

Editor's Note

Editorial Note for Volume 13 Issue 4

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Background

Socio-economic aspects are a major factor affecting health care management everywhere in the world with a special impact on countries where public support is either intrinsically poor or eventually ineffective.

This generates diversity at a high rate and single governments all around the world are required to take a very strong action against inequalities in health care to prevent severe generalized health problems in the lower classes and the consequent huge economic burden for their entire societies in the long run.

As apart from this relevant problem, however, other inequalities are impacting upon everyday life, including (a) stress affecting health care personnel (from students up to leading hospital physicians) and (b) effective management of widely spread diseases, like those impacting upon oral hygiene, prostate cancer and diabetes mellitus, where we need to underline the need for education, an often overlooked aspect of health care.

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All of the above has been addressed and an intriguing picture comes out of it concerning world-wide inequalities and possible solutions to them.

As for socio-economic aspects of diversity in health care a questionnaire and audit- based analysis of local conditions within public and private sectors in Bangladesh were used by Roy et al.[1] This led to the conclusion that - in the presence of high out-of-pocket payments and a nominally controlled rapidly growing private market - local authorities' compliance to the stringent central bureaucracy and their satisfaction appeared to be mutually exclusive. Regulatory reform was therefore concluded to be essential to ensure the rural population's health. Economic protection in healthcare and optimal utilization of the existing primary health care resources was considered to be a high priority in that country.

In terms of quality of life then, Fernandez-Cuadros et al.[2] investigated upon the effects of total knee arthroplasty technique. They found this operation to improve Health-Related Quality of Life in all its dimensions immediately and to do so only after a while for Physical Functioning and Role-Physical components. This made it fully justified in Spain from a clinical point of view.

Another huge problem in terms of diversity of care is homelessness, a phenomenon which unfortunately is as widely spread as largely disregarded in western countries. The determinants of homelessness has been the object of a very interesting study by Mabhala et al.[3], which was based on qualitative in-depth semi-structured interviews conducted in several centers for homeless people in the north west of England, UK. The four determinants emerging from the investigation were: home and childhood environments; experiences during school life; type of social lifestyle; and opportunities for access to social goods. Participants saw their homelessness as a manifestation of education and income inequality; unemployment and welfare; barriers to housing and other services; crime and living environment.

Dietary diversity was also investigated upon by Misker et al.[4] They tried to understand why households with insufficient access to food often face poor health and a vicious cycle between under nutrition and decreased productivity. Using a structured questionnaire they found that male gender of household heads, among other factors, associated with a higher degree of dietary diversity in Southern Ethiopia.

Care management was the object of other two studies, one concerning dental care in the Academic world, the other related to prostate cancer surgery. The former, led by Sinkford et al.[5], described how the ADEA Minority Dental Faculty Development grant program and its grantee institutions served as academic models for other health professional institutions to improve access to care in underserved communities, and to meet accreditation standards supporting quality and innovation in dental education in the light of sustainability of diversity and inclusion. The second analyzed radical robotic assisted laparoscopic prostatectomy (RALP) for localized prostate cancer with an overnight admission. As the technique is minimally invasive and patients operated on early in the list with no complications are fit for discharge by that evening, and the review of the literature on Daycase prostatectomies pointed to no severe complications, the authors, Goonewardene et al.[6], proposed a new follow-up protocol for Daycase radical RALP.

Another major item discussed upon in this issue, as already said, was the impact of stress on care. Arima[7] provided an overview of everyday conflicts between work and family duties in Japan, where 70% of female physicians forgo their promising careers because of 'difficulty in raising children', thus leading

overrepresentation of men in high positions and academic qualifications. This causes an increased need of 'overwork' part-time systems under regular employment, multiple 'physician-in-charge' systems, or 'work-sharing' systems in clinical settings, onsite nurseries, child-care services for sick children, financial support for babysitting expenses, mentoring systems for child-raising issues and support networks. The conclusion supported the need for 'career design lectures' within the educational curriculum to teach new physicians how to manage their personal careers for better quality of life in the upcoming generation.

Jahan[8] then analyzed main underlying causes of anxiety and depression in medical students superadded by the stress induced by medical curriculum and excessive anxiety, all of which eventually affecting learning ability and academic performance. He underlines that medical students should learn how to handle stress and anxiety by regular exercise, meditation or other relaxation techniques, structured time outs by starting even before joining medical school.

Nurses are also stressed by the hospital system everywhere in the world and even more where resources are scanty, thus generating ethical conflicts. Using six focal group discussions with 6-8 participants each in a specific area in Pakistan. Hamid et al.[9] identified three themes: compromised professional accountability to patient, uncooperative behavior of peers and poor image of a nurse in society. Ethical problems depended mostly on clinical practice constraints including conflict in hospital admission procedures, unavailability of medicines, conflict between informed and voluntary consent, false accusations by patients, care imbalance, compromised nursing care and deficiency in amenities, patient's expectations and cultural barriers.

Finally educational aspects have been addressed in this issue concerning diabetes management.

In greater detail, Elahi et al.[10] conducted a cross-sectional study on several diabetes clinics of an Iranian area through questionnaires, medical records and blood HbA1c. They found poor glucose control among patients and concluded that to improve the health status of Iranian people it was necessary to evaluate the quality of care provided at the national level to introduce appropriate solutions thereafter to implement patient and health personnel adherence to best treatment strategies.

In the end Strollo et al.[11] focused on lipodystrophy, a typical complication of drug injections repeatedly performed into the same skin area and/or needle reuse, associated mostly to insulin and – as shown in the paper – to other injectable drugs as well. They in fact described a possible association between the ultrasound structures of observed lesions and missing injection site rotation and suggested to intensify patient education to avoid the negative effects of inappropriate injection habits in terms of both quality of life and treatment efficacy.

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