems innovations that support cost-effective and fiscally sustainable health policies and the needs of health authorities, health professionals, patients, citizens and other key stakeholders; 2. Develop science-based frameworks for monitoring and evaluating the cost-effectiveness and budgetary impact of innovative solutions, including digital, new health promotion services and care models; 3. Build knowledge on the conditions for transferability and up-scaling of innovative health and care solutions across and within EU countries;

JAHEE

JOINT ACTION
HEALTH EQUITY EUROPE

Funded by the European Union's Health Programme (2014-2020)



Source: Dahlgren and Whitehead, 1993

The concept of “public good”

non exclusive: anyone can use them

non competitive: their use will not limit others to use them

The concept of “public good”

Progress of medicine and essential medicines shall be considered as global public goods and be accessible to all human beings living on our planet