INTERNATIONAL COUNCIL OF NURSES

Closing the gap: Increasing access and equity

International Nurses Day

12 May 2011

CLOSING THE GAP:
INCREASING ACCESS AND EQUITY

INTERNATIONAL NURSES DAY 2011

3, place Jean-Marteau, 1201 Geneva, Switzerland

ISBN: 978-92-95094-50-5

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Dear Colleagues,

Despite major achievements in the realisation of the Millennium Development Goals, there are still major gaps in the health status and life expectancy between high, middle and low income countries, between men and women and between rural and urban residents.

The ability to access health services is key to improving the health, well-being and life expectancy of all. Yet, achieving this fundamental requirement remains limited by cost, language, proximity, policies and practices, as well as many other factors.

As the principal and, in some cases, the only group of health professionals providing primary health care in many of the most challenging settings, nurses are essential to improving equity and access to health care and adding quality to the outcome of care.

This 2011 IND kit strengthens our understanding of access and equity and the effect of inequality on health. It outlines the barriers that exist and how we can increase access and equity. It also shines a light on the importance of the social determinants of health, demonstrating how nurses can address these and in so doing improve access and ensure equity in the care provided.

The International Council of Nurses believes that nurses have an important role in achieving health equity and developing a clear understanding of how the health sector can act to reduce health inequities.

Sincerely,

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INTRODUCTION

In 2001, the international community endorsed the Millennium Development Goals (MDGs). The commitment to the MDGs represented a determination to make significant improvements in the health status of the world's population and recognised that the burden of illness and disease was not equally distributed. Major gaps existed in the health status and life expectations between the wealthy and the poor, between the developed and developing nations, between men and women and between rural and metropolitan residents.

Ten years on, significant gains have been made, with the 2009 evaluation report highlighting improvements in regards to key health interventions such as malaria and HIV control and measles immunisation (UN, 2010). However, the report also highlights yawning gaps between the health, well-being and life expectancy of different groups of people.

The ability to access services is key. Access to services may be limited by cost, by language, by proximity, by policies and practices that make a service culturally inappropriate, by poor quality, or simply by lack of availability or explicit rationing policies.

It is also important to recognise that health is not merely a commodity produced by health services. Health is socially determined, as well as being influenced by genetics and environment. The ability to achieve good health or, conversely, the risk of suffering ill health, is affected by socio-economic status, geography, labour market participation, education, gender, sexual preference and a host of other elements that impact, both directly or indirectly on one's ability to achieve and maintain good health.

The essential link between health and the living environment was recognised in 2005 when the World Health Organisation (WHO) established the Commission on the Social Determinants of Health to "marshal the evidence of what can be done to promote health equity, and to foster a global movement to achieve it" (CSDH, 2008).

As noted by that Commission (CSDH, 2008, p. 188), nurses and other health professionals have an important role to play in achieving health equity, and developing a strong understanding of how the health sector can act to reduce health inequities is vital. Nurses also need to understand their own role in the provision of equitable, accessible health care. This kit aims to assist in that process.

CHAPTER 1

Understanding Access and Equity

Access

What is "access"?

Access refers to the ability to obtain an item or service at the required time. Exactly what constitutes good access is difficult to define, and will vary according to context. However, as noted by Chapman et al. "good access exists when patients can get the right service at the right time in the right place" (Chapman et al., 2004, p. 374).

> *"Access (n.) 1. The means or opportunity to approach or enter a place.>the right or opportunity to use something or see someone"*
>
> (Pearsall, 2002)

Key elements of access include availability, utilisation (use of available services by the population), relevance (services provided reflecting the service needs and preferences of the population groups), effectiveness (whether the desired treatment or service outcomes is achieved), and equity, which refers to differences in the access across different groups, as discussed later in this chapter (Chapman et al., 2004). Barriers to access can include:

- Lack of capacity and availability (including rationing). Examples include long waiting lists for particular types of treatment, shortages of infrastructure or staff so that a service can't be provided, or lack of services at the place or time they are needed.
- Cost. Full or partial payment for many types of health services remains the norm in many countries, which can be a significant barrier to the poor.
- Language and culture. Making provision for members of the community to access health services in their community language is an important part of making health care accessible and effective. Similarly, failure to cater for different cultural norms can adversely impact on the willingness of people to seek help as well as the effectiveness of treatment.
- Lack of knowledge and information. Access includes access to information about one's own health, about preventative strategies and approaches, and about the kinds of services that are available. For example, failing to provide public health messages in all community languages restricts access to information and can thereby directly impact both on an individual's health, and on their capacity to proactively work to improve health and identify and access the services they might need.
- Mobility and migration. Mobile populations may find it difficult to identify and access services, particularly if administrative barriers (e.g. requiring a long-term address for

registering at a medical practice) exist. Ensuring good practitioner engagement and continuity of care is also an issue.

- Employment. In some countries, access to health services is strongly linked to employment status, such as in the USA where many people are reliant on employer-sponsored health plans. Lack of employment can therefore limit access. Conversely, reliance on marginal, casual or cash-in-hand employment limits the ability for people to access health services without incurring significant costs through lost income.
- Staff sensitivity and preparedness. Professional standards and ethics require nurses and other health professionals to provide services competently and professionally, and to treat patients with respect and sensitivity. Effective training and management should support nurses in maintaining these standards.
- Discrimination. Despite the commitment of health services and professionals to deliver effective health care, instances of discrimination on the basis of gender, race, sexual preference or socio-economic status continue to exist. It is important to note that discrimination is not always active – the failure to address inequities effectively or provide treatment for or to stigmatise certain conditions can also represent a form of discrimination.

Restrictions in access can also impact directly on quality of care. For example, many people living in remote and rural locations in both the developed and developing world have less access to the range of health services and to the skills of qualified health practitioners such as nurses than do their city-based counterparts. This can directly impact on the quality of care received. For example, access to appropriate birthing care in rural areas has been identified as a key factor to be addressed in achieving improvements in maternal mortality (UN, 2010).

Improving access to care also involves "taking into account the social factors influencing access" (Ministry of Health and Social Policy of Spain 2010, p. 16). However, improving access may conflict with other policy imperatives such as cost containment (Chapman et al., 2004). The importance of addressing the social determinants of health is discussed in more detail later in this document.

Access and the right to access are important principles in themselves. However, as noted in the recent document commissioned though the Spanish Presidency of the European Union (EU), *Moving Forward Equity in Health: Monitoring Social Determinants of Health and the Reduction of Health Inequalities*, access is also an important way of achieving more equitable outcomes. For example, "universal access to health services and high-quality primary care for all children in all regions has proved effective in reducing child health inequalities" (Ministry of Health and Social Policy of Spain, 2010, p. 36).

Equity

> *"Equity (n) ...1.the quality of being fair and impartial.*
>
> (Pearsall, 2002)

While equity and associated concepts of fairness and justice are widely accepted and acknowledged as key tenets of progressive social policy, there is less universal agreement about how equity is defined, and how it is to be achieved. This is particularly complex when discussing health care systems and their outcomes, where opinions differ regarding which aspects are the most important to equalise, and to what extent (Osterle, 2002).

Equity objectives generally stress fairness in the way that resources and burdens are distributed across the population, and reducing inequities in that distribution. The notion of equity often also incorporates a consideration of opportunities, so that attainment of particular outcomes is equally available to people, subject to the choices that they make:

> "An equity approach stands in contrast to a 'basic needs approach' or 'poverty approach' which focuses on the poor and the disempowered without relating their condition to the rich and the powerful. Equity implies an approach that gives more to those who have little, and thus less to those who have much. Rather than the allocation of equal shares, equity implies the allocation of fair shares." (McCoy, 2003, p. 8).

The relationship between access and equity

"Unequal access to resources, capabilities and rights lead(s) to health inequalities." (Ministry of Health and Social Policy of Spain, 2010), and access to health systems is an important part of improving health outcomes. In health care, there are a number of concepts and assumptions commonly implied by the word "equity". It may imply a basic level of services that all persons are able to access and benefit from. In most developed countries this may include the ability to see a health professional when they are ill, the ability to access basic medicines, the ability to obtain emergency care, and the ability to receive care and support through childbirth.

The analysis of outcomes and "the extent to which empirical distributions correspond with specific interpretations of equity" is an important field of study in health care. Considerations include the distribution of health and ill-health itself, as well systematic considerations such as the distribution of public expenditure, use of services, cost and outcomes. This may include relative levels of access to different kinds of services, as well as the outcomes that are achieved by different patients. In his article "Evaluating Equity in Social Policy: A framework for comparative analysis", Osterle (2002) consolidates various authors' discussion of these notions into three simple dimensions, as quoted below. His article provides a useful discussion applying this framework to the provision of long term care.

- "WHAT is to be shared (e.g. resources, burdens);
- Among WHOM (the recipients); and
- HOW (the principles)"

(Osterle, 2002, p. 59)

> *"the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom"*
>
> UN Universal Declaration of Human Rights, 1948

Achieving equity in regard to "what" might involve defining a minimum set of services or level of resources that it is reasonable and acceptable for persons to have access to. This may also involve defining the particular quality standards or expectations that will apply. In some cases these will be tangible and quantifiable, e.g. whether the service is available, how long a person has to wait for the service, and whether the desired outcome was achieved successfully. In other cases, there may be more intangible factors such as the level of satisfaction with the service, the quality of interaction with the staff, the level of involvement in decision making, empowerment or the ability to exercise choice. These less tangible factors can be important measures of equity, particularly when dealing with service users who may come from diverse cultural backgrounds (Osterle, 2002, pp. 51-52).

The "whom" in Osterle's model refers to the fact that, even in developed countries, some people may be excluded from these services through social circumstance, geographical location or other factors (Osterle, 2002, pp. 52-53). While an egalitarian approach to equity might imply that all persons should receive an equal share, efforts to achieve equity in terms of outcomes may involve significant inequities in the level to which health resources are directed. This is where the "how" of delivering equity objectives becomes important. Central to these discussions is the concept of need, and the principle that the amount of resources allocated should in some way reflect it, so that "if the needs of A and B are unequal, they should receive an unequal amount of treatment or support. To what extent they should be treated unequally in order to reach an equitable distribution is part of the allocation principle" (Osterle, 2002, p. 53). However "need" can be a relative term in itself, and can be measured in different ways, such as mortality, morbidity or quality of life.

Although access to services may often be presented as an ideal, it may not result in equal outcomes, which may be impacted on by a range of environmental and non-environmental variables, such as climate or genetic pre-disposition. As noted by Osterle, "Social policies aimed at equalising access are aimed at equalising potential, not actual use of services" (Osterle, 2002, p. 52). As a result, service providers may target particular population groups or problems in order to achieve improved outcomes. This "positive discrimination" (Ministry of Health and Social Policy of Spain, 2010) or favouring of specific groups, who have been historically discriminated against in programmes or policies, is seen as a means by which health care systems can seek to achieve better equity in outcomes.

Various forms of rationing may also be used in an effort to balance the sometimes competing priorities of need and equity. For example, an elective surgery waiting list may be based on a

simple queuing system, but modified so that the queue is divided into different categories of "need" or urgency. In many countries, expected wait times are applied to the different categories as a quality measure.

"Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty."

Universal Declaration of Human Rights
(UN, 1948)

Ethics and human rights

The need to provide services, opportunities and rights to all persons "without distinction of any kind" is enshrined in the Universal Declaration of Human Rights, quoted elsewhere on this page.

The right to health, and the right for an equal opportunity for health, is part of this. As noted by McCoy (2003, p. 8)

> "The notion of equal opportunities to be healthy is also grounded in the human rights concept of non-discrimination and the need for governments (or the organised representation of society) to take the necessary measures to eliminate the unfair health consequences of social disparities. …Judging whether a process is equitable depends on the definition of what society accepts as an equal right of all. Some emphasise inequalities in health outcomes; others emphasise the opportunities for good health outcomes."

The Pan American Health Organisation (PAHO) has also recognised that the concept of justice is important, and that "all inequities are the product of unjust inequalities". It states that while "*just* and *unjust* are subject to various interpretations. In the context of health, one of the more accepted definitions of *just* refers to equal opportunities for individuals and social groups, in terms of granting access to and using the health services, in accordance with the needs of the various groups of a population, regardless of their ability to pay." (PAHO, 1999). This enshrines the notion of universal health care and access as part of a just health system.

Health care costs and rationing

Even in those countries where Governments have a policy commitment to universal health care provision, providing health services represents a significant, and often growing budgetary demand. Population-driven increases as well as increasing patient expectations, ageing populations and costs related to emerging technologies and pharmaceutical therapies drive costs upward. Many developing countries also require significant increases in national health budgets in order to meet basic population health needs, and battle against other sectors to carve out "fiscal space" for health (ICN & WHO, 2009).

One mechanism used within the health sector to manage this tension is rationing. In some cases, this is explicit, with publically funded access to certain treatments or services limited according to certain criteria such as an assessment of relative clinical need, means testing so that the public sector only provides the service to those unable to pay for it, or the exclusion of certain treatments from public sector as unnecessary or ineffective in improving health (e.g. cosmetic surgeries). While it can be argued that withholding any treatment from an individual is unethical (see for example Wood 2010), it can also be argued that introducing transparent rationing systems can at least provide the pre-condition for community discussion and debate about priorities when resources are limited.

Implicit rationing is more common. Cost-cutting strategies have resulted in raised thresholds for hospital admissions and shortened lengths of stay. Meanwhile, those same budgetary concerns have typically limited staff numbers). Rationing of nursing care, "may be a directly observable consequence of low staffing levels", as nurses use their clinical judgement to "prioritise assessments and interventions" (Schubert et al 2008 p.227-228). This can directly impact on quality of care and patient outcomes. This illustrates that decision-making about the level of care provided and to whom are being made at various levels on a daily basis. It is therefore important that issues of equity are analysed and considered at each of these levels.

As Dey and Fraser highlight in their discussion of aged-based rationing in the health system, the desire to limit the cost of health care and to develop ways to allocate the available resources raises important ethical dilemmas. Noting that age, as well as other factors, has often been an "important but implicit criteria in rationing at the clinical level" (Dey & Fraser, 2000, p. 530), they suggest that there is a tolerance for "rationing on the grounds of age where it would not be countenanced on other grounds such as gender, class or ethnicity" (Dey & Fraser, 2000, p. 517).

CHAPTER 2

The Burden of Inequality

Inter-national inequalities

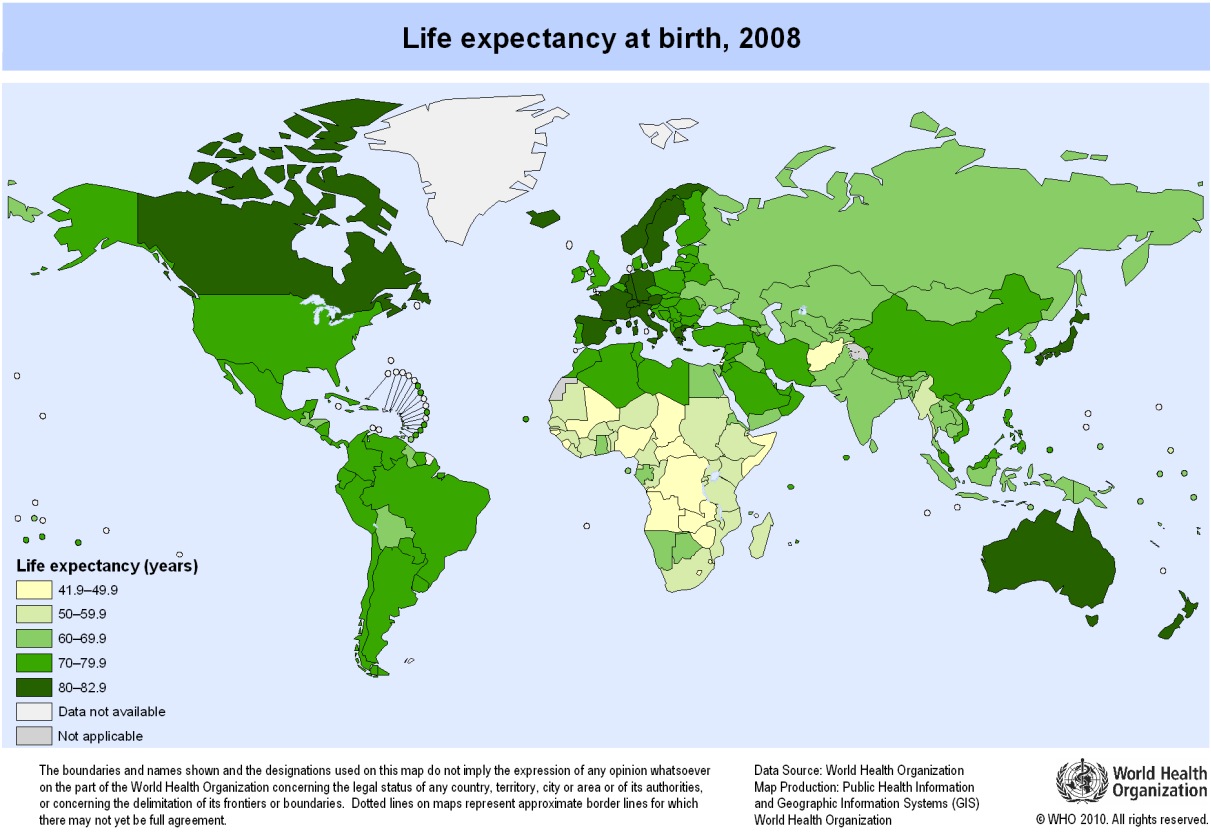
There are stark disparities in population health and in access to services across the world. As shown in Figure 1 below, some countries enjoy a life expectancy of over 80 years, while the life expectancy in others is less than 50 years.

Examples:

- Within the EU there is a ten-fold difference in the rates of infant mortality between the countries with the highest and the lowest rates.
- An estimated 17.5 million people died from cardiovascular diseases (CVDs) in 2005, representing 30% of all global deaths. Over 80% of CVD deaths occur in low- and middle-income countries (WHO, n.d. cited in CSDH, 2008 p.30).
- The lifetime risk of maternal death is one in eight in Afghanistan; it is 1 in 17 400 in Sweden, (WHO et al., 2007 cited in CSDH, 2008 p. 30).
- More than half the world's population lack any kind of formal social protection, with only 5-10% of people covered in sub-Saharan Africa and southern Asia, compared to coverage rates between 20 and 60% in middle-income countries (WHO, 2010e p.8).
- While a man in Estonia spends up to 71% of their life in good health, a man in Denmark can expect to live 90% of their life in good health (DETERMINE, 2010, p. 9)

> *"At the mid-point in the countdown to 2015, the target date set by the United Nations Millennium Declaration, there are several examples of success. However, great inequalities still exist within and between countries, and current trends suggest that many low-income countries will not reach the Millennium Development Goal targets"*
>
> Report of the Secretariat to the World Health Assembly (WHO, 2008a)

Figure 1: Life expectancy, 2008 (WHO, 2010)



Delivering on the Millennium Development Goals

The need to improve access and equity lies at the heart of the Millennium Development Goals (MDGs), which were agreed by 192 member states in 2001.

In his forward to the 2010 progress report (UN, 2010), UN General Secretary Ban Ki-Moon describes the MDGs as representing “human needs and basic rights that every individual around the world should be able to enjoy – freedom from extreme poverty and hunger; quality education, productive and decent employment, good health and shelter; the right of women to give birth without risking their lives; and a world where environmental sustainability is a priority, and women and men live in equality”.

The Goals are

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health

6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a Global Partnership for development.

The MDGs reflect the need for multi-sectoral approaches in order to improve the health, welfare and well-being of the world's population. Building on the work of the Commission on the Social Determinants of Health, the international commitment to the MDGs recognises the interconnection between health and other indicators of disadvantage: "avoidable health inequities arise because of the conditions in which people grow, live, work and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social and economic forces" (CSDH, 2008, p. i). The relationship between inequities in education, income, gender and health is discussed further in this chapter.

Health-related MDGs

Health related goals include reducing child mortality rates by two-thirds, maternal mortality ratios by three-quarters, and halting and reversing the spread of HIV, tuberculosis and malaria by 2015 (Stuckler et al., 2010).

A review of the health-related Millennium Development Goals conducted in 2008 (WHO, 2008a) found that while progress was being made, significant inequities remained. Most of the targets are unlikely to be met by 2015, and low-income countries are falling further behind their targets, as illustrated by the following excerpts from that report:

MDG 4: Reduce child mortality

- Global prevalence of underweight children had declined from 31% to 26% since 1990 but progress is slow and no progress has been made in Western Asia and remains at 46% is Southern Asia, where more than 25% of infants are underweight at birth.. (UN, 2010, p. 13)
- Sub-Saharan Africa now accounts for around half of the 8.8 million deaths that occur among children under five in 2008 (UN, 2010, p. 27)

MDG 5: Improve maternal health

- More than half of the 500 000 women that died of maternity related causes in 2005 were in sub-Saharan Africa, and one third in South Asia. Maternal mortality ratios in sub-Saharan Africa are 920 per 100 000 live births compared with 8 per 100 000 live births in industrialised countries (WHO, 2008a)

MDG 6: Combat HIV/AIDS, malaria and other diseases

- Despite dramatic increases in antiretroviral treatment in low-and middle-income countries, about a quarter of those who need the treatment in sub-Saharan Africa have no access to it. Coverage for children is even lower, at 15% (WHO, 2008a).
- It is estimated that 243 million cases of malaria in 2008 led to 863,000 deaths. 89% of these occurred in Africa (UN, 2010, p. 46).

- In low and middle income countries, the proportion of HIV-positive pregnant women receiving antiretroviral treatment for prevention of mother-to-child transmission of HIV was as low as 11%.
- Only one third of children under five with fever in Africa receive any anti-malarial treatment (WHO, 2008a).

WHO reported that services than can be delivered by outreach such as immunisation have shown encouraging results, "those interventions requiring a functional health system … are having less impact" (WHO, 2008a, p. 2).

> *"Disparity is a shocking reality we cannot hide from. This is a global injustice. It is a travesty of human rights on a global scale"*
>
> Nelson Mandela, 2003 (cited in McCoy, 2003)

Key constraints identified in achieving these goals include:

- Shortages of well-trained health workers;
- Insufficient responses by governments to the health needs of their populations, for a variety of reasons, in "fragile states"; and
- The need for greater cooperation between sectors: private, public, voluntary, and community and faith-based.

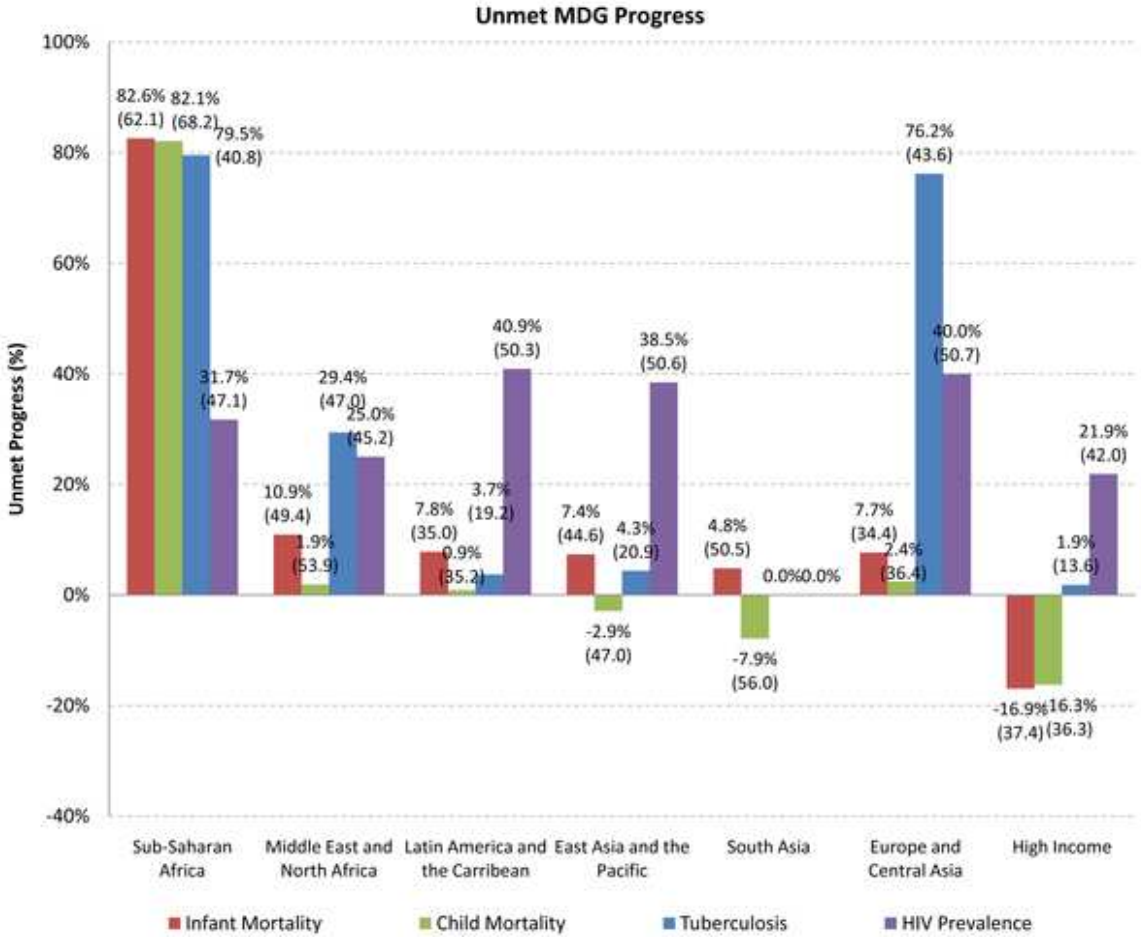
The need for increased donor funding and greater government spending on health was also noted. However, statistical analysis of the data conducted by Stuckler et al. analysed variations in rates of change in MDG progress versus expected rates for each country. The variations are illustrated in the chart developed by the authors, included in Figure 2, and found that,

> "...lower burdens of HIV/AIDS and NCDs[1] were associated with much greater progress towards attainment of child mortality and tuberculosis MDGs than were gains in GDP. An estimated 1% lower HIV prevalence or 10% lower mortality rate from NCDs would have a similar impact on progress towards the tuberculosis MDG as an 80% or greater rise in GDP, corresponding to at least a decade of economic growth in low-income countries." (Stuckler et al., 2010)

This finding highlights the crucial role to be played by health systems and health providers in promoting health, preventing avoidable disease, and addressing morbidity in key areas in achieving the MDG goals, and realising the lives saved and illnesses prevented that those goals represent.

[1] Non Communicable Diseases

Figure 2: Unmet MDG progress (Stuckler et al., 2010)



Gender

Every year more than 350,000 women die from preventable complications related to pregnancy and childbirth (Ban, 2010). As the United Nations notes in its most recent report on the MDGs, "gender equality and the empowerment of women are at the health of the MDGs and are preconditions for overcoming poverty, hunger and disease." (UN, 2010, p. 4)

The United Nations' *Global Strategy for Women's' and Children's Health* was launched in 2010 in an effort to address preventable death and illnesses and improve access to services for women, focussing on "equity of access and outcomes, making sure we reach those who are especially disadvantaged and marginalised". Achieving the MDGs is a key part of this, and would equate to saving the lives of four million children and about 190,000 women in 2015 alone (Ban, 2010).

In addition, the establishment of the UN Women's Agency in 2010, to be headed by former Chilean President Michelle Bachelet, recognises the importance of addressing gender inequities. The new agency aims to promote women's rights and full participation in global affairs.

Addressing gender inequity also effectively means acknowledging men's health and service delivery needs. Some countries have developed or are developing men's health policies (e.g. UK, Ireland, Australia). As well, the WHO has recognised the importance of engaging men and boys in promoting gender equality and improving the health of both men and women, recently releasing *Policy approaches to engaging men and boys in achieving gender equality and health equity*. The policy brief outlines and promotes policy approaches which can "accelerate shifts towards gender equality in the home, decrease levels of violence and sexual exploitation, support emerging safer sex practices, and reduce men's excessive consumption of alcohol." (WHO, 2010a)

Examples

- Growing evidence linked gender-based violence with the spread of HIV (UN, 2010, p. 44).
- African-American women represented 67% of new AIDS cases in the USA in 2005, yet were underrepresented in clinical trials (Cohn, 2007, p. 272).
- A study on inequalities in health care for the over 65 age group in the OECD found that women face higher out-of-pocket expenses due to their lower income and lower labour participation rate, including less access to employer sponsored health care (Corrieri et al., 2010, p. 15).
- Men in England are 14% more like to develop cancer than women, mainly because of unhealthy lifestyles, and 66% of English men are overweight compared to 57% of women. (WCRF, 2010).

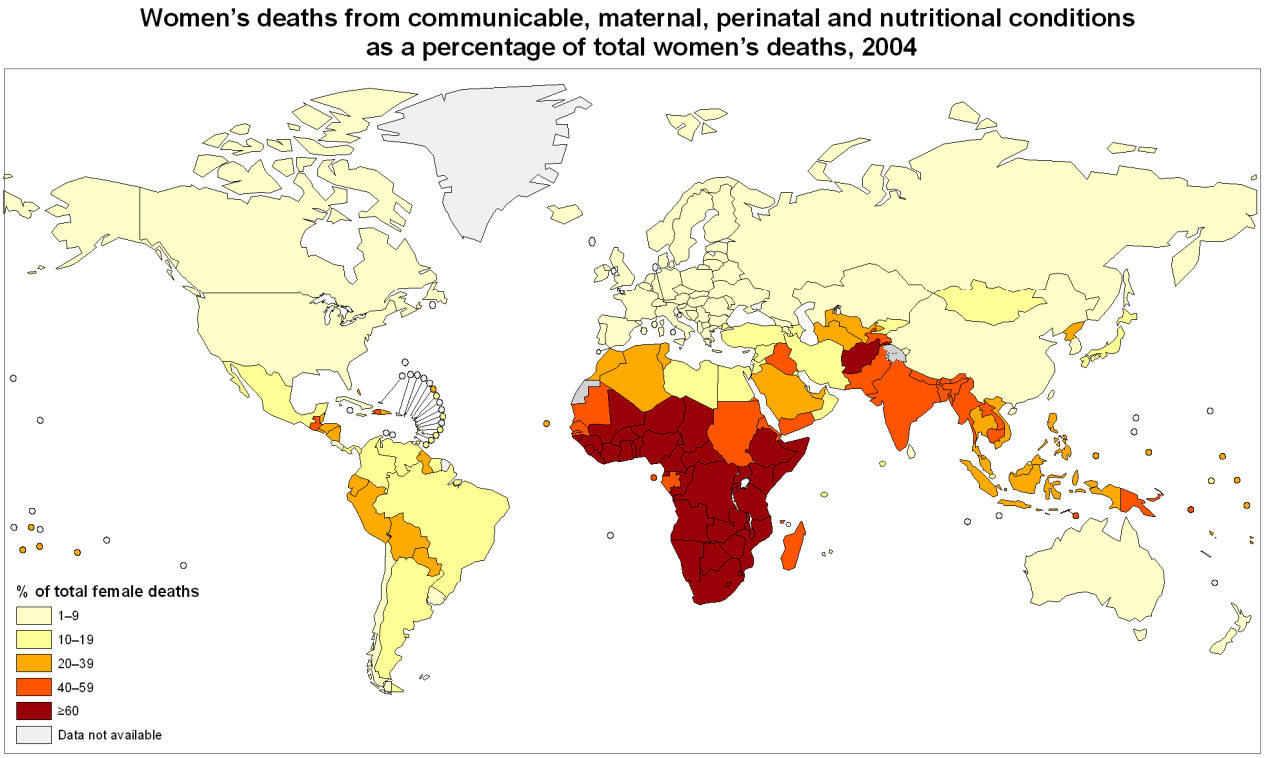
Nurses Help At-Risk New Mothers Cope

As a registered public health nurse with the Nurse-Family Partnership (NFP) programme, Rita visits the homes of first-time, low-income mothers, many of whom are still teenagers. She works intensively with these mothers to improve maternal, prenatal, and early childhood health and well being, with the expectation that her intervention will help achieve long-term improvements in the lives of at-risk families.

When Rita visits each family, she focuses on the mother's personal health, the quality of her caregiving for her child, and the parents' own development. She begins visiting while the mother is still pregnant, (before the 28th week, ideally between the 12th and 20th week) and continues through the first two years of the child's life. Rita also investigates and works with the mother's existing support system, including family members, fathers when appropriate, and friends, to help families access other health and human services they may need.

A recent study of the programmes' outcomes showed that the visits made by Rita and the other nurses have resulted in a reduction of pre-term and low-birth-weight babies, improved parenting and home environments, reduced quickly recurring and unintended pregnancies, increased participation in the workforce, and reduced incidence of conduct disorders, involvement in crime, and delinquency.

Figure 3: Women's deaths from communicable, maternal, perinatal and nutritional conditions as a percentage of total women's deaths, 2004 (WHO, 2006)



Ethnicity and culture

There is widespread evidence from across the world that ethnicity and culture can have a significant influence on both the accessibility of health services and the quality of care that is provided by those services (see examples below). The ability to provide effective services to people from different cultures is often referred to as "cultural competence". As outlined by Brach and Fraser (2000), lack of cultural competence in service delivery can lead to a range of consequences including:

- Missed opportunities for screening due to lack of knowledge about prevalence of different conditions amongst different groups;
- Lack of knowledge about traditional remedies and possible harmful interactions; and
- Diagnostic errors resulting from poor communication.

Ineffective communication – whether because of language difficulties or differing interpretations or understanding – can lead to poor patient experience and reduce the ability for the person to participate effectively in decision making regarding care and treatment, to the extent that meaningful consent cannot be given. Discussing health service utilisation of Roma people in the UK, Van Cleemput notes that "cultural insensitivity, whether arising from ignorance or from racist attitudes, was a strong feature in accounts of compromised communication" (2010, p. 320).

It is also important to note that cultural background can influence help-seeking behaviour, and therefore have an important influence on whether a person accesses health care at an appropriate time. For example, Van Cleemput notes that a "cultural belief that they should be seen to be fighting ill-health" and presenting "a social identity of being strong and tough" can lead a person from a Roma community (referred to as Gypsy or "traveller" in Van Cleemput's article) "to feel judged if they present as depressed or unwell" (Van Cleemput, 2010, p. 318). Effectively service delivery needs to seek ways to negotiate and overcome such cultural barriers to access.

Examples:

- In the USA, black women are more likely than white women to die of breast cancer, despite a lower incidence of the disease.
- Life expectancy at birth (LEB) among indigenous Australians is substantially lower (59 for males and 65 for females in the period 1996-2001) than that of all Australians (77 for males and 82 for females for the period 1998-2000) (Australian Human Rights Commission 2008). In the USA, 886 202 deaths would have been averted between 1991 and 2000 if mortality rates between whites and blacks were equalised. This contrasts to 176 633 lives saved by medical advances (CSDH 2008).
- A review of research on immigrants' utilisation of health services in the USA showed that foreign born patients were more likely to report feeling discriminated against, particularly those who are non-white, non-citizens, and/or have low English proficiency (Derose et al., 2009, p. 367).

Socio-economic status

The poor experience significant barriers to health care including limited purchasing power, lower rates of health insurance, lower health literacy and often live in slums or remote or rural areas which are often underserved by health systems and experience shortages of health professionals (Bhattacharyya et al., 2010). Unhealthy attitudes and behaviours are also associated with social exclusion, with higher rates of obesity and smoking, and higher risk of developing a drug addiction (Ministry of Health and Social Policy of Spain, 2010, p. 43). The living conditions experienced by many of the world's poor, such as lack of safe drinking water and sanitation, inadequate housing and poor nutrition also contribute to both the prevalence of and susceptibility to disease. For this reason, the Commission on the Social Determinants of Health called for reinforcement of "the primary role of the state in the delivery of basic services essential to health". (CSDH, 2008, p. 15). Even where health care is provided free, the poor are less likely to access it due to time lost from work and incidental costs such as transport (Birdsall & Hecht, 1995).

Examples:

- In Europe, the excess risk of dying among middle-aged adults in the lowest socio-economic groups generally ranges from 25% to 50% and can be as high as 150% (Mackenbach, 2005 cited in CSDH, 2008).
- In Indonesia, maternal mortality is three to four times higher among the poor compared to the rich (Graham et al., 2004 cited in CSDH, 2008).
- In Scotland in 2006, men could, on average, expect 67.9 years of healthy life and women 69 years. In the most deprived 15% of areas in Scotland, men could only expect 57.3 years of healthy life and women 59 years.
- In Porto Alegre, Brazil, child mortality in poor households in 1980 was found to be twice the level of wealthier families (Birdsall & Hecht, 1995, p. 2).
- Women in the richest 20% of the population are up to 20 times more likely to have a birth attended by a skilled health worker than a poor woman (WHO 2010e).
- In some settings, coverage of diphtheria–tetanus–pertussisvaccine (DTP3) among the poor can be as low as 10% of that for the rich (WHO 2010e).
- Canadian research has shown hospitalisation rates for multiple health indicators were consistently higher for people living in low socio-economic status areas than for the middle and high groups across the census metropolitan areas.

Location and rurality

Geography is a significant factor in access to services, and often co-exists with other social risk factors that are known to contribute to poor health such as low socio-economic status and poor sanitation and living conditions. In developing regions, children in rural areas are more likely to be underweight that urban children, and in Latin America, the Caribbean and parts of Asia, this disparity has increased in recent years (UN, 2010, p. 5).

A recent project has also highlighted significant disparities within different urban areas, with a third of the urban

"Health inequality really is a matter of life and death."

Dr Margaret Chan, Director-General, WHO
(WHO, 2008b)

Nurse practitioners improve access to chronic care in community settings

Juggling two different speciality programmes of nursing and nephrology Lesley is a nephrology nurse practitioner in Australia who manages both pre and post-end stage kidney disease and chronic disease in Aboriginal and non-Aboriginal people across both urban and rural settings. Lesley and her team travel long distances to conduct chronic disease clinics where she makes a difference through outreach services. Lesley and the team are able to go to the patients in settings convenient to them and take that little bit of extra time with the patients to holistically assess the physical, mental and social impact of chronic diseases and treatment on the patients. Lesley provides holistic care and has the added advantage of having advanced clinical skills. She assesses patients to make a diagnosis and implements a pharmaceutical or non-pharmaceutical management and treatment plan. Lesley has diagnosed many new cases of hypertension, diabetes and potential renal disease and has seen good success in chronic care in her community. Because of this success the programme will be expanded to include a diabetic nurse practitioner and a cardiac nurse practitioner which will strengthen the chronic care model.

population worldwide living in slums or shanty towns. The analysis shows that there are differences within, as well as between, cities. The report sees addressing these issues within cities as an important part of achieving the MDGs (WHO et al., 2010).

Examples:

- The rural-urban ratio of the prevalence of underweight children under 5 in China is approximately 4.5 to 1 (although low by world standards). In developing countries, children are twice as likely to be underweight in rural areas (UNICEF 2010).
- Makwiza et al. have reported that despite free antiretroviral therapy (ART) services for treatment of HIV, patients in Malawi "especially poor rural patients face significant barriers in access and adherence to services" (Makwiza et al., 2009, p. 8).
- In sub-Saharan Africa, only 18 per cent of rural women are using any form of contraception, compared to 32 per cent of urban women (UNICEF 2010).
- Sanitation coverage in the developing world is 70% higher in urban areas than in rural areas (UNICEF 2010).

Addressing rural health needs through better use of nursing

In 2007 Colville Rural Nursing Ltd (CRNL) was established to meet the needs of families in a rural area of New Zealand. CRNL is entirely nurse-led and incorporates both district and public health nursing. Each CRNL nurse has specialist qualifications, such as midwifery and acupuncture, and one has a clinical master's degree in nursing with prescribing and is a nurse practitioner candidate. Ongoing education and professional develop are fundamental to their practice.

In January 2010, New Zealand's National Health Committee released a major report making recommendations on how to address the challenge of "delivering sustainable comprehensive health services to rural communities" (National Health Committee New Zealand, 2010, p. v).

The report makes recommendations in the areas of service delivery, system performance, and planning, data collection and research.

Building on the lessons of CRNL and others, key recommendations to improve service delivery include encouraging the development of nurse-led clinics.

(National Health Committee New Zealand, 2010)

Educational status

As illustrated by the examples below, there is a correlation between educational attainment and health status, as well as higher costs for health care. Higher levels of education have also been associated with better willingness and ability to access sometimes complex health care services, as well as participate in preventative health care activities such as screening programmes.

Examples:

- In the Netherlands, females and males with low educational status have a life expectancy of7 years less than those with higher educational status, and live 18 years less in good health (DETERMINE, 2010, p. 6).

- The prevalence of long-term disabilities among European men aged 80+ years is 58.8% among the lower educated versus 40.2% among the higher educated (Huisman, Kunst & Mackenbach, 2003 cited in CSDH, 2008)
- A lower educational level is associated with higher out-of-pocket payments for prescription drugs and higher probability of insufficient insurance protection amongst over 65 year olds in the OECD (Corrieri et al., 2010, p. 6).
- Lower educational standards are associated with lower use of preventative measures, e.g. mammography screening (Corrieri et al., 2010, p. 7)
- Contraceptive use is four times higher among women with a secondary education than among those with no education (UN, 2010, p. 5).

Disability

Although people with disabilities tend to have a high level of contact with health systems and services, there is evidence that many disabled people have difficulty accessing care that is appropriate to their needs.

Brown et al. (2010) note that two significant reports released in the UK have identified problems: Health Care for All identified problems including systematic institutional discrimination and failure to comply with and implement the Disability Discrimination Act. A parliamentary investigation in 2008 detailed breaches of human rights in respect to the right to life, freedom from degrading and humiliating treatment, and the right to privacy and family life (Brown et al., 2010, p. 354).

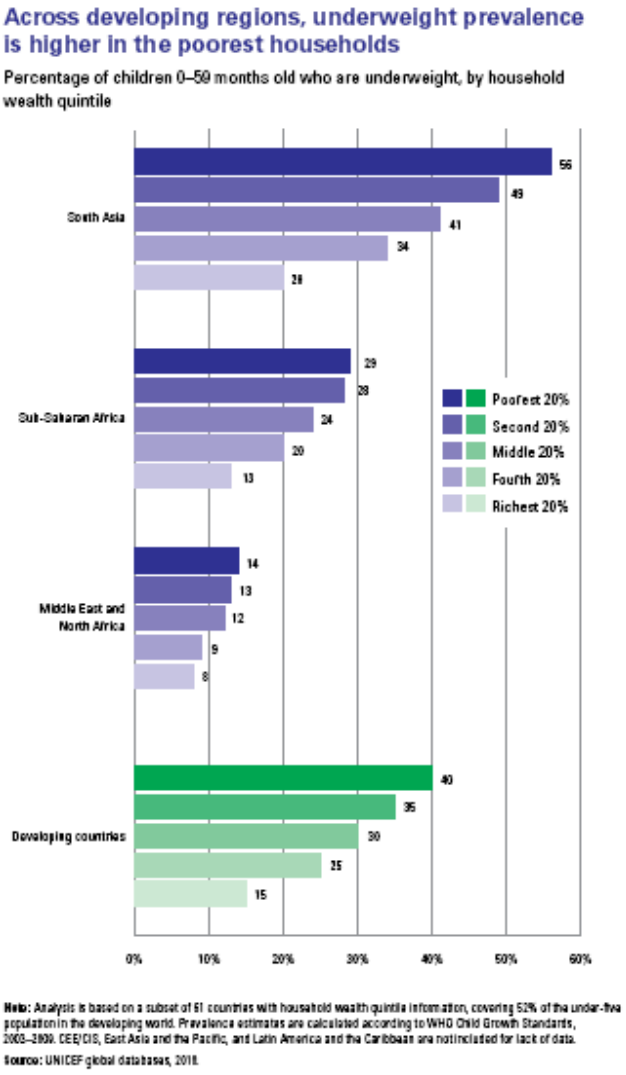
Examples:

- Mortality is three times higher in adults with learning disabilities than in the general population, reflecting the complex co-morbidities experienced by many people with learning disabilities (Brown et al., 2010, p. 354).
- Even in countries close to achieving universal primary education, children with disability are more likely to be excluded from education (UN, 2010, p. 5).

Diet and nutrition

Diet and nutrition have a significant impact on health, and have a close relationship with socio-economic status in both developing and developed countries. In cities, increasing consumption of foods high in fats and energy has led to what has been referred to as a "global obesity epidemic" (CSDH, 2008, p. 62). Meanwhile, in less developed areas, particularly rural areas, inadequate nutrition continues to be a major challenge, particularly among children and pregnant women in many parts of the world, where lack of nutrition in the early years hinders development and can establish lifelong health deficits. Reducing the global prevalence of underweight children is a key target in aims to reduce child mortality.

Figure 4: Percentage of underweight children 0-59 months old



Both these phenomenon are strongly associated with poverty. In the USA, Drenowski has highlighted that the density of fast-food outlets is higher in poorer areas, and that foods high in fat and sugar are generally cheaper than those with higher nutritional value. He argues that "the growing price gap between healthy and unhealthy foods … supports the causal link between poverty and obesity" (Drenowski 2009, p. 538). The sentiment is echoed by Dowler in Europe, who points out that "the evidence is that structural and social issues, such as the amount of time and money people can devote to pursuit of good food and active living, the cost and accessibility of each of them, the physical area where households are located, and the general social circumstances of the lives of those classified as lower classes … constrain and govern choice to a considerable extent." (Dowler, 2001, p. 702).

As illustrated in the examples below, high levels of diabetes, primarily associated with rising obesity, are also evident in indigenous communities in many parts of the world. In these cases, ongoing issues related to social dislocation and dispossession combine with other factors such as rurality and isolation, poor access to appropriate health services, and high unemployment to contribute to the problem.

Examples:

- Global prevalence of underweight children is 26%, and remains at 46% in Southern Asia, where more than 25% of infants are underweight at birth (UN, 2010, p. 13).
- Across developing regions, underweight prevalence in children under 5 is higher in the poorest households (UNICEF, 2010, p. 16)
- Underweight prevalence in children under 5 is more common in rural areas (UNICEF, 2010, p. 16)
- Very high rates of diabetes mellitus (DM) and its associated complications have been recorded amongst indigenous populations in the Americas and Asia-Pacific: (Hanley, 2006)
  - the prevalence of type 2 DM is 2-3 times higher in Native Americans compared with other American adults
  - a community-based screening programme in the Torres Strait Islands indicated a diabetes prevalence of 26%, six times higher than the general population of Australia.
- The highest rates of obesity and Type 2 diabetes in the USA are observed among those with the lowest education and income levels and in the most deprived areas (Drenowski, 2009).

CHAPTER 3

Measuring Access and Equity

Using existing data sources

The Commission on the Social Determinants of Heath has sought to improve national health equity surveillance by proposing two sets of indicators, which generally focus on the use of broad level population data – already collected in many countries – to identify inequities:

- A minimum health equity surveillance system, and
- A comprehensive national health equity surveillance framework.

These indicators are provided in detail in the Annex.

There is often a significant resource of untapped information available in existing data sources which can be analysed using an access or equity lens. For example, the UK's Quality and Outcomes Framework (QOF) was primarily introduced as a payment system for general practitioners (GPs) but provided researchers with "a rich new source" of primary care data, particularly as it allowed health information to be linked to other sources of information such as information about the local socio-economic environment. Sigfrid et al. examined 'exception reports', which are made when a patient is excluded from the outcome measure.[2] The researchers found a correlation between 'exception reporting' of diabetic patients and deprivation, with the highest rates in the most deprived populations. The authors conclude that "analysis of 'exception reporting', and not simple target achievement, when investigating health inequity' is important (Sigfrid et al., 2006, p. 224), and argue that this information can be valuable in developing strategies to improve services for hard-to-reach populations.

This case illustrates a key challenge in seeking to measure access, which is to try and assess not just who is accessing the service, but also who is not.

Key indicators of inequities

A Working Paper prepared by the OECD in 2009 (de Looper & Lafortune, 2009) describes the range of leading indicators that can be used to measure inequities in health status and in access to health care services. The indicators for measuring inequalities in health status include:

- Those related to life expectancy and mortality,
- Those related to morbidity and disease, and

[2] As this may occur for valid reasons such as patient dissent, failure to attend reviews or intolerance to medication, practitioners are able to exclude the record so they are not unfairly penalized.

- Composite indicators which include both these types of information.

The indicators of access and use include:

- Health insurance coverage,
- Health care utilisation in relation to different services,
- Measures of unmet care needs, and
- Out-of-pocket expenditure as a share of household income.

(de Looper & Lafortune, 2009, p. 12)

The authors note that simpler measures – such as measuring the gap between the lowest and highest socioeconomic groups – emphasize the plight of the least advantaged, and are most often used for routine and long term data collections. More complex measures use regression-based techniques to measure inequities across all population groups. Examples include the 'relative index of inequality' and the 'concentration index'. However, the data required, the complexity of calculation and the more difficult interpretation are disadvantages (de Looper & Lafortune, 2009, p. 14).

Visiting nurses of Moldova are a lifeline to many

As a Visiting Nurse, Irine spends her time in the homes of elderly and disabled people. Her country, Moldova, is a newly independent state of Eastern Europe that has experienced severe economic decline and a sharp increase in poverty since the post-Soviet period. Most of the population live under the poverty line, but the retired and disabled have been hardest hit. The Visiting Nurses Programme was created by the Moldova Red Cross Society to provide medical and social assistance to these groups, whose allowances are too small to cover even basic needs, including medicines and treatment.

The salaries of the nurses themselves are very low. Irine only earns US$23 per month, but despite this she and her fellow nurses are very devoted to the people they care for. The programme continues to seek funding to maintain the activities of its core 30 visiting nurses, but with such great need still apparent, hopes to expand to 100 nurses who can assist 2,000 beneficiaries. Irine and the other nurses appreciate the fact that their support is the only lifeline to these lonely, impoverished people.

Research has found that different indicators can sometimes lead to different conclusions. As noted by Wagstaff et al (1991), a study on the relationship between chronic diseases and social class in Sweden compared with another carried out in England and Wales, showed that "opposite conclusions were reached" when different indicators were used (Schneider, et al., 2005, p. 1). The assessment concludes that most of the tools are limited in their capacity to assess equity as part of the analysis, though it does note that many of the economic evaluation tools either incorporate various assumptions regarding equity or are implicitly or explicitly included in the analysis (WHOCC for Health Technology Assessment, 2008).

This suggests that there is still some way to go in ensuring that equity considerations are integrated into programme and policy development. As noted by de Looper and Lafortune "an important consideration in choosing an appropriate measure of health inequality is the ease in which they allow for routine data updating and ongoing monitoring" (de Looper & Lafortune, 2009, p. 14). This is particularly true in countries or regions who may have limited data available and/or limited capacity to develop and implement complex data collections.

It should also be noted that the measures used to assess equity and access may themselves discriminatory. As pointed out by Dey and Fraser, "any measure that relies on years of life may discriminate by age, just as any measure that includes quality of life may discriminate by disability" (Dey & Fraser, 2000, p. 521/22). This implies that the indicator must also be appropriate for the use to which it is being put. For example, a measure such as Disability Adjusted Life Years (DALY) may provide a useful insight into the health status of people from different occupational groups, and contribute to an assessment of the health impact of different work roles. However, if used (in isolation of other considerations) to assess where health resources are most efficiently allocated (e.g. prioritising access to hip replacement surgery) it may inhibit access to those with a pre-existing disability.

Tools for assessing equity

The availability of appropriate tools to measure and assess access and equity are central to efforts to improve health service delivery (Sigfrid et al., 2006) and health outcomes.

The WHO Collaborating Centre for Health Technology Assessment based at the University of Ottawa provides an Equity Oriented Toolkit[3] for "needs-based technology assessment" to promote sound decision making and resource allocation. It provides examples of a range of tools from across the world for assessing burden of illness, community effectiveness, economic evaluation and knowledge translation and implementation. These tools may be specific analytical methods such as the Disability-Adjusted Life Years, checklists such as the Health Impact Screening Checklist, software programmes such as the Harvard Policy Maker, or databases such as The Cochrane Library, etc.

Included in each set of tools is a comparison of each including its ability to gauge equity, assessed in terms of:

- Measuring/monitoring
- Community participation, and
- Advocacy.

Measuring health workforce inequalities

Comparing the density of the health workforce is a simple tool which can be used to illustrate the inequities in health workforce distribution worldwide. This is a particularly powerful set of data as a number of studies have established strong correlations between health workforce density and health outcomes. This provides a broad level analysis, and does not take into account the distribution of workers within particular areas, nor how this distribution compares to the health needs of the population. However, the disparities between countries are stark, and demonstrate the significant inequity in access to health workers, as shown in Figure 6, p. 31.

[3] See www.cgh.uottawa.ca/whocc/projects/eo_toolkit/about.htm

The *Global Atlas of the Health Workforce* provided by the WHO makes this basic level of health workforce data widely available, and allows users to examine a range of health workforce issues such as age distribution, and compare numbers in rural and non-rural areas. It is produced in order to inform policy, programmes and decision-making and includes data on a range of health worker types, including nurses and midwives. The data shown in Figure 6 (p. 31) is drawn from the Atlas.

Nevertheless, in 2006 the World Health Report described the availability of information on the extent and nature of the health workforce problem as "patchy at best" (WHO, 2006, p. 126). For many countries, collecting baseline data on the numbers of health workers in the country, their employment status and their location is challenging. This is not a problem confined to the less-well resourced: incomplete datasets, lack of coordination between different organisations and jurisdictions, disconnection between datasets (e.g. employment records versus professional registration records versus emigration and immigration records) can mean that the basic information on the distribution of nurses and other health professionals is hard to identify.

Nurses to the Homeless: A Lesson in the Real World

Nursing students Kate and Jennifer are led along the Spokane River on a cold October morning. Martha from Outreach is their guide and she calls out to Gypsy, who is resting under a shower curtain duct-taped to a tarp in a thicket of thorn trees. He's battling emphysema and has been short of breath lately. Allowing the nurses to examine him, Gypsy peels off his coat and starts unbuttoning his flannel shirt, revealing scars on his chest. "I think maybe you better take my pulse. I had a triple heart bypass up in Montana," he reports. Kate finds that it is high, 160 over 100 and tells him he needs to visit the clinic the next day to get some new blood pressure medication. They give him some juice and power bars, noticing that a half carton of eggs seem to be the only food around. They promise to check back the following week and bring the blankets he needs.

Every student at Washington State University who graduates with a nursing baccalaureate is required to take a semester of community health nursing. For some in Spokane, that means a semester of working with a needy downtown population--among them the poor, homeless, mentally ill, drug- and alcohol-addicted, and abused. The programme succeeds in raising awareness about the relationship between health and poverty. Jennifer admits she was shocked by this part of her training: "I didn't know there were this many homeless people in Spokane and had no idea where they were. You could be walking by a trail to where they sleep, and never know it. I actually recognize people now. Instead of 'Oh there's a homeless person over there,' it's like 'hey there's Gary.' They have names now."

CHAPTER 4

Barriers to Access and Equity

Health expenditure

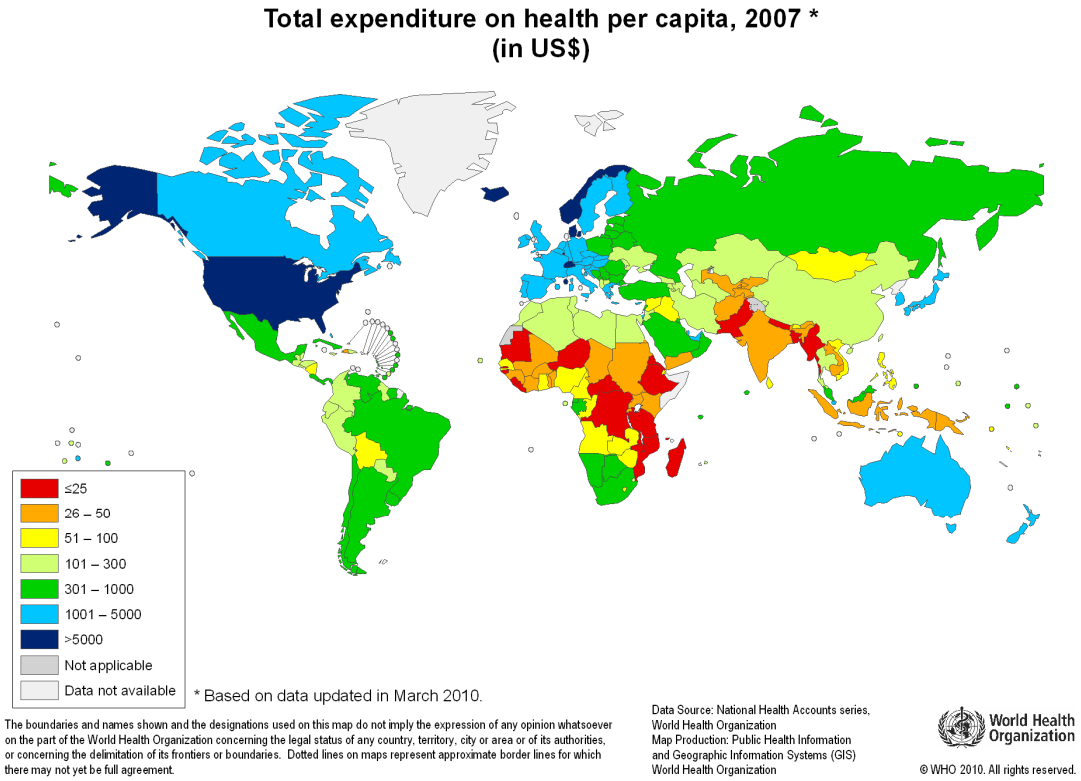
Expenditure on health services varies widely across the world, as illustrated by the WHO's mapping of health expenditure per capita (see Figure 5, p. 30). This has a direct impact on the provision of services across the health care spectrum, as well as the ability for countries to train, recruit and retain health workers. Governments are the main employers of skilled health workers in low- and middle income countries and their spending levels help determine staffing levels (ICN & WHO, 2009).

The way in which the available funds are distributed also plays a critical role in the extent to which they are accessed and used. Fees for health services, including incidental costs such as transport and lost income also "shape patient capacity to complete treatment" (WHO Regional Office for Europe, 2010).

Analysis of public spending, including spending on health care, using an equity 'lens' can throw a revealing light on the way that funding and financing mechanisms ameliorate or reinforce inequity. For example, an analysis of public expenditure in Indonesia in 1990 showed that the bottom 20% of households received only 2% of public spending for health, while the top 20% obtained 30% of public expenditures. (Birdsall & Hecht, 1995, p. 4). Birdsall and Hecht also note that, where the rural poor often have limited access to the most basic health services (e.g. Kenya, Pakistan, Peru), "a high proportion of public resources going to urban hospitals should suggest a problem with inequity." (Birdsall & Hecht, 1995, p. 7).

A review of studies examining access to health care services for immigrants in the USA identified only four studies examining health care costs, but found significant and shocking disparities: "Nationally, health care expenditure were 55% lower for immigrant adults and 74% lower for immigrant children that their U.S.-born adults and children, respectively, even after adjusting for age, income, insurance status and health status" (Derose et al., 2009, p. 368).

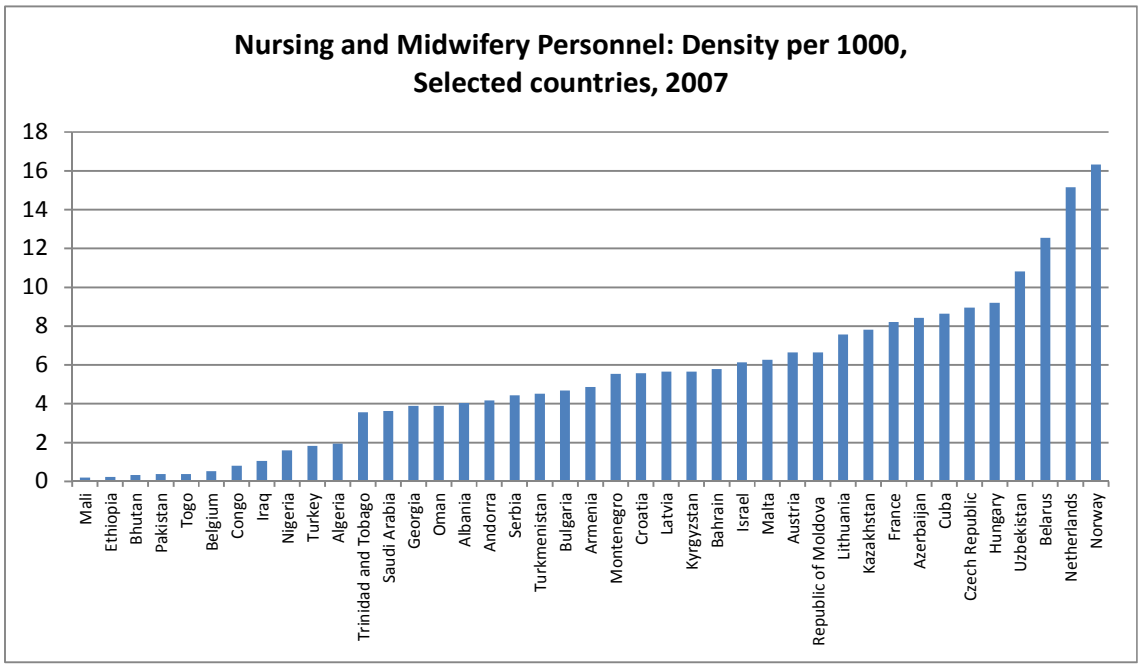
Figure 5: Total expenditure on health per capita, 2006 (in US$) (WHO, 2006)



Human resources

The world's health professionals are unevenly distributed. The density of the health workforce varies within and across regions by up to a factor of ten, and there are also large variations in the skill mix of health providers. In 2007, the number of nurses and midwives per 1000 population was only 0.2 in Mali, while it was 16.33 in Norway. The ratio of nurses to physicians ranges widely from nearly 8:1 in the African region to 1.5:1 in the Western Pacific Region (ICN & WHO, 2009).

Figure 6: Nurses and midwives per 1000 population (selected countries), 2007



Source: Data drawn from "Global Atlas of the Health Workforce" (WHO, 2010b)

Shortage of nurses and other health human resources (HRH) remains a huge barrier to appropriate access to health services in many parts of the world. For example, a study examining access to testing, counselling and ART in Malawi found that shortage of HRH posed "serious challenges to the equitable and sustainable delivery of ART in Malawi" citing a vacancy rate of around 50 percent for all professional health worker posts sector-wide (Makwiza et al., 2009, p. 8).

Where health workers exist, their distribution is a significant issue. Many rural areas in both developed and developing countries experience shortages of health professionals including nurses. For example, Ghana experiences "severe distribution differentials in terms of geography as well as between tertiary and primary care sites" (Dovlo, 1998). Similarly, a review of English language journals found that shortages of trained professionals in rural areas inhibited access to HIV/AIDS palliative care services (Harding et al., 2005, p. 252). In addition, the more limited opportunities for training and professional development for staff based in rural areas may also affect quality of care. This may lead to resisting changes which would lead to a shift in public funding to basic care, as this would require professional staff to be redeployed from urban to rural areas where living and working conditions are often more difficult, and access to professional development opportunities limited (Birdsall & Hecht, 1995).

The WHO has recently released global policy recommendations on *Increasing access to health workers in remote and rural areas through improved retention* (WHO, 2010c). A series of recommendations in the areas of education, regulation, financial incentives and personal and professional support are outlined. In addition the document stresses that "adhering to the principle of health equity will help in allocating available resources in a way that contribute to the reduction of inequalities in health" (WHO, 2010c, p. 3).

Increasing access through nurse prescribing

In Sweden district nurses with additional training have prescriptive authority. The Swedish Medical Products Agency created a list of products which nurses can prescribe. This list has over 230 brands of medications that qualified community nurses can prescribe for 60 conditions. Evaluation of nurse prescribing showed positive results in terms of improving access for patients, the elderly and disabled people.

CHAPTER 5

Increasing Access and Equity

Addressing the social determinants of health

The essential link between health and the living environment was recognised in 2005 when the WHO established the Commission on the Social Determinants of Health to ”marshal the evidence of what can be done to promote health equity, and to foster a global movement to achieve it” (CSDH, 2008).

As noted by Reutter and Duncan, nurses have a long track record of recognising the link between health and the environments in which people live and work, as well as a long standing engagement with advocacy, activism and policy development to improve key health determinants such as housing, child welfare and women’s suffrage. As early as 1861 Florence Nightingale was citing “the connection between health and the dwellings of the population” as “one of the most important that exists” (Reutter & Duncan, 2002, p. 294).

The Commission argues that while society has traditionally looked to the health sector to deal with concerns about disease, the fact that mortality and morbidity flows from people’s living and working conditions means that, “action on the social determinants of health must involve the whole of government, civil society and local communities, business, global fora, and international agencies” (CSDH, 2008, p. 1).

> *“People who are living in poverty, who are socially excluded, are more likely to lack access to accurate information and good quality health care, as well as to other basis political and social power resources. Sickness and weak social protection can further exacerbate the risk of poverty and social exclusion Ethnic minorities and migrants, the unemployed or underemployed, the poor, women, children, the sick and the aged are especially prone to fall into this poverty trap and vicious circle of powerlessness.”*
>
> Ministry of Health and Social Policy of Spain (2010, p. 41)

Accordingly, the Commission’s overarching recommendations are to

- Improve daily living conditions;
- Tackle the inequitable distribution of power, money and resources; and
- Measure and understand the problem and assess the impact of action.

The Commission's comprehensive final report, *Closing the gap in a generation: Health equity though action on the social determinants of health* (2008)[4] sets out key areas in which action is needed, provides analysis of social determinants of health and concrete examples of types of action that have proved effective in improving health and health equity in countries at all levels of socio-economic development.

PAHO and WHO have developed a self-instructional course on the social determinants of health and policy formulation. While the module is mainly targeted at WHO/PAHO staff members, it is also a useful resource for nurses and other health professionals involved in designing programmes and policy and all those wishing to increase knowledge and develop skills for "applying SDH approach to public policies and other strategies via personal and institutional capacity-building". (PAHO/WHO, 2009).

The following general objectives are listed for the Introductory Module:

- Understand health equity as a value that reflects social justice theory and constitutes a basic factor for the right to health.
- Recognise the potential of identifying health inequities as a strategic element in designing more equitable public policies.
- Recognise intersectoral policies and concerted action strategies from the SDH perspective.
- Analyse the recommendations drawn from the reports drafted by the Commission on Social Determinants of Health and its nine Knowledge Networks, as well as foster their discussion and adoption, taking into account both the conditions and priorities in each country.

For further information see http://dds-dispositivoglobal.ops.org.ar/curso/.

The role of health systems

While addressing health inequities is not the role of health services alone, health services can impact on health inequities. The WHO has defined a "health-equity-enhancing" system as one that will "a) lessen health inequities through the provision of equity-promoting services; and b) steward wider action on the social determinants of health" (WHO Regional Office for Europe, 2010, p. v).

The WHO Commission on the Social Determinants of Health identified the following key features of a health system that addresses health inequity in its report *Challenging Inequity Through*

Pediatric Nurse Practitioners improve access in New York State

In the USA, New York State, paediatric nurse practitioners (PNPs) provide primary health care services. They promote and maintain wellness through regular physical examinations, provide growth and development monitoring, immunisations and manage childhood illnesses such as upper respiratory and ear infections and diarrhoea. The PNPs follow patients in both ambulatory and inpatient settings and manage the care of the child and family in the hospital. The PNP services have improved access, quality and cost-effectiveness of care.

[4] h

Health Systems (2007):

- "The leadership, processes and mechanisms that leverage intersectoral action across government departments to promote population health;
- Organisational arrangements and practices that involve populations, groups and civil society organisation, particularly those working with socially disadvantaged and marginalised groups, in decision and actions that identify, address and allocate resources to health needs;
- Health care financing and provision arrangements that aim at universal coverage and offer particular benefits for socially disadvantaged and marginalised groups (specifically, improved access to health care; better protection against the impoverishing costs of illness; and the redistribution of resources toward poorer groups with greater health needs); and
- The revitalisation of the comprehensive primary health care approach as a strategy that reinforces and integrates the other health equity promoting features identified above"

(Gilson et al., 2007, p. v)

The report emphasises that providing a system which has these characteristics and can address inequity requires "both technical analysis and political commitment" (Gilson et al., 2007, p. xvii).

Service development and delivery

At the level of local service delivery, access can be improved by enlarging the overall capacity to deliver services, where possible, ensuring that the maximum possible outputs are achieved with the existing level of resources, targeting resources to underserved areas and improving specific aspects of care such as care continuity (Chapman et al., 2004). Where the demand for services outstrips supply, waiting lists and other rationing mechanisms may be used. However, when this occurs, it is important that the criteria for allocating resources are both transparent and open to public scrutiny and debate (Dey & Fraser, 2000). This will help ensure that rationing policies are not discriminatory or unfair. After reviewing innovating approaches to improving access to primary care services, an important plank of efforts to improve health and prevent ill-health, Chapman et al. conclude:

> "access to primary care may be improved by diversifying modes of provision, by enhancing the roles of staff and by implementing services more flexibly. In reducing access inequalities, the key may be to prioritise the allocation of limited resources in well-targeted services, serving previously assessed gaps in care and/or communities" (Chapman et al., 2004, p. 380)

A review conducted by Bhattacharyya identified innovations in health service delivery that had the potential to improve services for the poor. The review concludes that exemplary practices in service delivery include "patient-experience focused strategies such as tailoring designs and services to meet the needs of the poor", cross-subsidisation, efficiency strategies (e.g. specialisation), and high volume approaches which reduce unit cost as well as operational approaches to increase availability of services such as outreach and telemedicine (Bhattacharyya et al., 2010, p. 8). Other examples of successful strategies to increase access to marginalised groups include the development of mobile services such as caravans which provide basic screening services at shopping centres or other public places, outreach services specifically designed to target hard-to-reach population groups, and introducing mechanisms to reduce waiting times .

Nurses deliver award winning outreach

In 1988, the BC Centre for Disease Control (BCCDC), Canada, began an Outreach Street Nurse Program in order to reach those most at risk of HIV infections. The programme provides prevention services focused on HIV and sexually transmitted infections (STIs) for people who do not access mainstream health care. Services include clinical care, education and training, project development and implementation and research.

The nurses are "committed to reaching the populations who typically face barriers to health services and face stigma and discrimination in the face of complex health and social issues" and are "grounded in values of respect, health equity and social justice".

The programme also co-produced an award winning documentary and teaching tool, Bevel Up: Drugs, Users & Outreach Nursing which is widely used in health education, practice and policy nationally and internationally.

The programme received a Human Rights Award from the International Centre of Nursing Ethics in 2010.

(BC Centre for Disease Control, 2010)

The review identifies ten case studies of exemplars, including the Bhagwan Mahaveer Viklan Sahayata Samiti (BMVSS) an Indian organisation which has developed a lower limb prosthetic to meet the needs of amputees in developing nations. As well as developing an innovative prosthetic, BMVSS have implemented a number of measures to make the service more accessible and attractive to the poor.

- Allowing patients to check in at any time of the day or night;
- Providing patients with free room and board if they have to stay the night, and providing families with free meals at the clinic;
- Ensuring fittings are completed in one session, minimising number of visits and time away from work (Bhattacharyya et al., 2010, pp. 4-5).

Further examples of innovative approaches to service delivery can be found at The European Portal for Action on Health Equity, a web-based resource established by the EU consortium on the Socio-Economic Determinants of Health. It includes a good practice directory providing details of a range of projects which have been successfully developed to address inequity through innovated and targeted approaches to service delivery and development (DETERMINE, 2009).

Funding and financial mechanisms through an equity lens

Developing funding and financial mechanisms which seek to address inequities in health and promote access to the poor or otherwise disadvantaged can play an important part in addressing inequity and promoting health. Identified strategies include:

- "Reduce out-of-pocket payments by removing public sector use fees and developing innovative ways to limit other health care costs (such as drug and transport costs)".
- "Widen geographical access to comprehensive services by investing in public primary and secondary services in currently under-served areas and strengthening referral linkages".
- "Re-allocate government resources between geographical areas taking account of population health needs and all available funding sources".
- "Adequately fund the local level and PHC, within the framework of universal coverage".

(Gilson et al., 2007, pp. xii-xvi)

The authors further note that it may also be useful to "test" other strategies such as "community-based health insurance (or insurance schemes dedicated to particular population groups) as mechanisms for protecting poorer groups against catastrophic payment levels, learning from existing national and international experience about how to avoid the many pitfalls of such schemes and extend coverage, particularly to the most disadvantaged" (Gilson et al., 2007, p. xiii)

Improving access in South African townships

In South Africa nurses work as clinic managers and practitioners at township clinics that are visited by 200 to 300 patients daily. They supervise staff including junior nurses, health promoters and volunteers. Nurses take histories and perform physical examinations, and if there is no physician, they provide comprehensive care, including prescribing medications. On scheduled days nurse travel in a specially equipped van to take health care to the people thus increasing access to populations.

Use of data to monitor access and equity

Routine monitoring and surveillance

The WHO Commission on Social Determinants of Health has identified that the establishment of "routine systems for health equity and the social determinants of health are in place, locally, nationally and internationally" as a key area for action (CSDH, 2008, p. 206). Specifically, the Commission recommends that

- "Governments ensure that all children are registered at birth without financial cost to the household. This should be part of improvement of civil registration for births and deaths".
- "National governments establish a national health equity surveillance system, with routine collection of data on social determinants of health and health inequity".
- "WHO steward the creation of a global health equity surveillance system as part of a wider global governance structure".

(CSDH, 2008, p. 206)

Identity: Every Child's Right

Between 48 and 50 million babies every year will join those who will spend their lives without an official identity or citizenship. An unregistered child can be denied basic rights such as access to education and health including, for example, essential vaccination. Unregistered and undocumented children are extremely vulnerable to exploitation.

In response, ICN and the International Confederation of Midwives joined forces in 2007 to release a Birth Registration Toolkit designed to raise awareness amongst nurses and midwives of the importance of birth registration and to guide nursing and midwifery groups and associations in exploring and addressing the issue in their country.

Copies are available at www.icn.ch/images/stories/documents/publications/free_publications/birth_registration_toolkit.pdf

(ICN & ICM 2007)

The establishment of routine health monitoring and surveillance mechanisms is an important first step in assessing the health status of the population, and how health and access to health services is distributed within a community. Ideally, the Commission says "all countries should, as a minimum, have basic health equity data available that are nationally representative and comparable over time" (CSDH, 2008, p. 181).

The Commission's comprehensive Final Report, *Closing the gap in a generation: Health equity through action on the social determinants of health* (2008) outlines both minimum requirements for an equity surveillance system and a comprehensive surveillance framework. Details of these are provided in the Annex.

CHAPTER 6

Nurses Enhancing Access and Equity

Professionalism and ethics

The International Council of Nurses has the principles of human rights and equity as an integral part of nursing ethics. This is affirmed within the preamble *to The ICN Code of Ethics for Nurses* (2006) which states that

> "Inherent in nursing is respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. Nursing care is respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status." (ICN, 2006, p. 1).

Many elements of the Code directly address issues of equity and access, including

- The nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual family and community are respected (ICN, 2006, p. 2).
- The nurse shares with society the responsibility for initiating and supporting action to meet the health and social need of the public, in particular those of vulnerable populations (ICN, 2006, p. 2).
- The nurse, acting though the professional organisation, participates in creating and maintaining safe, equitable social and economic working conditions in nursing.

The Code also provides guidance for how it may be enacted for nurses in different contexts. Some examples are provided below. Copies of the ICN Code are available at www.icn.ch/images/stories/documents/about/icncode_english.pdf

Table 1: Excerpt from ICN Code of Ethics for Nurses (ICN, 2006, p. 5)

Element of the Code#1: NURSES AND PEOPLE		
Practitioners and Managers	**Educators and Researchers**	**National Nurses' Associations**
Provide care that respects human rights and is sensitive to the values, customs and beliefs of all people.	In curriculum include references to human rights, equity, justice, solidarity as the basis for access to care	Develop position statements and guidelines that support human rights and ethical standards.
Develop and monitor environmental safety in the workplace.	Sensitise students to the importance of social action in current concerns.	Advocate for safe and healthy environment.

In her article on nursing ethics, Nancy Crigger discusses the development of a nursing ethic within a framework of globalisation. She identifies five elements that may "facilitate a more fitting and equitable global ethic" (Crigger, 2008, p. 21):

- Inclusion and balance: including the views of the marginalised as well as considering the perspectives provided by science, religion, anthropology, etc.
- Balance of community and individual: so that the common good as well as the individual benefit is considered.
- Use of reflexivity, or the ability to reflect critically and realistically to one's own practice as well as seeing issues from an alternative point of view.
- Openness to new approaches to human rights, in particular a focus on "freedoms" rather than rights, which in turn allow opportunities and capacities to develop.
- Business and technology being viewed in a manner which acknowledged their capacity to entrench, as well as address inequities.

These ethical guidelines assist nurses to ensure that their care provision is just and equitable, improves the patient experience and the quality of care, and ensures that stigma and discrimination are eliminated from nursing as a whole.

Training and skills development

Effective training and skills development, including a commitment to ongoing learning development, is also needed if nurses are to deliver the accessible care which promotes equity and is free of discrimination.

Brown et al. identify shortcomings in nursing care for the disabled including negative views and lack of skill and knowledge about the needs of this client group. They also note, however, that many nurses have not received sufficient training to enable them to deliver quality care, citing a study of practice nurses which found that only 8% of respondents received training on issues related to learning disabilities.

It is also important that managers, including nurse managers, and employers ensure that they equip their employees with information and training appropriate to the needs and preferences of the local community. Actively seeking to recruit staff who are members of local minority groups, and to support those staff in the workplace, is also an important step to both making services more accessible to clients and to ensuring that those clients receive the same quality of care enjoyed by the majority.

Cultural competency

Ensuring that the workforce is culturally competent is an important part of increasing the utilisation of health services for all members of the community, but also helps improve quality of service by improving the patient experience and communication between health service providers and service users.

Key techniques for improving cultural competence have been identified by Brach and Fraser (2000) as follows

- Use of interpreter services.
- Recruitment and retention of staff who are members of minority groups.
- Training to increase cultural awareness, knowledge and skills.
- Coordinating with traditional healers.
- Use of community health workers.
- Culturally competent health promotion.
- Including family and/or community members.
- Immersion into another culture.
- Administrative and organisational accommodations, including location of services, changes to the physical environments and hours of operation.

Culturally Sensitive Nurses Straddle the Border

All sorts of undesirable health records are being broken at the US-Mexican border, home to nine million people. These include highest teen pregnancy rate, highest obesity rate, highest diabetes rate, and highest rate of car crash injuries caused by not wearing seatbelts.

About 3.4 million people here fall below 200 percent of the poverty level. More than a third are trapped in substandard living conditions requiring special assistance. The vast majority cannot afford health insurance, so do not seek preventative medical care and have difficulty understanding why they need to look after their blood pressure or cholesterol levels when they do not feel ill. To complicate matters further, the economic disparity between Mexico and the US compels more than 800,000 people to cross the 2,000-mile-long border every day.

Rudy is one of the culturally and linguistically competent nurses playing a key role in reducing the serious health inequities faced by U.S.-Mexican border populations. A family nurse practitioner with a medical centre on the Arizona/Mexican border, he is also president of the local chapter of the Hispanic nurses association. “As nurses,” he explains, "we see their health problems every day: heat exhaustion, hypothermia, and poisoning. They get so thirsty crossing the desert that they'll drink anything, including antifreeze. If they make it to the ER, we send them to dialysis.”

“The worst disease at the border is poverty,” Rudy emphasizes, “It results in unemployment, teen pregnancy, lack of quality housing, domestic violence, diabetes, cancer and more."

Developing roles and flexibility

The development of new roles for nurses has also been investigated as an important strategy to improve access to many services.

Increasing the role and deployment of clinical nurse specialists and nurse practitioners has been demonstrated to improve quality care and reduce organisational costs. Chapman et al. conducted a review of strategies employed to improve access to primary care in the UK, and found that nurse-led primary care has been used to "combat poor service access in areas having difficulties recruiting and retaining GPs", and that nurse-led triage and telephone consultations could save time and improve access without affecting quality of care (though they go on to note that telephone access can infringe access to people with poor English language skills, hearing or speech impediments or no access to phones) (Chapman et al., 2004).

Introducing appropriate new cadres in some areas has also been an effective way to reduce costs without adversely affecting patient satisfaction (ICN, 2010), and has been successfully employed in areas of severe workforce shortage.

Research

Evidence has shown that disparities arise in the area of research, as well as in other areas of health service delivery. A recent article analysing nurse researchers in the area of HIV found that clinical research did not always adequately represent the population in question. For example, in the USA it was found that although black women represented 67% of new AIDS cases in 2005, they were underrepresented in all clinical trials. The author notes that this is not only poor practice in terms of clinical research, but also "precludes learning about the political, social and individual factors that influence the spread of the disease" (Cohn, 2007).

Cohn argues that nurses, with their experience of direct patient care and communication and the high degree of trust that they share with the general public in many countries, are "uniquely positioned" to ensure that patients are well informed and that research protocols are developed in a way that ensures proper

Nurses as "Care Connectors"

In Ontario, Canada, about 780,000 people lack access to a family health care provider. One province is addressing this lack of access by appointing two full-time nurses in each of the province's 14 Local Health Integrated Networks to liaise with patients and health care providers. The nurses, called "Care Connectors", identify nurse practitioners and physicians who are accepting patients, and refer patients to them. Referrals are prioritized according to the patients' answers to a health needs questionnaire.

As of September 2010, 76,000 patients had registered with the service. Of those, 5,600 were deemed to have high needs, and 75% of them have been referred. Also, 75% of all referred patients, including those in northern and rural communities, have been referred to a provider within 10km of their home.

(Canadian Health Services Research Foundation, 2010)

participation and representation from all population groups. "Specifically, nurses recognise the importance of collaboration with marginalised population in management and treatment of disease" (Cohn, 2007, p. 274).

A tool to assist nurses undertaking research in addressing equity issues in their work has been developed by The Campbell and Cochrane Equity Methods Group. The Equity Checklist for Systematic Review Authors outlines a series of research questions aiming to guide researchers in incorporating an equity perspective in all the aspects of a review, including search strategies and methods, the description and methodology of the studies considered, as well as analysis of the results (Ueffing et al., 2009). The authors encourage use and distribution of the checklist, which is available at http://equity.cochrane.org/our-publications.

Lobbying, advocacy and policy development

Nurses play an important role in policy development through developing a voice in analysis, advocacy and research, particularly within the domains of health service delivery and restructuring. However, as authors such as Reutter and Duncan argue, the need to address the social determinants of health means that there is also a need for strong advocacy in the realm of broader public policy which "extend beyond traditional health agencies and government health departments to bring together sectors such as finance, agriculture, education, transportation, energy and housing" (Reutter & Duncan, 2002, p. 295).

National nursing associations provide a means by which nurses' interests can be articulated and provide a first point of contact with key stakeholders in government and civil society, and are key to the development of an effective contribution to policy debates on both how the health system is oriented, structured and managed, but also on broader policy issues which address the social determinants of health. A joint publication on macroeconomics by ICN and the WHO suggests areas for the nursing community to pursue in seeking to support workforce development and better health, including engaging in national and local debates on the financing and funding of health systems, and the importance of skilled health workers in achieving outcomes (ICN & WHO, 2009, p. 34).

Nurses in the house of parliament

At the Westminster palace in London a nurse is part of a modern occupational health service. Most of her time is taken with providing a walk-in service for MPs, peers and the other thousands of employees and visitors at the palace. The nurse deals with "just about anything you would see in a GP surgery and A&E combined". Her work ranges from dispensing pain killers for headaches to answering her bleep for emergencies such as cardiac arrests or dealing with sports injuries.

The nurse is also responsible for carrying out screening for current and prospective employees and health promotion activities, such as fitness and raising awareness of travel health for MPs who go overseas on business. The nurse ensures medical and nursing coverage during ceremonial events such as opening of parliament which involves a doctor, an ambulance and a lot of first aiders. Politicians work strange hours often debating until the early hours of the morning and this means they may neglect their health as they may not have time to look after themselves. The nurse sees many famous faces but true to her professionalism treats everyone in the same way.

Lobbying and advocacy thus are a key part of nursing's role in addressing issues such as equity and access, and involve the development of a different skill set and knowledge base. Nurse education is beginning to reflect this need, with the introduction of graduate courses which seek to build the skills needed for nurses to engage effectively in public policy development (Reutter & Duncan, 2002).

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ANNEXES

Commission on Social Determinants of Health: Equity Surveillance

Minimum Health Equity Surveillance System (CSDH, 2008, p. 181)

Health outcomes

- Mortality: infant mortality and/or under-5 mortality, maternal mortality, adult mortality, and LEB;
- Morbidity: at least three nationally relevant morbidity indicators, which will vary between country context and might include prevalence of obesity, diabetes, under-nutrition and HIV;
- Self rated mental health

Measures of Inequity:

- In addition to population averages, data on health outcomes should be provided in a stratified manner including stratification by
    - Sex
    - At least two social markers (e.g. education, income/wealth, occupational class, ethnicity/race
    - At least one regional marker (e.g. rural/urban, province);
- Include at least one summary measure on absolute health inequities between social groups, and one summary measure of relative health inequities between social groups.
- Good quality data on the health of Indigenous people should be available, where applicable

Comprehensive national health equity surveillance framework (CSDH, 2008, p. 182)

Health Inequities

Include information on

- Health outcomes stratified by
    - Sex

    - At least two socioeconomic stratifies (education, income/health, occupational class);
    - Ethnic group/race/ indigeneity;
    - Other contextually relevant social stratifies;
    - Place of residence (rural/urban and province or other relevant geographical unit);
- The distribution of the population across the sub-groups
- A summary measure of relative health inequity: measure include the rate ration, the relative index of inequality, the relative version of the population attributable risk, and the concentration index;
- A summary measure of absolute health inequity: Measures include the rate difference, the slope index of inequality, and the population attributable risk.

Health outcomes

- Mortality (all causes, cause specific, age specific);
- ECD;
- Mental health;
- Morbidity and disability;
- Self-assessed physical and mental health;
- Cause-specific outcomes.

Determinants, where applicable including stratified data

Daily living conditions

- Health behaviours
    - Smoking;
    - Alcohol;
    - Physical activity;
    - Diet and nutrition;
- Physical and social environment;
    - Water and sanitation;
    - Housing conditions;
    - Infrastructure, transport and urban design;
    - Air quality;
    - Social capital;

- Working conditions:
    - Material working hazards
    - Stress

Health care

- Coverage;
- Health-care system infrastructure;

Social protection

- Coverage;
- Generosity

Structural drivers of health inequity

- Gender
    - Norms and values
    - Economic participation
    - Sexual and reproductive heath
- Social inequities
    - Social exclusion
    - Income and wealth distribution
    - Education
- Sociopolitical context
    - Civil rights
    - Employment conditions
    - Governance and spending priorities
    - Macroeconomic conditions

Consequences of Ill-health

- Economic consequences
- Social consequences

Position Statement

Annex 2

Informed patients

ICN Position:
The International Council of Nurses (ICN) strongly believes that everyone has the right to up-to-date information related to health promotion and maintenance of health and the prevention and treatment of illness. Such health information should be easily accessible, timely, accurate, clear, relevant, reliable and based on evidence or best practice. Additionally, everyone should have access to accurate, reliable and transparent information on scientific research, pharmaceutical care and technological innovations in promoting health, preventing and treating illness.

People have a right to privacy and to confidentiality of information about their health. Appropriate sharing of information is a pre-requisite for nurses and other health professionals to establish honest, collaborative relationships with patients and their families or carers.

People are entitled to access to information, in an appropriate format and to the level of their understanding that enables them to make informed choices and decisions regarding their health. Information for patients and carers should be responsive to their needs and circumstances including their spiritual, religious, ethnic and cultural needs as well as their language skills and health literacy levels[5]. Risks and benefits of healthcare interventions and options should be explained to patients and, where appropriate, to their families and carers.

Nurses and other health professionals should work in partnership with patient organisations, self care groups and other interested parties to ensure that patients and the public have access to appropriate information about health and health services. Inherent in this is the expectation that nurses will be involved in research into the nature, quality and impact of patient information on health outcomes and nursing practice.

Background
People who take an active role in their health make better-informed decisions on self-treatment, engage in healthier lifestyles and are more likely to be satisfied with their care and health outcomes.[6] Nurses and other health professionals should acknowledge individuals' rights to make informed decisions and choices about how to manage their own health and to accept or reject health care or treatment.

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[5] Health literacy is defined here as the ability to understand, internalise and effectively use health information in everyday life.

[6] Department of Health. Chronic Disease Management and Self-Care. National Service Frameworks. (2002). A practical aid to implementation in primary care. Expert Patient Programme. Progress Report. February 6, 2003. www.doh.gov.uk/cmo/progress/expertpatient/index.htm

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Nurses and other health professionals need to have the knowledge and skills to manage information; to assist patients in accessing, managing and utilising information; and to contribute to and assess the evidence base regarding the impact of informed patients on health outcomes.

They should respond to patient self-identified information needs and patient needs assessment, rather than rely solely on professional knowledge or pre-conceived ideas.

Information should be made available to patients/consumers using a variety of information and communication technologies and should be presented in accordance with recognised or agreed quality standards.

Initial and continuing education and training of nurses and other health professionals should provide them with the competencies necessary to ensure that patients and the public are well informed, and to work in partnership with them to better meet their health needs.

ICN acknowledges that informed patients are crucial for ensuring patient safety and should be part of the efforts to improve quality and safety of health care.

Adopted in 2003
Reviewed and revised in 2008

Related ICN Positions:	**ICN Publications:**
• Patient Safety • Health Information: Protecting Patient Rights	• Patient Talk! The ICN Informed Patient Project (2003)

The International Council of Nurses is a federation of more than 130 national nurses associations representing the millions of nurses worldwide. Operated by nurses and leading nursing internationally, ICN works to ensure quality nursing care for all and sound health policies globally.

Position Statement

Annex 3

Universal access to clean water

ICN Position:

The International Council of Nurses (ICN) believes that the right to clean water is non-negotiable. Secure access to safe water is a universal need and fundamental human right; an essential resource to meet basic human needs, and to sustain livelihoods and development. Water is a public good and ICN opposes privatisation of water services and resources. ICN also believes that with commitment and political will by governments and others, clean and safe water can be made accessible to all people at low cost using appropriate technology.

ICN supports the target set in the UN Millennium Development Goals that aim to halve by 2015 the number of people without sustainable access to safe drinking water[7]. Access to safe water is a key aspect of effective poverty alleviation strategies.

ICN calls on nurses and national nurses associations (NNAs) to:

- Work with representatives of other sectors such as local government and water resources to lobby for clean and safe water supply.
- Urge their governments to provide safe and accessible water to the whole population.
- Lobby for a pro-poor and gender sensitive approach based on understanding of the roles of women and men in water management, so that women and men can participate equally to increase access to clean water**.**

Further ICN calls on nurses and NNAs to work with national and international bodies concerned with water supply to:

- Heighten vigilance and ensure safety of water supplies from intentional attacks, using biological, chemical or other harmful agents.
- Lobby for sound regulatory policies that ensure universal access to clean water.
- Monitor the public health impact of deregulation and privatisation of water supply, especially on vulnerable populations.

ICN is concerned that climate change and global warming often associated with drought, flooding and disruptions of water supply will threaten public health.

[7] United Nations. UN Millennium Summit, Sept. 2000.

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Background

Nurses work with individuals, families and communities to promote health, to prevent illness, to restore health and to alleviate suffering[8]. Nursing's mission to achieve these goals would be frustrated without access of the population to clean and safe water supply.

Rapid population growth, industrialisation, urbanisation, agricultural intensification, climate change and water-intensive lifestyles are resulting in global water crisis. About 20 per cent of the population lacks access to safe drinking water, while 50 per cent lacks access to a safe sanitation system[9].

More than 3 million people die each year from water-related diseases such as diarrhoea[10]; and millions suffer from diseases such as dysentery and trachoma. Disease due to poor sanitation and hygiene cause the deaths of 2 million children every year[11].

Due to environmental degradation and pollution, sources of water supply are threatened with contamination by sewage and harmful bacteria, chemicals such as nitrates; heavy metals such as lead, mercury, and arsenic; and persistent organic compounds.

The lack of clean water supply poses a serious threat to public health. It also adds to the heavy burden of women in some countries, who often travel long distances to fetch water on their back, with serious health consequences. Despite the back-breaking task to collect water, such water is often contaminated with animal, human, or industrial waste and other contaminants with harmful consequences to health.

There is growing concern that sources of water supply can be targeted for attack by bacteriological, chemical or other agents with the intention to cause harm to large populations.

Global trends toward deregulation and privatisation of water supply represent serious barriers to universal access to clean and safe water.

The impact of climate change and global warming represents a threat to availability of safe water.

[8] International Council of Nurses (2000), Code of Ethics for Nurses. Geneva: ICN.
[9] www.unep.org
[10] World Health Organization. Water and Health. Bulleting of the World Health Organisation, 79 (5), 486.
[11] WSSCC/WHO/UNICEF Global Assessment Report, 2000

Adopted in 1995
Reviewed and revised in 2008

Related ICN Positions:

- Reducing environmental and lifestyle-related health hasards
- Towards elimination of weapons of war and conflict
- Nurses and primary health care
- Nurses and human rights

ICN Publications

- Fact Sheet on Safe Household Water: Preventing Disease, Saving Lives.

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Position Statement

Annex 4

Publicly funded accessible health services

ICN Position:
The International Council of Nurses (ICN) and its member national nurses associations (NNAs) advocate for the development of national health care systems that provide a range of essential health services accessible to all the population, as determined within the country in both preventive and curative care.

Where such services are not publicly funded, ICN believes that governments have a responsibility to ensure accessible health services to vulnerable groups.

Essential and accessible health services should be determined by each country's health needs. They should balance efficiency and cost-effectiveness with quality, striving to achieve this balance within the resources available.

ICN supports efforts by national nurses associations to influence health and public policy that is based on the health priorities for the nation, equity, accessibility of essential services, efficiency (including productivity), cost-effectiveness, and quality care.

ICN promotes educational preparation in management and leadership development that prepares nurses for a broad range of roles and responsibilities. ICN supports efforts by national nurses associations to ensure that government policy for publicly funded health services does not downgrade the level of nursing education required by the complex demands of these services.

ICN and its member associations support and promote the principles of primary health care as a means of helping promote availability of and accessibility to essential health services at a cost that communities and nations can afford.

To ensure accessible, cost-effective and quality services, appropriate regulatory principles, standards and mechanisms need to be established and be applied equally to both private and public health services.

Nursing education systems should ensure curricula are regularly updated to meet the needs of the changing environment, that they are appropriately implemented, and that ongoing education needs are addressed.

A healthy nation is a vital national resource. A prime goal of each nation must be to achieve the best health status possible for the population within the resources available.

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ICN and member associations need to maintain effective networks with relevant stakeholders to help ensure resource allocation and availability of services is based on needs and priorities, promotes primary health care, and considers quality considerations as well as costs.

This goal is made more difficult because of:

- increased demand for health services (due to factors such as the changing nature and amount of health problems, aging populations and rising public expectations);
- rising health care costs often associated with insufficient resources and with an increased emphasis on costly applications of advanced technology;
- inadequate use of available resources because of inefficiencies in the planning and priority setting, utilisation and management of health care systems.

Health system reform in many countries is trying to address these problems. This has implications for both private and public components of health systems.

Adopted in 1995
Reviewed and reaffirmed in 2001

Related ICN Position:

- Promoting the Value and Cost Effectiveness of Nursing

ICN Publications:

- **Cost Effectiveness in Health Care Services - Guidelines for National Nurses' Associations and Others**, Geneva, ICN, 1993
- **Costing Nursing Services**, Geneva ICN, 1993

Recommended Further Reading & Resources

Challenging Inequity through Health Systems (Gilson et al. 2007) Final Report of the Knowledge Network on Health Systems, WHO Commission on the Social Determinants of Health

www.who.int/social_determinants/resources/csdh_media/hskn_final_2007_en.pdf

Closing the gap in a generation: Health equity though action on the social determinants of health (CSDH, 2008) whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

Equity-Oriented Toolkit (WHOCC for Knowledge Translation and Health Technology Assessment in Health Equity, 2004)

www.cgh.uottawa.ca/whocc/projects/eo_toolkit/index.htm

The European Portal for Action on Health Equity

www.health-inequalities.eu

Global Learning Device on Social Determinants of Health (PAHO/WHO, 2009)

http://www.who.int/pmnch/topics/conferences/200902_paho/en/index.html

The ICN Code of Ethics for Nurses (ICN, 2006)
www.icn.ch/images/stories/documents/about/icncode_english.pdf

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