



UNIVERSITÀ DI PISA

IL CONCETTO DI SALUTE

Lara Tavoschi

Lezione di oggi

- Concetto di salute
- Agenzie di salute pubblica nazionali/internazionali



La salute – cos'è?



Che intendiamo per Salute?

“La salute è uno stato di completo benessere fisico, mentale e sociale e non semplicemente l’assenza di malattia e di infermità”

OMS, 1948

Che intendiamo per Salute?

Approccio funzionale

“La salute è uno stato di **capacità ottimale** di un individuo per un efficace **svolgimento dei ruoli** e dei compiti per i quali esso è stato socializzato.” (*Pearson T.: Patients physicians and illness. E. Garthly Jaco and Free Press, N.Y. 1972*)

“La salute è determinata da una **capacità di comportamento** che include componenti biologiche e sociali per **adempiere alle funzioni** fondamentali.” (Bonnie P.: The concept of Health. A social medical approach. Scand. J. Med. 1,2,1973)

Che intendiamo per Salute?

Approccio percettivo

“La salute non è semplicemente assenza di malattia, è qualcosa di positivo, **un’attitudine felice alla vita** e una lieta accettazione delle responsabilità che la vita stessa comporta”. (Singerist H.E., 1941)

“La salute è legata al “senso di coerenza” di ciascuno inteso come un orientamento all’essere confidenti che qualsiasi **stimolo che provenga dall’interno o dall’esterno durante la nostra vita è strutturato, prevedibile e spiegabile, che abbiamo le risorse** per rispondere alle richieste che questi stimoli ci rivolgono...” (Antonowsky, 1987)

Che intendiamo per Salute?

Approccio adattativo

“La salute è il prodotto di una **relazione armoniosa** tra l'uomo e la sua ecologia.” (Rossdale M.,1965)

“La salute è l'**adattamento perfetto e continuo** di un organismo al suo ambiente.” (Wylie C.M, 1970)

Che intendiamo per Salute?

Approccio adattativo

«Health is defined not by the doctor, but by the person, according to his or her functional needs [...]

By replacing perfection with adaptation, we get closer to a more compassionate, comforting, and creative programme for medicine»

www.thelancet.com Vol 373 March 7, 2009

Editorial

What is health? The ability to adapt

Health is not a "state of complete physical, mental, and social well-being". And nor is it "merely the absence of disease or infirmity". The first part of this formulation is enshrined in WHO's famous founding constitution, adopted in 1946. It was supposed to provide a transformative vision of "health for all", one that went beyond the prevailing negative conception of health based on an "absence" of pathology. But neither definition will do in an era marked by new understandings of disease at molecular, individual, and societal levels. Given that we now know the important influence of the genome in disease, even the most optimistic health advocate surely has to accept the impossibility of risk-free wellbeing.

That said, the conjunction of the physical, psychological, and social remains powerfully relevant to this day. Indeed, this framework should be extended in two further dimensions. First, human health cannot be separated from the health of our total planetary biodiversity. Human beings do not exist in a biological vacuum. We live in an interdependent existence with the totality of the living world. The second dimension is in the realm of the inanimate. The living world depends upon a healthy interaction with the inanimate world. Thanks to the science of climate change, we now understand only too well how contingent our human wellbeing is on the "health" of the Earth's systems of energy exchange.

Science has contributed to our understanding of wellbeing through an ingenious apparatus of techniques that reveal not only the causal pathways of ill health but also evidence for their amelioration. But the language of science can be inhibitory. For example, the notion of suffering is no longer fashionable. It is not a scientific word; it seems vague and old-fashioned, harking back to a time of clinical impotence, when patients had to endure and tolerate pain without respite or relief. Science aims to deliver the means to eliminate much of what once passed for human suffering.

But as the opening article in our Series on health in the occupied Palestinian territory shows, dimensions of suffering, especially at the community level, are measurable and often severe. Science has not eradicated suffering, despite its enormous power to deliver technologies to improve health. Being more humble about the experience of individuals, rather than simply drawing up reductive report cards of their health status, opens up the possibility for a more realistic understanding of what it means to be healthy. The fact is that one cannot be healthy in an unhealthy society.

Health certainly has to encompass these complex determinants of illness. But to say this can induce a feeling of fatigue, even defeat. The obstacles to a minimum quantity of health seem so huge and so complex that it is almost impossible for a single doctor to have any influence on their effects. But if we take a more modest view of what health means, perhaps we may be able to transcend the complexities of disease and offer a very practical mission for modern medicine.

That mission was set out most clearly by a French physician, Georges Canguilhem, in his 1943 book, *The Normal and the Pathological*. Canguilhem rejected the idea that there were normal or abnormal states of health. He saw health not as something defined statistically or mechanistically. Rather, he saw health as the ability to adapt to one's environment. Health is not a fixed entity. It varies for every individual, depending on their circumstances. Health is defined not by the doctor, but by the person, according to his or her functional needs. The role of the doctor is to help the individual adapt to their unique prevailing conditions. This should be the meaning of "personalised medicine".

The beauty of Canguilhem's definition of health—of normality—is that it includes the animate and inanimate environment, as well as the physical, mental, and social dimensions of human life. It puts the individual patient, not the doctor, in a position of self-determining authority to define his or her health needs. The doctor becomes a partner in delivering those needs.

For a scientific journal too, Canguilhem's definition is liberating. By using adaptability as the test of health, a journal can evolve to address the changing circumstances of disease. Adaptability frees us to be agile in the face of shifting forces that shape the wellbeing of individuals and populations. Canguilhem's definition also allows us to respond to disease globally, taking account of the context of conditions in a particular place, as well as time.

Health is an elusive as well as a motivating idea. By replacing perfection with adaptation, we get closer to a more compassionate, comforting, and creative programme for medicine—one to which we can all contribute. ■ *The Lancet*



See Series page B37

www.thelancet.com Vol 373 March 7, 2009

781

Che intendiamo per Salute?

Approccio adattativo

«requirement for **complete** health “would leave most of us unhealthy most of the time »

«we propose the formulation of health as the **ability to adapt and to self manage**»

BMJ 2011;343:d4163 doi: 10.1136/bmj.d4163

BMJ

BMJ 2011;343:d4163 doi: 10.1136/bmj.d4163

Page 1 of 3

ANALYSIS

How should we define health?

The WHO definition of health as complete wellbeing is no longer fit for purpose given the rise of chronic disease. **Machteld Huber and colleagues** propose changing the emphasis towards the ability to adapt and self manage in the face of social, physical, and emotional challenges

Machteld Huber *senior researcher*¹, J André Knottnerus *president, Scientific Council for Government Policy*², Lawrence Green *editor in chief, Oxford Bibliographies Online—public health*³, Henriëtte van der Horst *head*⁴, Alejandro R Jadad *professor*⁵, Daan Kromhout *vice president, Health Council of the Netherlands*⁶, Brian Leonard *professor*⁷, Kate Lorig *professor*⁸, Maria Isabel Loureiro *coordinator for health promotion and protection*⁹, Jos W M van der Meer *professor*¹⁰, Paul Schnabel *director*¹¹, Richard Smith *director*¹², Chris van Weel *head*¹³, Henk Smid *director*¹⁴

¹Louis Bolk Institute, Department of Healthcare and Nutrition, Hooftstraat 24, NL-3972 LA Driebergen, Netherlands; ²Department of General Practice, Maastricht University, Scientific Council for Government Policy, Postbus 20004, NL-2500 EA The Hague, Netherlands; ³Department of Epidemiology and Biostatistics, School of Medicine, University of California at San Francisco, USA; ⁴Department of General Practice, VU Medical Center, Amsterdam, Netherlands; ⁵Centre for Global eHealth Innovation, Toronto General Hospital, Toronto, Canada; ⁶Department of Public Health Research, Wageningen University, The Hague, Netherlands; ⁷Pharmacology Department, National University of Ireland, Galway, Ireland; ⁸Stanford Patient Education Research Center, Palo Alto, CA, USA; ⁹National School of Public Health/New University of Lisbon, Portugal; ¹⁰General Internal Medicine, Radboud University Nijmegen Medical Centre, Nijmegen, Netherlands; ¹¹Netherlands Institute for Social Research, The Hague, Netherlands; ¹²UnitedHealth Chronic Disease Initiative, London, UK; ¹³Department of Primary and Community Care, Radboud University Nijmegen Medical Centre; ¹⁴Netherlands Organisation for Health Research and Development, The Hague, Netherlands

The current WHO definition of health, formulated in 1948, describes health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”¹ At that time this formulation was groundbreaking because of its breadth and ambition. It overcame the negative definition of health as absence of disease and included the physical, mental, and social domains. Although the definition has been criticised over the past 60 years, it has never been adapted. Criticism is now intensifying,^{2,3} and as populations age and the pattern of illnesses changes the definition may even be counterproductive. The paper summarises the limitations of the WHO definition and describes the proposals for making it more useful that were developed at a conference of international health experts held in the Netherlands.⁴

Limitations of WHO definition

Most criticism of the WHO definition concerns the absoluteness of the word “complete” in relation to wellbeing. The first problem is that it unintentionally contributes to the medicalisation of society. The requirement for complete health “would leave most of us unhealthy most of the time.”⁵ It therefore supports the tendencies of the medical technology and drug industries, in association with professional organisations, to redefine diseases, expanding the scope of the healthcare

system. New screening technologies detect abnormalities at levels that might never cause illness and pharmaceutical companies produce drugs for “conditions” not previously defined as health problems. Thresholds for intervention tend to be lowered—for example, with blood pressure, lipids, and sugar. The persistent emphasis on complete physical wellbeing could lead to large groups of people becoming eligible for screening or for expensive interventions even when only one person might benefit, and it might result in higher levels of medical dependency and risk.

The second problem is that since 1948 the demography of populations and the nature of disease have changed considerably. In 1948 acute diseases presented the main burden of illness and chronic diseases led to early death. In that context WHO articulated a helpful ambition. Disease patterns have changed, with public health measures such as improved nutrition, hygiene, and sanitation and more powerful healthcare interventions. The number of people living with chronic diseases for decades is increasing worldwide; even in the slums of India the mortality pattern is increasingly burdened by chronic diseases.⁶

Ageing with chronic illnesses has become the norm, and chronic diseases account for most of the expenditures of the healthcare system, putting pressure on its sustainability. In this context the

Correspondence to: M Huber, m.huber@louisbolk.nl

Reprints: <http://journals.bmj.com/cgi/ReprintForm>

Subscribe: <http://resources.bmj.com/bmj/subscribers/how-to-subscribe>

Approccio adattativo



Salute pubblica



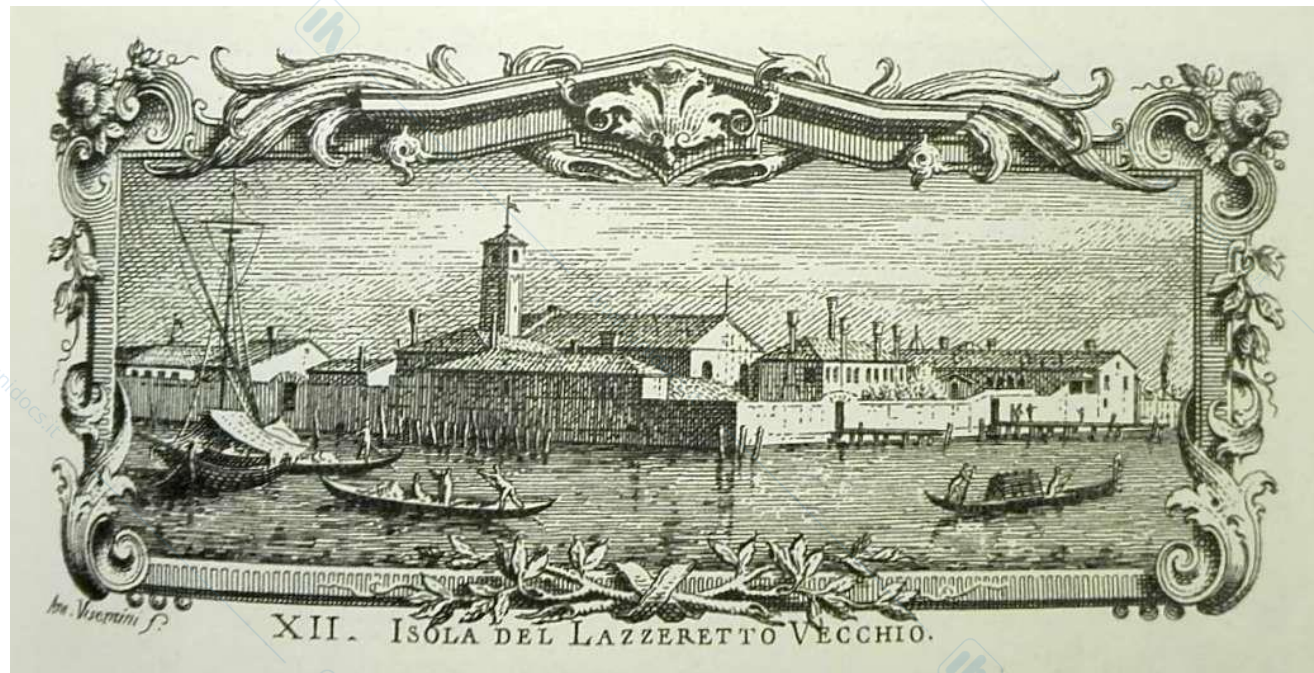


UNIVERSITÀ DI PISA

CENNI DI STORIA

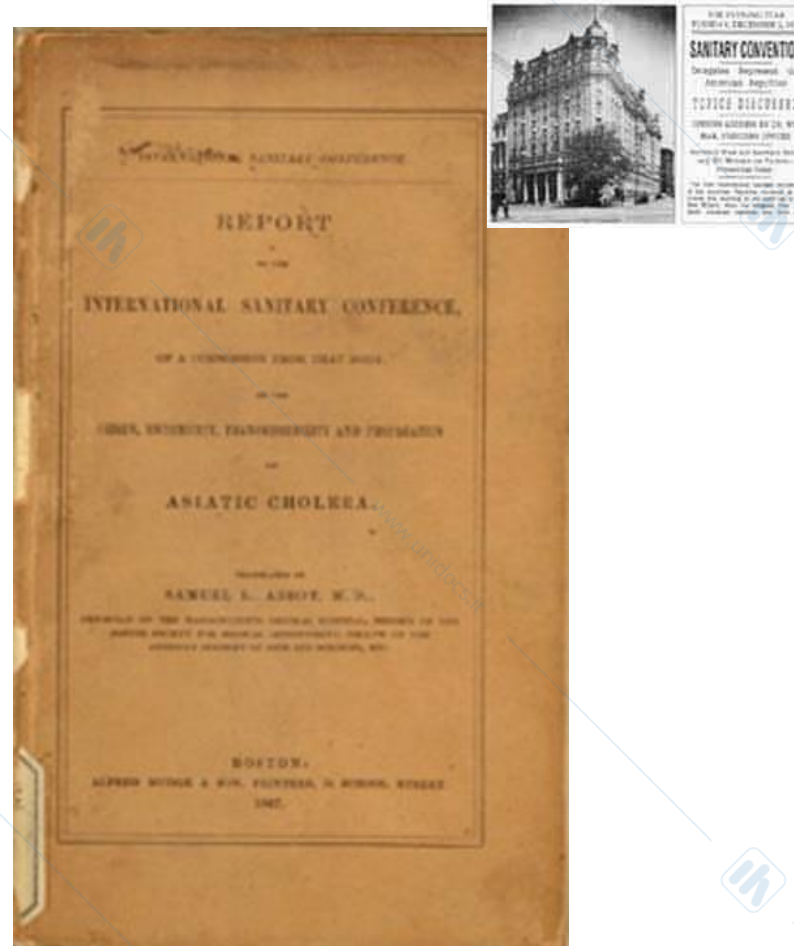
Istituzione della quarantena (o contumacia)

- Nel 1347 la repubblica di venezia istituisce la quarantena per le navi in arrivo dalle zone colpite dalla peste



First International Sanitary Conference, Paris 1851

- Tra il 1816 e il 1899, si registrarono sei pandemie globali di colera
- First International Sanitary Conference organizzata a Paris nel 1851
- Delegati da 11 paesi



Markel H. [Public Health](#). 2014 Feb;128(2):124-8
Stern et al. [JAMA](#). 2004;292(12):1474-1479

International Sanitary Conferences

1851-1900

- 10 international sanitary conferences vennero organizzate nel period 1851-1900
- La **quarantena**: fermare l'importazione transnazionale di malattie infettive vs interessi commerciali
- Focalizzate al contenimento di epidemie di: **colera**, **peste**
- 1903 ratifica della International Sanitary Convention

https://www.who.int/global_health_histories/background/en/

International Bureaus of Health

- 1902 Pan-American Sanitary Bureau (now Pan-American Health Organization or PAHO)
- 1907 Office International d'Hygiène Publique (OIHP), a Parigi
- 1923 Health Organizations of the League of Nations



- Applicazione di metodi moderni di epidemiologia come la **sorveglianza di malattia, notifica/segnalazione di caso, e communication technologies**
- Si espande l'azione oltre la quarantena

Markel H. [Public Health](#). 2014 Feb;128(2):124-8
Stern et al. [JAMA](#). 2004;292(12):1474-1479

World Health Organization



WHO viene fondata quando la sua Costituzione divenne operative il 7 Aprile 1948 – una data celebrata ogni anno come il World Health Day.

<http://www.who.int/>

Constitution of WHO

WHO remains firmly committed to the principles set out in the preamble to the Constitution

Constitution of the World Health Organization: Principles

- Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
- The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest co-operation of individuals and States.
- The achievement of any State in the promotion and protection of health is of value to all.
- Unequal development in different countries in the promotion of health and control of diseases, especially communicable disease, is a common danger.
- Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.
- The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.
- Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.
- Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

<http://www.who.int/about/mission/en/>

Art. 32 della Costituzione 1948

- La Repubblica **tutela la salute come fondamentale diritto dell'individuo e interesse della collettività**, e garantisce **cure gratuite** agli indigenti.
- Nessuno può essere obbligato a un determinato trattamento sanitario se non per disposizione di legge.
- La legge in nessun caso può violare i limiti imposti dal rispetto della persona umana.

Dichiarazione di Alma Ata -1978

L'assistenza sanitaria di base è quella assistenza sanitaria essenziale, fondata su metodi pratici e tecnologie **appropriate, scientificamente valide e socialmente accettabili, resa universalmente accessibile** agli individui e alle famiglie nella collettività, attraverso la loro piena partecipazione, a un costo che la collettività e i paesi possono permettersi ad ogni stadio del loro sviluppo nello spirito di responsabilità e di autodeterminazione.....



Dichiarazione di Alma Ata -1978

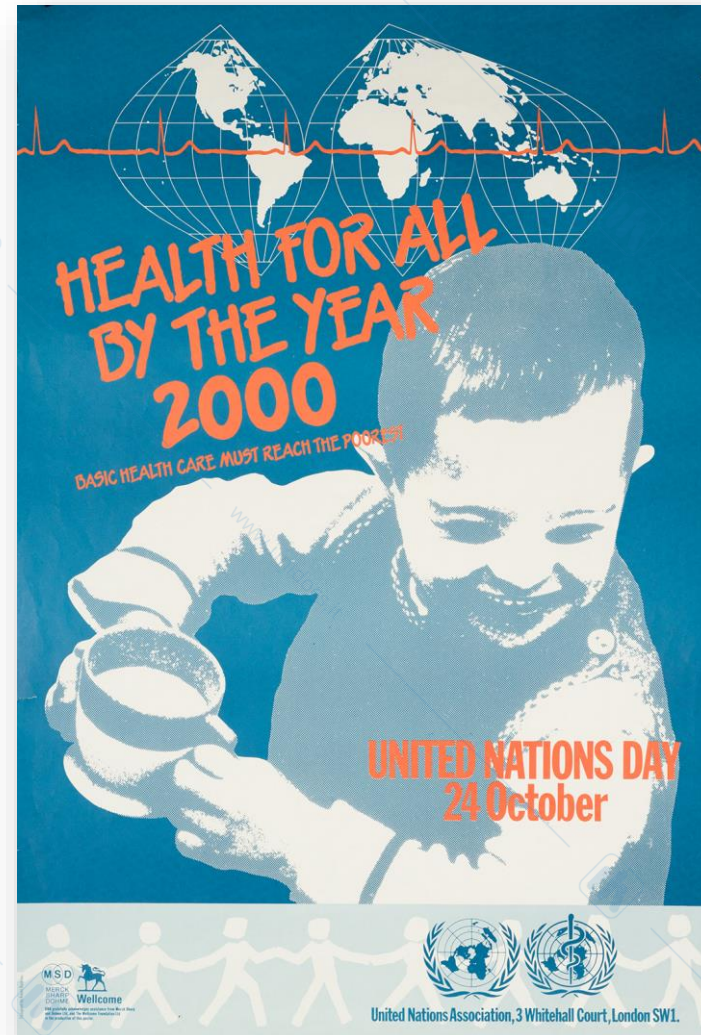
L'assistenza sanitaria di base fa parte integrante sia del sistema sanitario nazionale, di cui è il perno e il punto focale, sia dello sviluppo economico e sociale globale della collettività.

E' il primo livello attraverso il quale gli individui, le famiglie e la collettività entrano in contatto con il sistema sanitario nazionale, avvicinando il più possibile l'assistenza sanitaria ai luoghi dove le persone vivono e lavorano, e **costituisce il primo elemento di un processo continuo di protezione sanitaria**



Health for All by 2000

- Nel 1981 l'OMS lanciò la campagna "Health for ALL" entro l'anno 2000 con l'intento di equiparare lo stato di salute e l'accesso ai servizi tra paesi sviluppati e paesi in via di sviluppo.
- Per raggiungere questo obiettivo il concetto di Primary health care fu sviluppato.

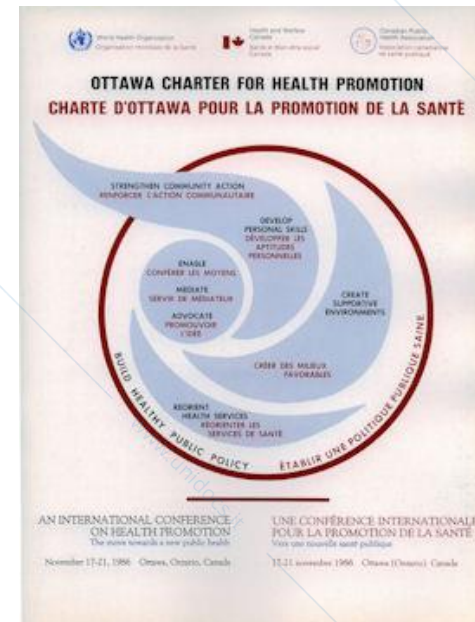


Legge 23 dicembre 1978 n. 833

- Istituzione del Sistema Sanitario Nazionale
- Uniformità delle condizioni di salute su tutto il territorio nazionale, garantendo a tutti i livelli uniformi di assistenza.
- I livelli uniformi di assistenza sono “l’insieme delle attività che devono essere erogate dal SSN”
- Si istituiscono le Unità Sanitarie Locali, che sono originariamente strutture operative dei Comuni

Carta di Ottawa 1986 – Conferenza mondiale sulla promozione della salute

- “... La promozione della salute è il processo che mette in grado le persone di aumentare il proprio controllo sulla propria salute e di migliorarla ...”.
- Gli obiettivi della Promozione della salute sono:
 - rafforzare le capacità e le competenze degli individui
 - modificare le condizioni sociali, ambientali ed economiche in modo tale da mitigare l’impatto che esse hanno sulla salute del singolo e della collettività.



Carta di Ottawa 1986 – I Conferenza mondiale sulla promozione della salute

- Conformemente al concetto di salute, inteso come un diritto fondamentale dell'uomo, la Carta di Ottawa evidenzia alcuni requisiti fondamentali per la salute fra i quali la **pace, adeguate risorse economiche, l'alimentazione e l'abitazione, un ecosistema stabile e un uso sostenibile delle risorse.**
- Il riconoscimento di questi requisiti fondamentali sottolinea gli inestricabili legami esistenti tra le **condizioni socioeconomiche, l'ambiente fisico, lo stile di vita delle persone e la salute.**
- Questi legami forniscono la chiave di comprensione olistica della salute, fondamentale nella definizione di **promozione della salute**



Carta di Ottawa 1986 – Conferenza mondiale sulla promozione della salute



I determinanti di salute



Dahlgren G, Whitehead M; 1993

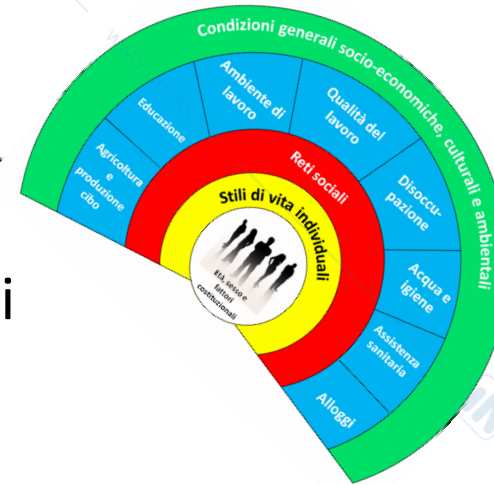
Determinanti di salute

Determinanti non modificabili: sesso, età, geni

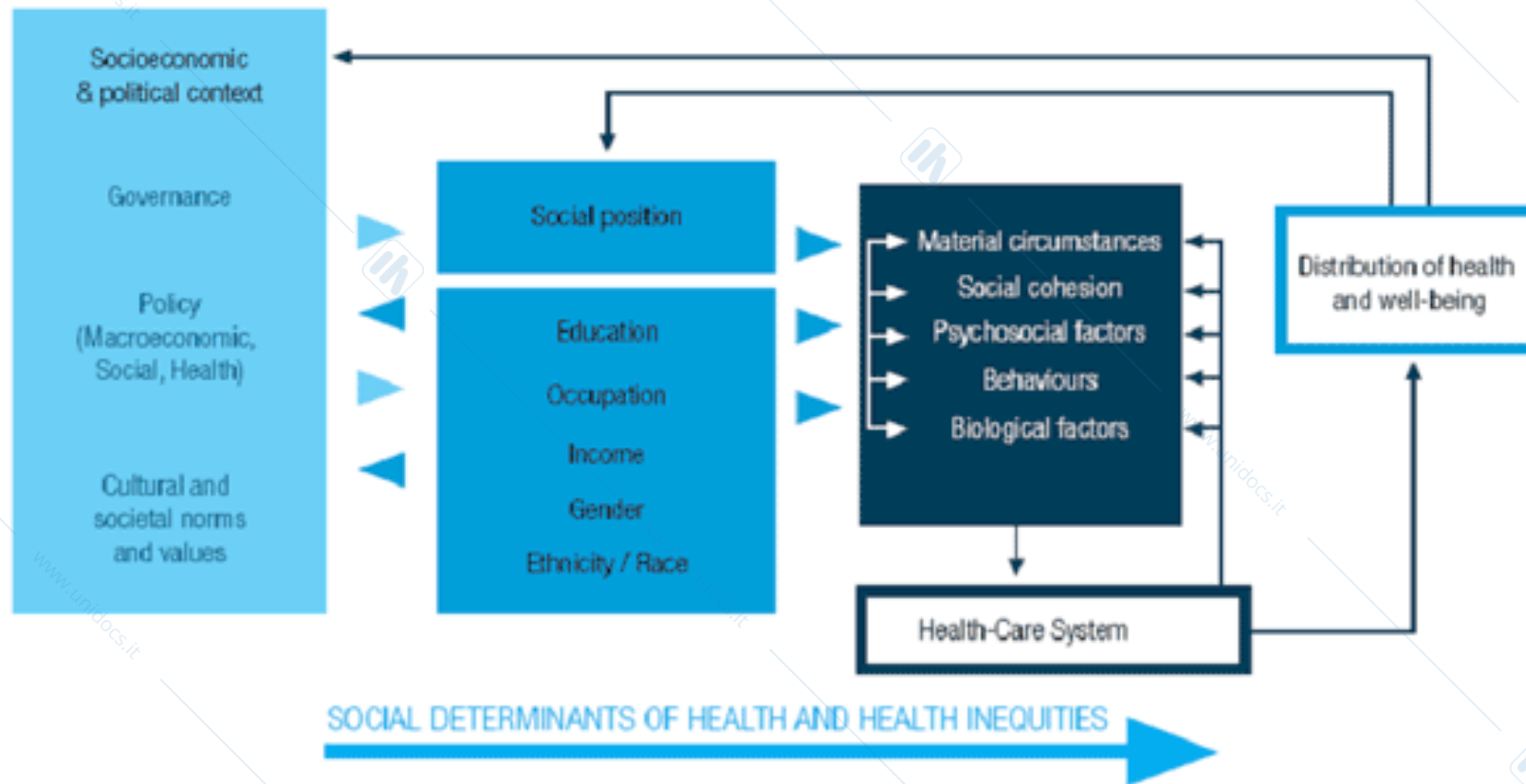
Determinanti modificabili

Determinanti prossimali: stili di vita, condizioni abitative, reddito, istruzione, relazioni sociali (capitale sociale), impiego, accesso ai servizi

Determinanti distali: Politiche sanitarie, politiche assistenziali, fattori geopolitici, cambiamento climatico



Determinanti di salute e determinanti di disuguaglianza in salute

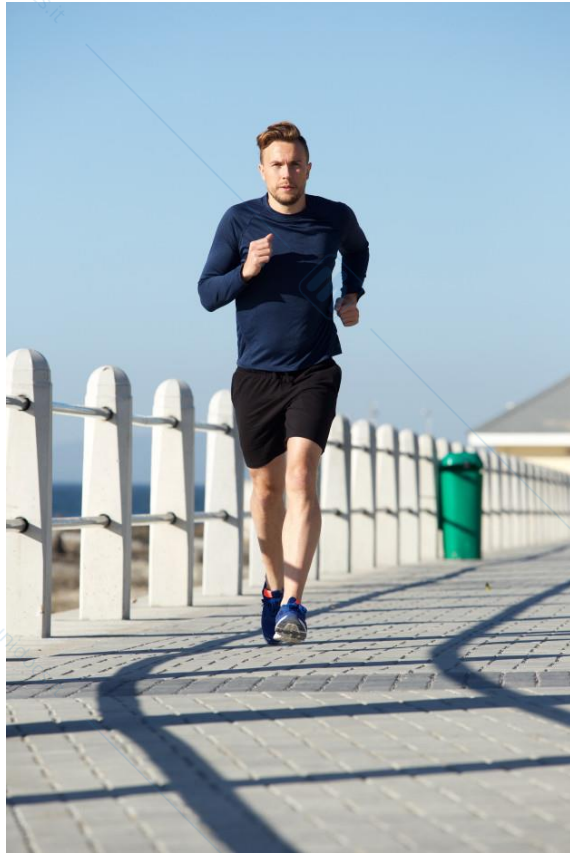


Source: Amended from Solar & Irwin, 2007

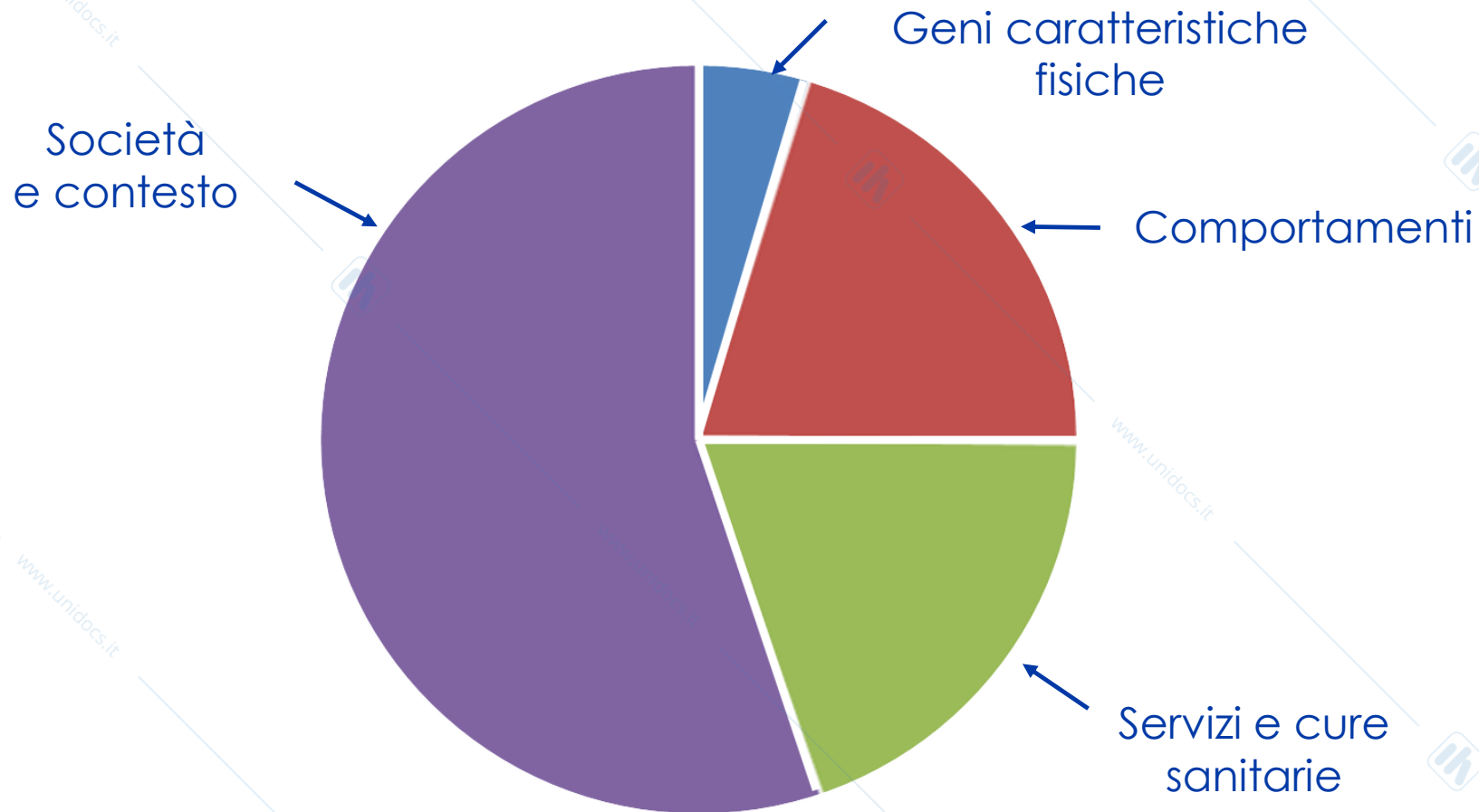
Approfondimento:

<https://www.saluteinternazionale.info/2009/01/i-determinanti-della-salute-una-nuova-originale-cornice-concettuale/>

Uguali o diversi?

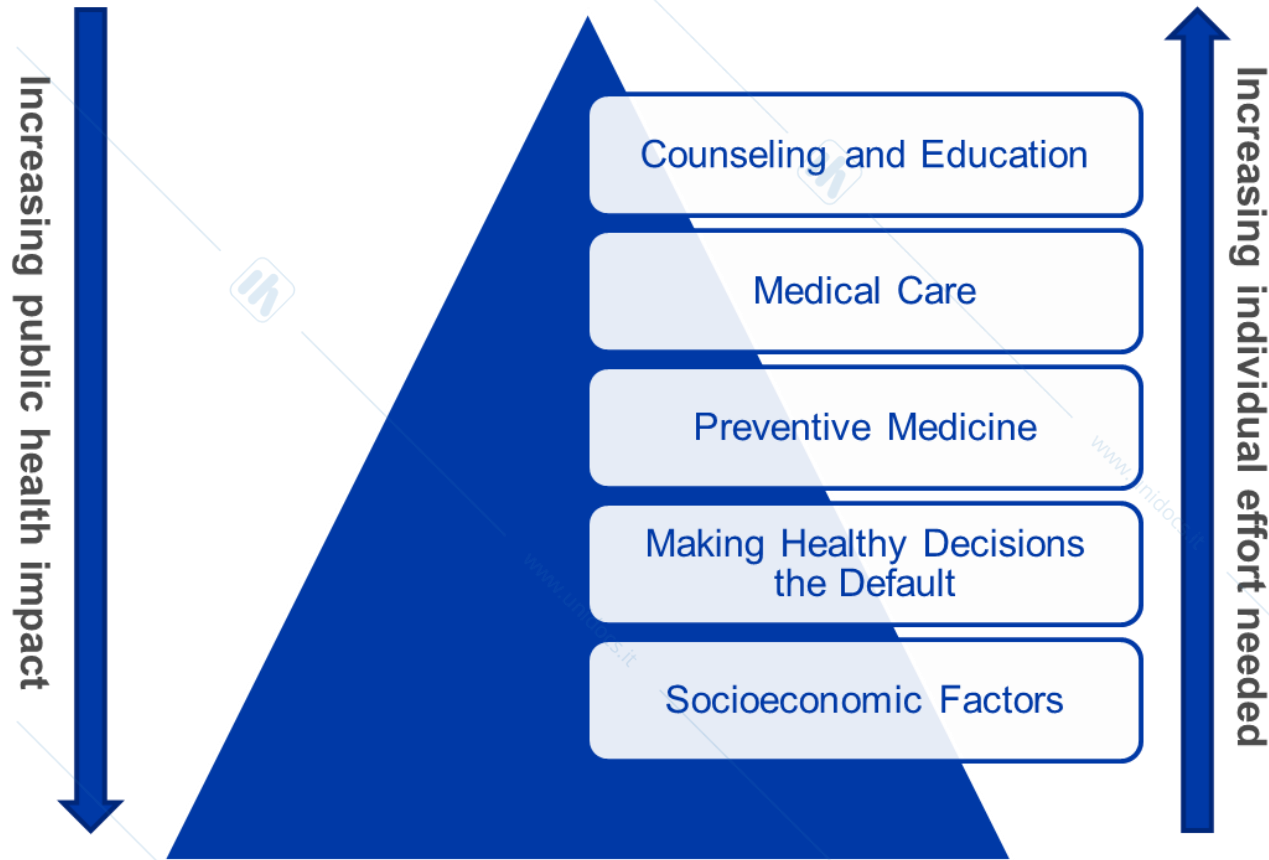


Cosa determina la salute di una popolazione?



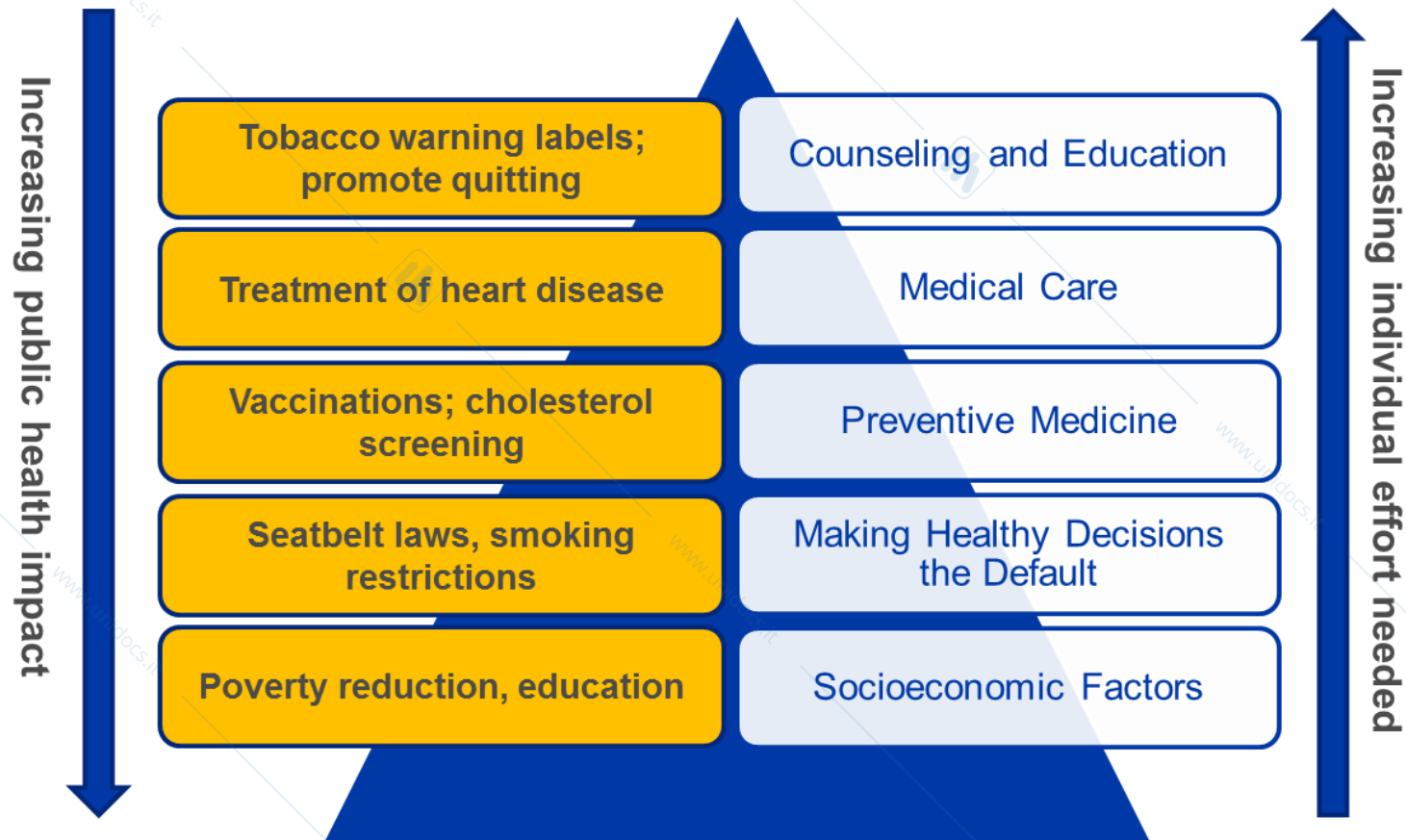
Centers for Disease Control and Prevention. Social determinants of health. <http://www.cdc.gov/socialdeterminants/FAQ.html>.

Impatto sulla salute



Frieden TR. Framework for public health action: the health impact pyramid. Am J Public Health 2010;100:590–5.

Health Impact Pyramid



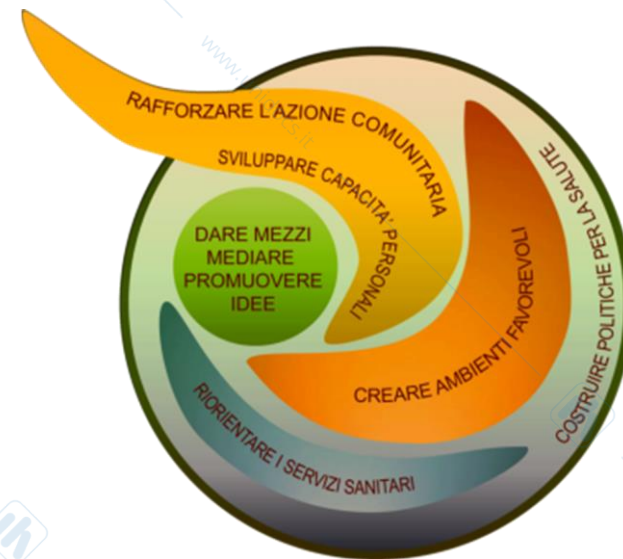
Frieden TR. Framework for public health action: the health impact pyramid. Am J Public Health 2010;100:590–5.

Bisogni di salute

- Bisogni di salute sono in(de)finiti: niente limiti esplicitamente condivisi al livello massimo di salute disponibile e/o ottenibile
- Migliore è la salute, più elevati e sofisticati i bisogni percepiti. Popolazioni in condizioni di salute deprivate percepiscono ed esprimono bisogni di salute minori.
- Bisogni di salute di popolazione variano nel tempo, nello spazio e sono dipendenti da fattori demografici, ambientali etc

Come contrastare le disuguaglianze di salute?

- Rafforzare le capacità individuali
- Rafforzare le comunità
- Migliorare l'accesso ai servizi sanitari
- Promuovere cambiamenti sociali e macro-economici



Universal Health Coverage (2030)



Set of multi-dimensional aspiration goals adopted by government leaders on 25 September 2015.



• 17 Sustainable Development Goals (SDGs) comprised with 169



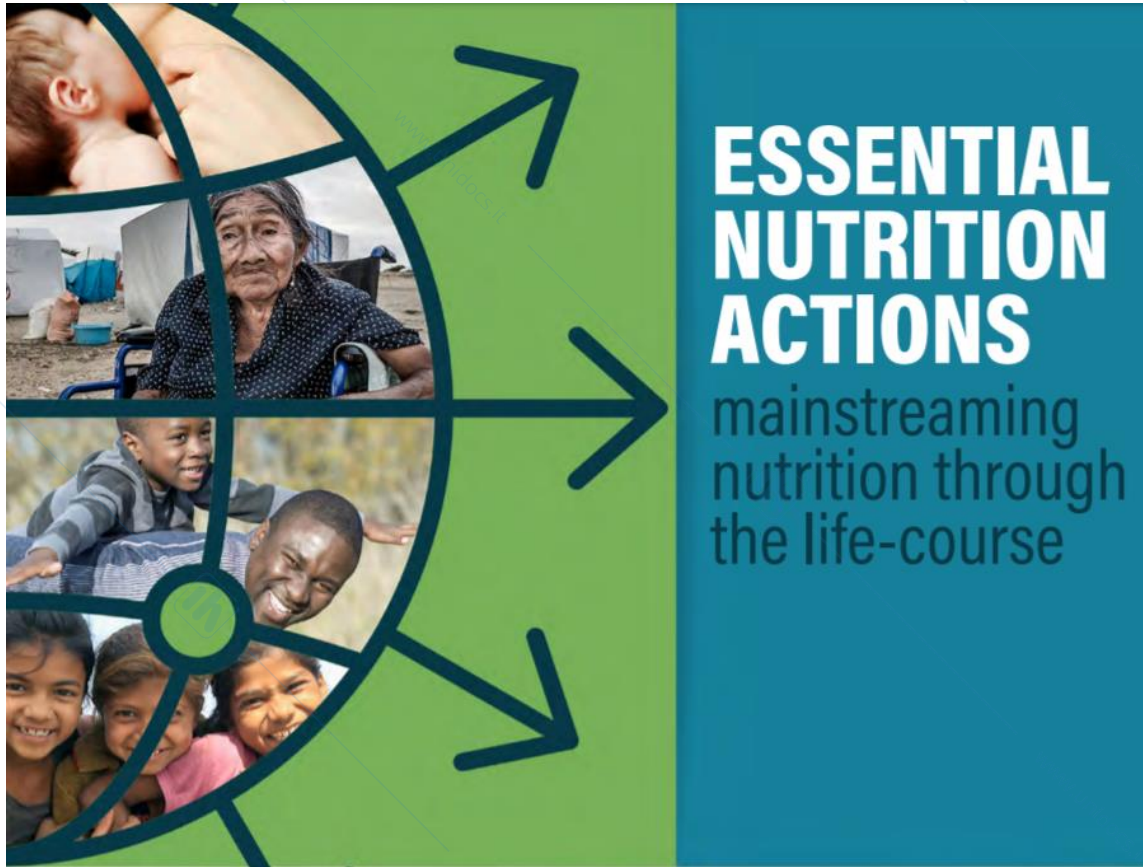
WHO welcomes landmark UN declaration on universal health coverage

23 September 2019 | News release | New York



**UNIVERSAL
HEALTH
COVERAGE:
EVERYONE,
EVERYWHERE**





FOCUS: STRATEGIA GLOBALE NUTRIZIONE

Malnutrizione – doppio problema



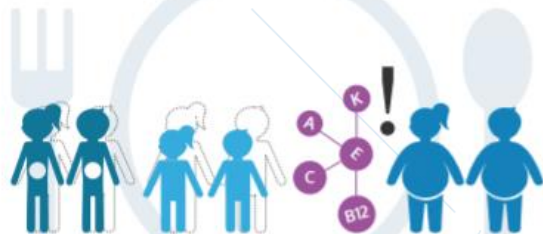
World Health Organization

THE DOUBLE BURDEN OF MALNUTRITION

WHAT

THE DOUBLE BURDEN OF MALNUTRITION IS CHARACTERISED BY THE COEXISTENCE OF:

1



Undernutrition (wasting, stunting & micronutrient deficiencies) along with overweight and obesity

2



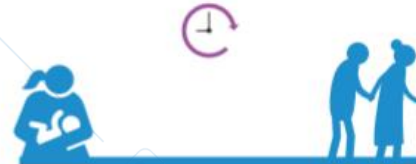
and diet-related noncommunicable diseases

3



within individuals, households and populations

4



throughout life

<https://www.who.int/nutrition/double-burden-malnutrition/en/>

Malnutrizione – doppio problema

WHERE



ACROSS THE GLOBE

1.9 BILLION
ADULTS, 18 years and
older, are overweight

>600 MILLION
of these are OBESE



264 MILLION
WOMEN of reproductive age are
affected by iron-amenable anaemia

462 MILLION
ADULTS are underweight

42 MILLION
children under the age of
5 years are **overweight or obese**



156 MILLION
children are **stunted**
(too short for age)



50 MILLION
children are **wasted**
(too thin for height)



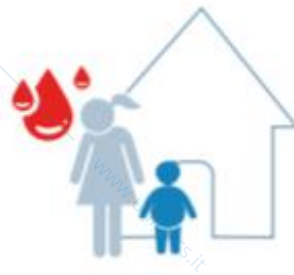
Malnutrizione – doppio problema



INDIVIDUALS
with the simultaneous presence of two or more types of malnutrition, or development of multiple types over a lifetime



HOUSEHOLDS
with multiple family members affected by different forms of malnutrition



POPULATIONS
with both undernutrition and overweight prevalent in the same community, region or nation



Malnutrizione – doppio problema

WHY ACT

THE DOUBLE BURDEN IS AN IMPORTANT OPPORTUNITY FOR ACTION ON MALNUTRITION IN ALL ITS FORMS



Addressing malnutrition is essential to achieving the Sustainable Development Goals



Nutrition is critical to both health and economic development



Focus and investment for integrated solutions will tackle malnutrition in all its forms

GOOD NUTRITION



PROMOTES MATERNAL, INFANT AND CHILD HEALTH

IMPROVES SCHOOL & EDUCATION PERFORMANCE



SUPPORTS STRONGER IMMUNE SYSTEMS

REDUCES THE RISK OF DISEASE



Malnutrizione – doppio problema

- **Diminuzione malnutrizione infantile** (basso rapporto altezza/età): tra 1990 e 2018 la prevalenza in bambini <5 anni è diminuita dal 39.2% al 21.9%, o da 252.5 mln a 149.0 mln (Africa and South-East Asia)
- **Obesità sta incrementando.** La prevalenza di bambini sovrappeso è salita da 4.8% a 5.9% tra il 1990 e 2018, corrispondente a più di 9 mln di bambini.
- Il numero degli adulti sovrappeso o obesi sta aumentando in ogni regione e paese, con 1.9 miliardi di persone sovrappeso nel 2016, di cui 650 mln (13% popolazione globale) obese.

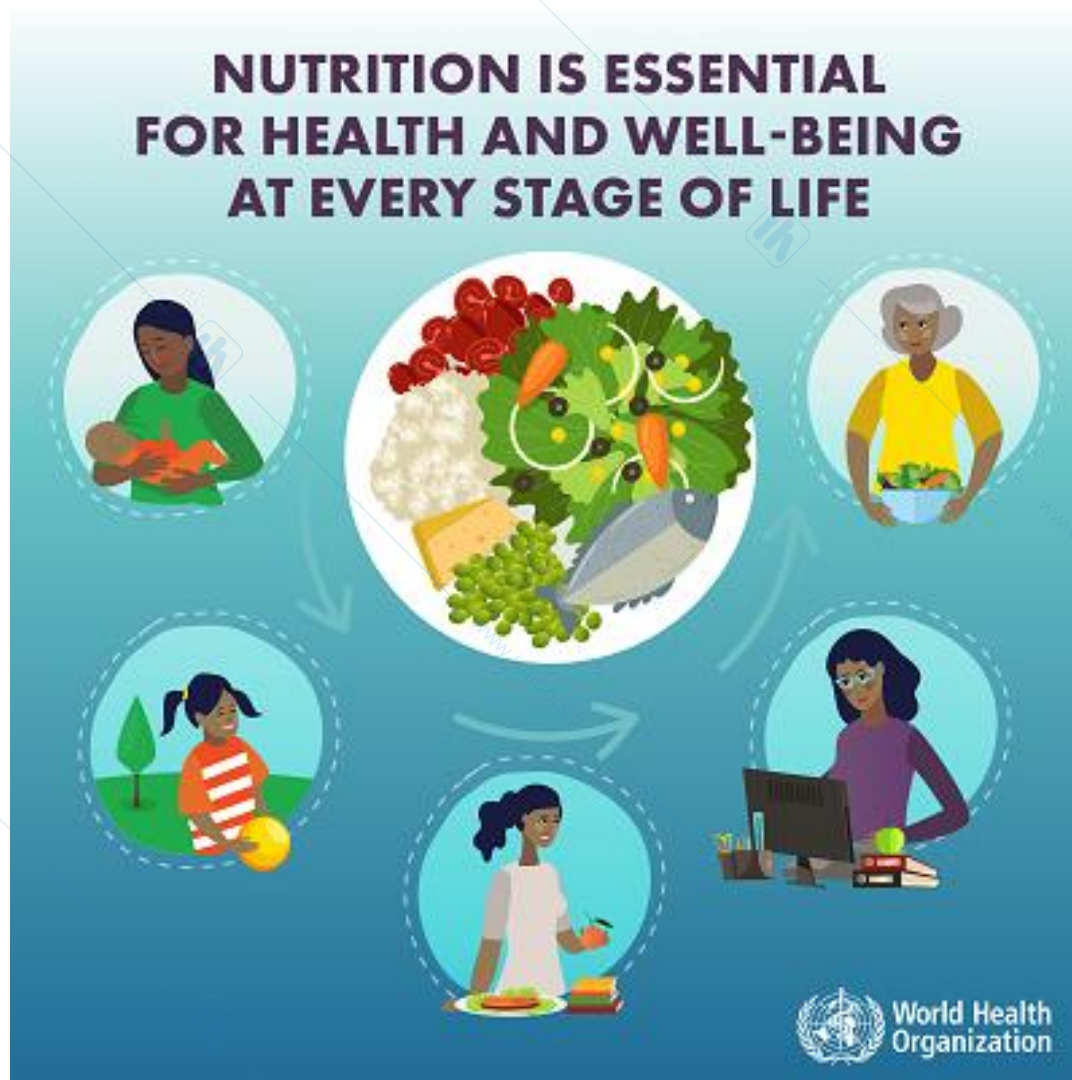
WHO recommendations on nutrition

- Nutrition is the intake of food, considered in relation to the body's dietary needs.
- Good nutrition – an adequate, well balanced diet combined with regular physical activity – is a **cornerstone of good health.**
- Poor nutrition can lead to **reduced immunity, increased susceptibility to disease, impaired physical and mental development, and reduced productivity.**

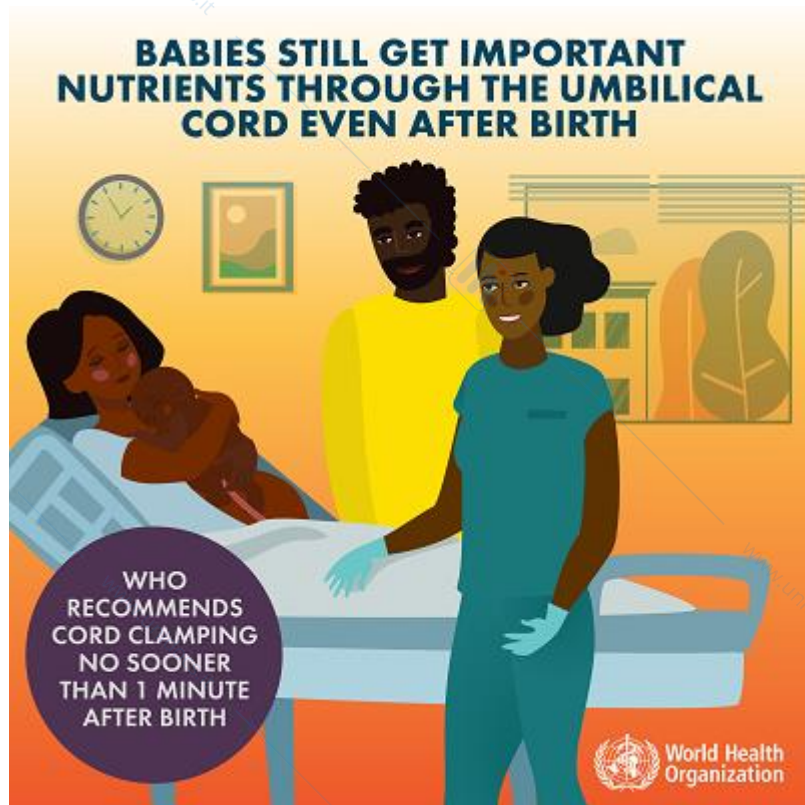
Fonte: <https://www.who.int/nutrition/en/>



Nutrizione: Azioni essenziali



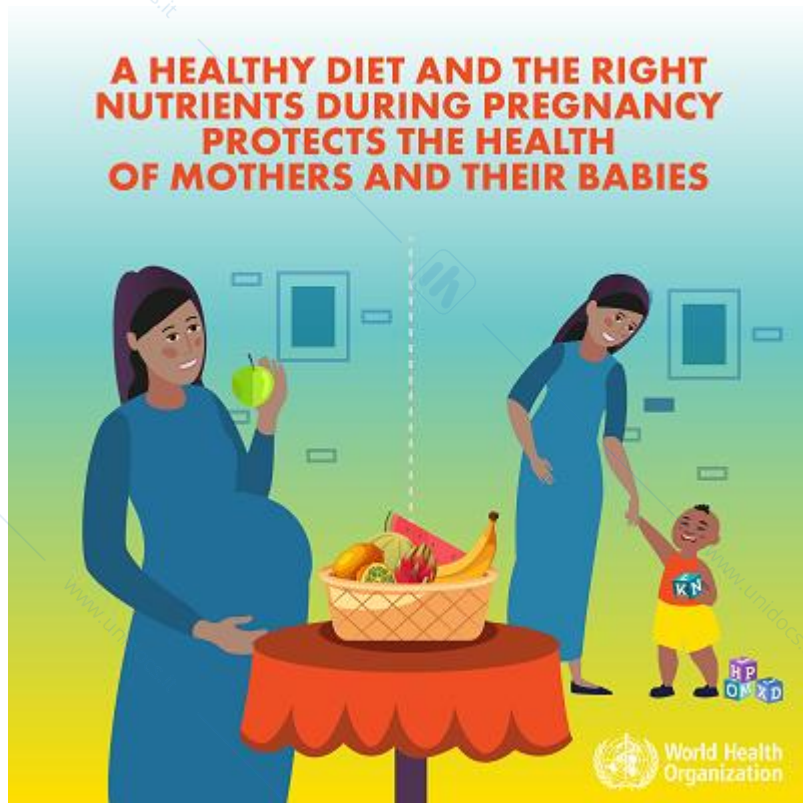
Nutrizione: Life course approach



Nutrizione: Life course approach



Nutrizione: Life course approach



Obiettivi globali per il 2025

Global nutrition targets 2025: Policy briefs



Overview



Stunting

TARGET: 40% reduction in the number of children under-5 who are stunted



Anaemia

TARGET: 50% reduction of anaemia in women of reproductive age



Low birth weight

TARGET: 30% reduction in low birth weight



Childhood overweight

TARGET: No increase in childhood overweight



Breastfeeding

TARGET: Increase the rate of exclusive breastfeeding in the first 6 months up to at least 50%



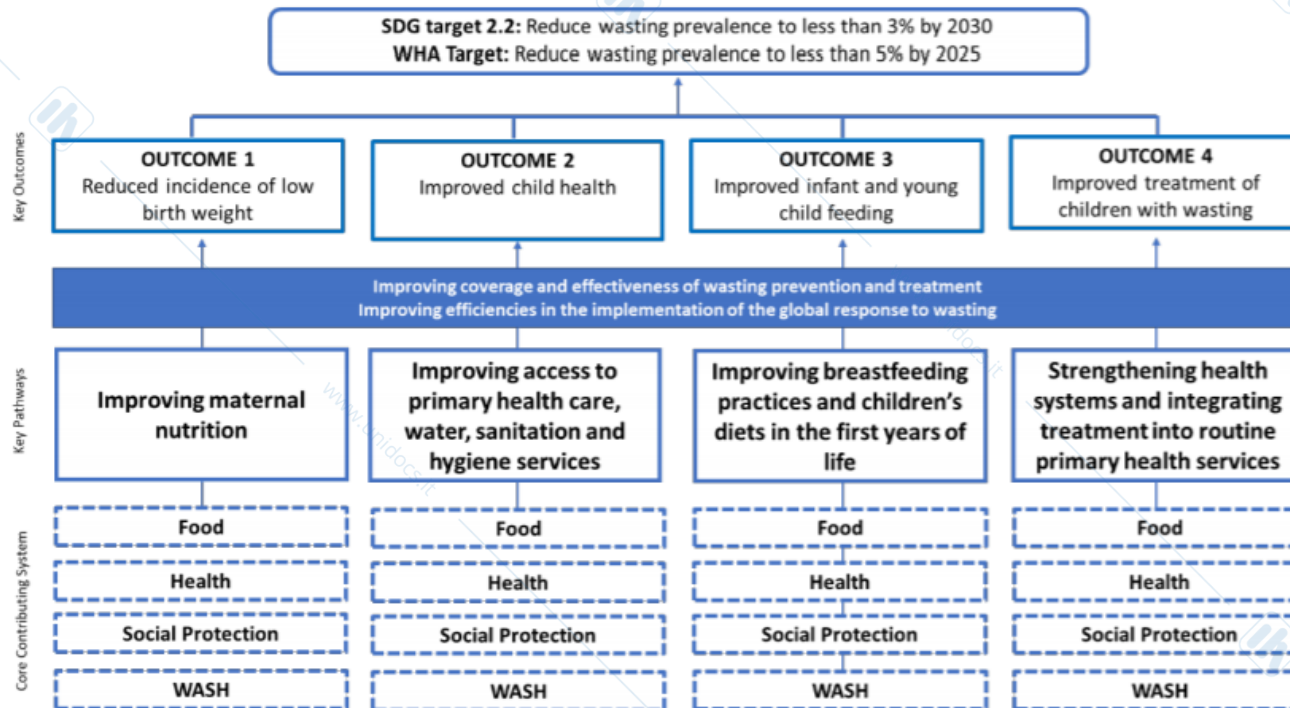
Wasting

TARGET: Reduce and maintain childhood wasting to less than 5%

Global action plan on child wasting

THE FRAMEWORK FOR ACTION

The objective of the GAP is to reduce wasting prevalence to less than 5% by the year 2025 and further reduce wasting prevalence to less than 3% by the year 2030.

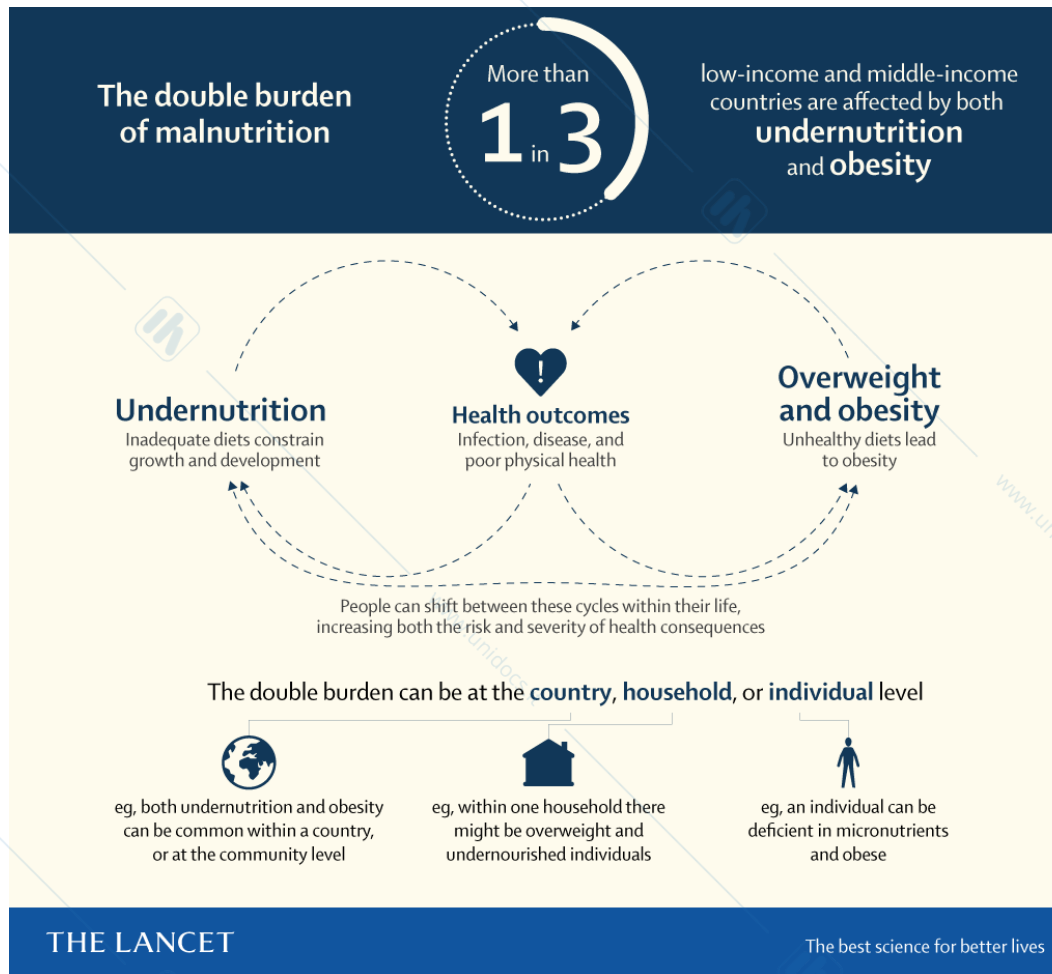


GLOBAL ACTION PLAN ON CHILD WASTING

A framework for action to accelerate progress in preventing and managing child wasting and the achievement of the Sustainable Development Goals

<https://www.who.int/publications/m/item/global-action-plan-on-child-wasting-a-framework-for-action>

The Lancet collection



<https://www.thelancet.com/series/double-burden-malnutrition>