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HEALTH-DISEASE:

THE PROXIMITY OF CARE IN A WORLD
WITHOUT BORDERS AND RAPID MOBILITY

Manuel Lopes - PhD in Nursing Sciences, University of Évora, Coordinator of the National Network of Long-term Integrated Care. Portugal

Felismina Mendes - Coordinating Professor, PhD in Sociology, School of Nursing, University of Évora; Researcher at the Centre for Research in Sport, Health and Human Development (CIDESD-UEvora)

Lucília Nunes - Coordinating Professor, PhD in Philosophy, President of the Technical Scientific Council of the School of Health of the Polytechnic Institute of Setúbal

Alice Ruivo - Coordinating Professor, PhD in Psychological Development and Intervention, Director of the School of Health of the Polytechnic Institute of Setúbal

António Amaral - Coordinating Professor, PhD in Organization and Management of Companies, Vice-Chairman of the Technical Scientific Council of the Nursing School of Coimbra

ABSTRACT

Objective: This article offers an in - depth reflection on the proximity of care in a rapidly changing world where health problems require local responses, although they have lost their local expression in the globalized world we live in. **Methods:** This is an essay that presents an in-depth formulation on global health and nursing interventions in this context. **Results:** Reflecting on the proximity of care in a world at borders and with rapid mobility requires an analysis of global health and the indicators in which it is expressed; the ethical-moral and political dimension of health and economic development and health. **Conclusions:** A global health perspective, which analyzes and secures health care in global terms is imperative but has to allow global and local action. At the same time, this perspective can never omit that access to health care is a right and a prime factor of human development.

Keywords: Global health; nursing care; ethic.

INTRODUCTION

Following the report *“Um futuro para a Saúde - todos temos um papel a desempenhar”* (“A future for health - we all have a role to play”), the Directorate-General for Health and the Calouste Gulbenkian Foundation promoted a national debate with nurses and citizens to reflect, within the framework of the recommendations and challenges, on the nursing responses to health in the future.

Because we all have a role to play, Nursing must prepare itself, within its sphere of action, responsibility and skills, to strengthen performance and participation in the health team, ensuring better responses to citizens’ health needs, a relevant factor for the development of the Health System as a whole.

In this context, we were proposed to reflect on the theme “Health-disease: the proximity of care in a world without borders and with rapid mobility”. We propose to do so with reference to the fact that we live in a globalised world, with mobility never before seen nor possible, and simultaneously with enormous inequalities, mainly between hemispheres. This requires a global perspective of health, since the associated problems are no longer limited to local expression, although at the same time they require a local solution, always assuming that access to health care is a right and a major factor of human development.

FRAMEWORK

Health is one of the most important indicators of people's development. To prove this, we invoke the concept of Human Development proposed by the Pakistani economist Mahbub ul Haq (1995) and defined as the process of expanding people's choices and freedoms so that they have the capacity and opportunities to be what they want to be. Contributing indicators such as health, education and income contribute to this concept, as well as to the calculation of the Human Development Index. If we analyse a little of each of the three indicators, but above all the relations between them, we easily perceive that both health and education are determinants for the exercise of the freedoms mentioned. On the other hand, education and income constitute health determinants by expressing the close link between health and human development, which is why we attribute the aforementioned centrality to it. From another perspective, as human development is strengthened, the exercise of human rights is consolidated.

In this context, thinking about health is to place it in a network of relationships between multiple variables ranging from the micro dimension (i.e., genetic code) to the macro dimension (e.g., health and environment policies); relationships that are already duly theorized and designated as determinants and subsequently assumed and developed by the World Health Organization (WHO) as social determinants of health.

Thinking about health is thus increasingly less of an issue that can be solved in isolation by a country and is increasingly a problem of the relation of that country to the world it is in, whether we consider it in relation of greater proximity with its neighbouring space or in a more global perspective. This global framework of health issues has gained increasing relevance with the development of the globalization movement.

Thus, in the case of Portugal, thinking about health must oblige us to look at our natural integration into the European space, characterized, among other things, by the free movement of people and goods, but also by the high standards of human development generally achieved.

The free movement of people and goods associated with the increase and ease of mobility make Europe a space crossed by millions of people daily, placing pressures on the health system due to both the cultural and linguistic diversity of users and the potential fast spread of any disease. As an example, it should be noted that Lisbon airport reached 18 million passengers in the year 2014, almost twice the Portuguese population, not wanting to say that they all come from the European area.

In the case of Portugal and taking into account the geographic position and the transatlantic relations, thinking about health means also integrating north-south relations. In this case and in addition to the aforementioned elements, many others need to be addressed. In fact, if the demands placed on the system by our European integration are high, those which arise from our relations with the countries of the Southern Hemisphere are of increasing demand and of a different nature, which is why we will pay particular attention to them.

In addition to the arguments put forward, it is expected that each country in thinking about its health system will also see it as a way to contribute to global health and human development.

In this context, it is important to consider health and within this, the contribution of nurses to health, taking into account the integration of Portugal in an economic space considered to be of enormous development and free circulation (i.e. EU), but also its geographical location and its historic opening to the countries of the Southern Hemisphere, combined with globalization and the ease of movement. We will pay special attention to these last dimensions, considering the imbalances of development between the mentioned hemispheres and the consequences that they have for global health, as well as for Portuguese health. To do this, we will characterize the Human Development Index (HDI) as well as several other indicators of health and health determinants from a global perspective.

A brief overview of global health - the differences via health indicators

With regard to the HDI and according to the latest Report of the United Nations Development Programme⁽¹⁾, there is almost a perfect division between the northern and southern hemispheres, with very high levels of human development in the former and very low levels in the latter (see figure 1).

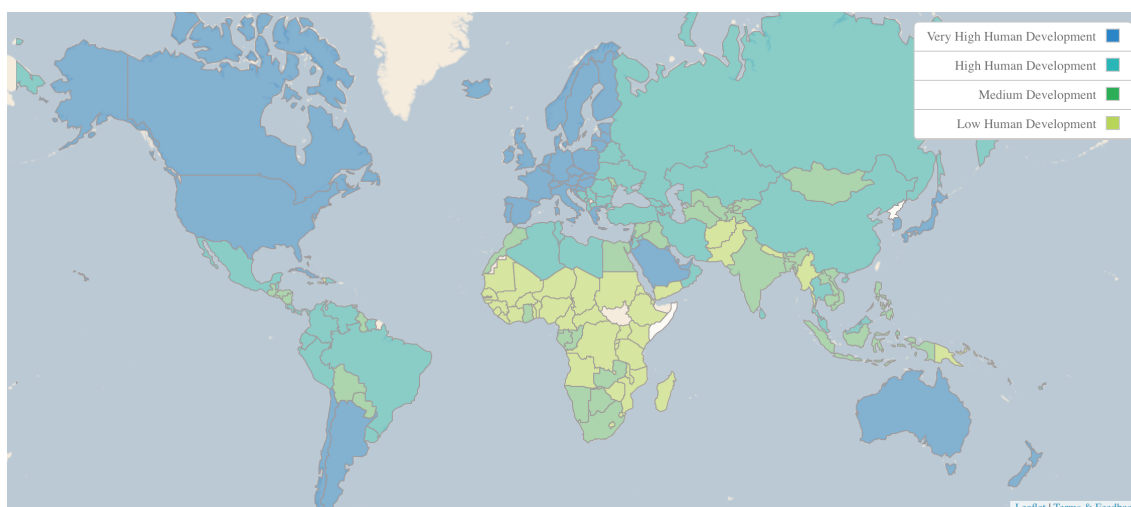


Figure 1 - Overview of the Human Development Index.

Source: Selim Jahan⁽²⁾.

If we look at the various indicators that compose the HDI, we find that this division is present in all of them in a more or less pronounced way. Thus, the under-five mortality rate varies between 2 deaths/1000 live births in Luxembourg and 182 deaths/1000 live births in Sierra Leone⁽¹⁾. Despite this gap between the countries mentioned, we should also mention that it was much larger in 1990 (6 versus 386 deaths per 1000 live births), as can be seen visually in figure 2. Mean Life Expectancy at Birth ranges from 45.6 years in Sierra Leone to 83.6 years in Japan.

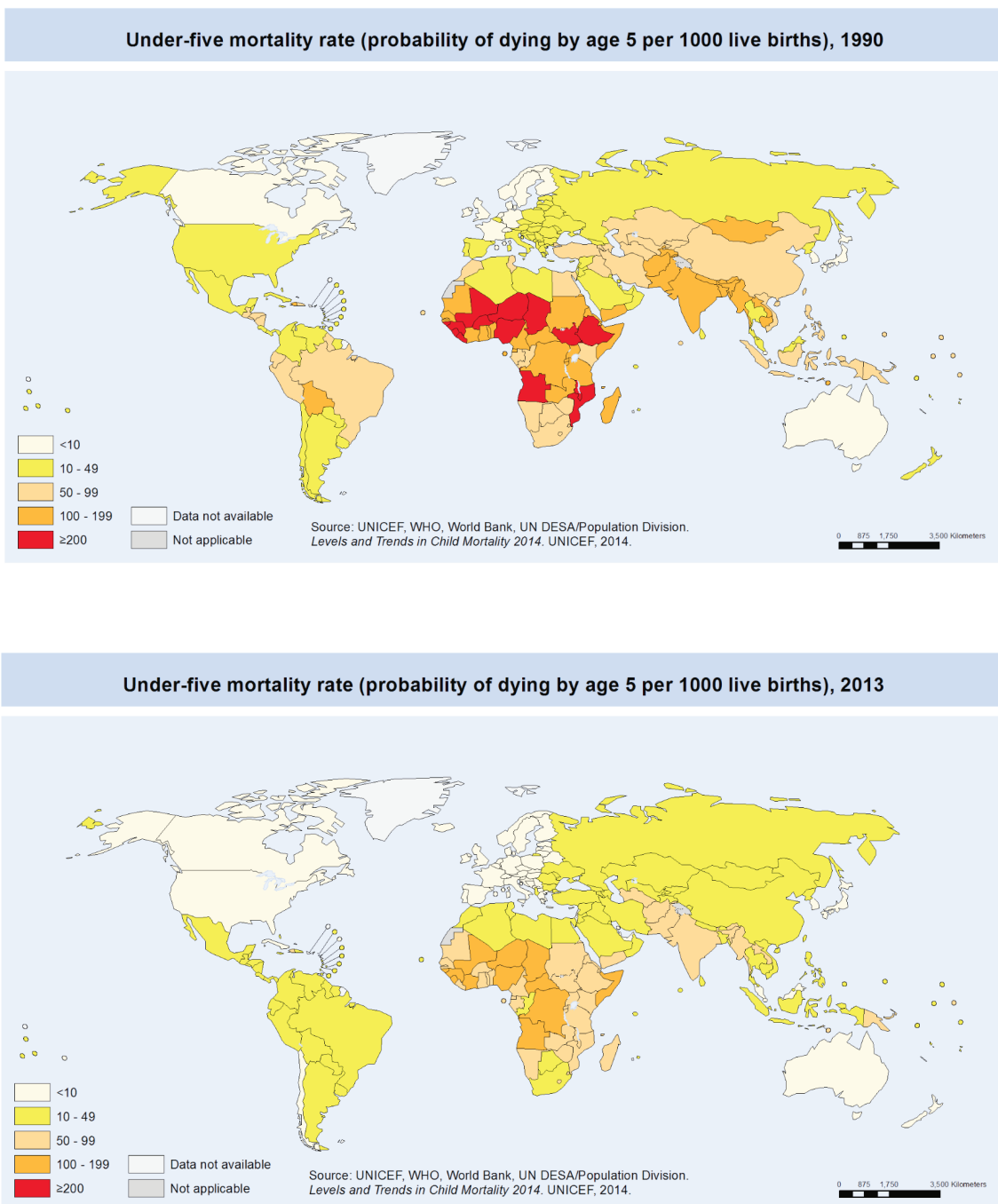


Figure 2 - Under-five mortality rate/1000 inhabitants - 1990-2012.
Source: WHO, 2015.

If the comparison between the hemispheres includes the type of diseases, we find that while in the northern hemisphere there is an epidemiological transition from infectious diseases to degenerative diseases, a pattern of infectious diseases remains in the southern hemisphere. As an example, and according to WHO (2014), between 2010 and 2013 only countries in the southern hemisphere reported outbreaks of cholera. A similar conclusion can be drawn regarding meningococcal meningitis. If we analyse the maps of incidence of tuberculosis, we find the same division between the hemispheres, and the conclusion is therefore possible (WHO, 2014).

On the other hand, in the northern hemisphere, with a marked difference in the average life expectancy at birth, cardiovascular, cerebrovascular and oncological diseases prevail, all of them with an increasing tendency to be chronic diseases.

It is also worth looking at some of the millennium development goals (MDGs). Thus, in relation to the first (MDG1 - poverty and hunger), we chose atrophy in children under the age of 5, once again noting the classical division between hemispheres, in which case the African continent predominantly prevails with alarming indicators. Regarding the level of poverty, we can see two distinct things and both of great gravity. The first 30 countries on the list of the poorest are all from the southern hemisphere; In this set of countries, poverty reaches between 48% (Cameroon) and 80% of the population (Chad).

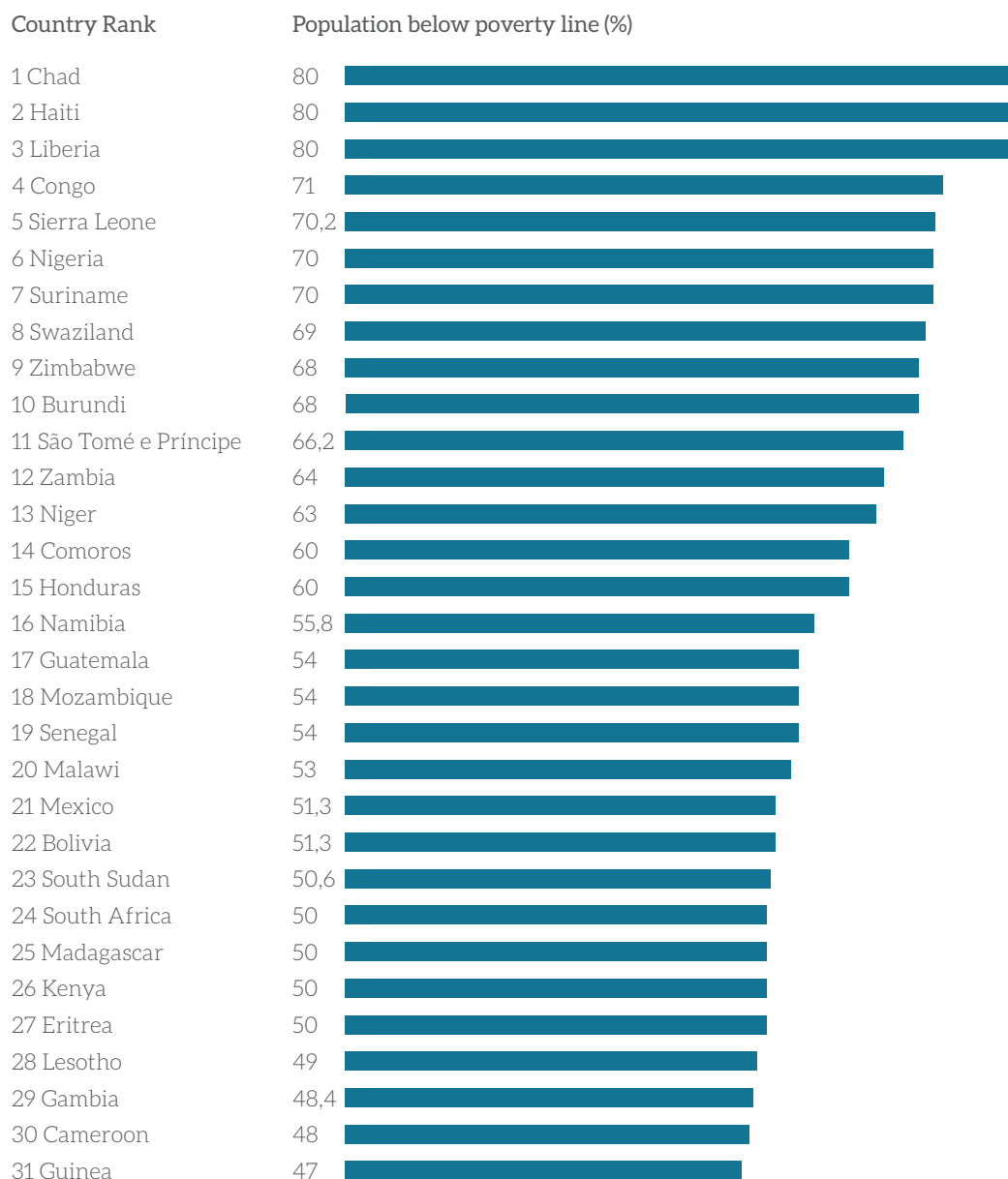


Figure 3 - List of the first 30 countries with the highest percentage of population below the poverty level.

Source: (WHO, 2014).

Regarding children's health (MDG4) we have already mentioned under-five mortality rates, but the conclusions are the same if we talk about infant mortality. On the other hand, in relation to women's health (MDG 5), we found abysmal differences between the two hemispheres regarding childbirth care by health professionals, as well as maternal mortality.

Regarding environmental sustainability (MDG 7), we find that while in the northern hemisphere, 100% of the population has access to drinking water, in most of the southern hemisphere, only half or less have access to drinking water. It is also in the southern hemisphere that people are more exposed to environmental pollution at home, resulting from the use of solid fuels.

As regards the DPT-3 vaccination coverage, there is a similar tendency to the one described hitherto, with coverages that are around 100% in the northern hemisphere while in the southern hemisphere around 50%, despite the positive evolution that has been observed in recent decades. However, this evolution seems to be fragile since it regresses whenever there is some instability of a different nature.

When analysing the health resources and starting with the density of doctors and nurses and partnerships, we find that in any case the north-south gap remains with differences ranging from 0.1 nurses/1000 inhabitants in Lesotho to 17.4 nurses/1000 inhabitants in Switzerland. For physicians, the difference varies between 0.008 doctors/1000 inhabitants in the United Republic of Tanzania and 7.7 doctors/1000 inhabitants in Qatar.

With regard to health financing, we consider total health expenditure with a clear north-south divide with countries like Myanmar spending an amount equal to 1.8% of their GDP while the United States of America has an expenditure equivalent to 17.9% of GDP. For a more adequate understanding of this dimension (i.e., health financing), we should also consider total health expenditure per capita at the average exchange rate (US\$ 2012), with disparities ranging from \$14.7 per capita in Eritrea to \$9,055.4 per capita in Norway.

Let us now turn to some composite indicators.

Let us begin with the Gini Coefficient^(a) through which we naturally perceive that in this case the north-south inequality remains⁽¹⁾.

(a) Synthetic indicator of inequality in income distribution that takes on values between 0 (when all individuals have equal income) and 100 (when all income is concentrated on a single individual). The coefficient can also range from 0 to 1.

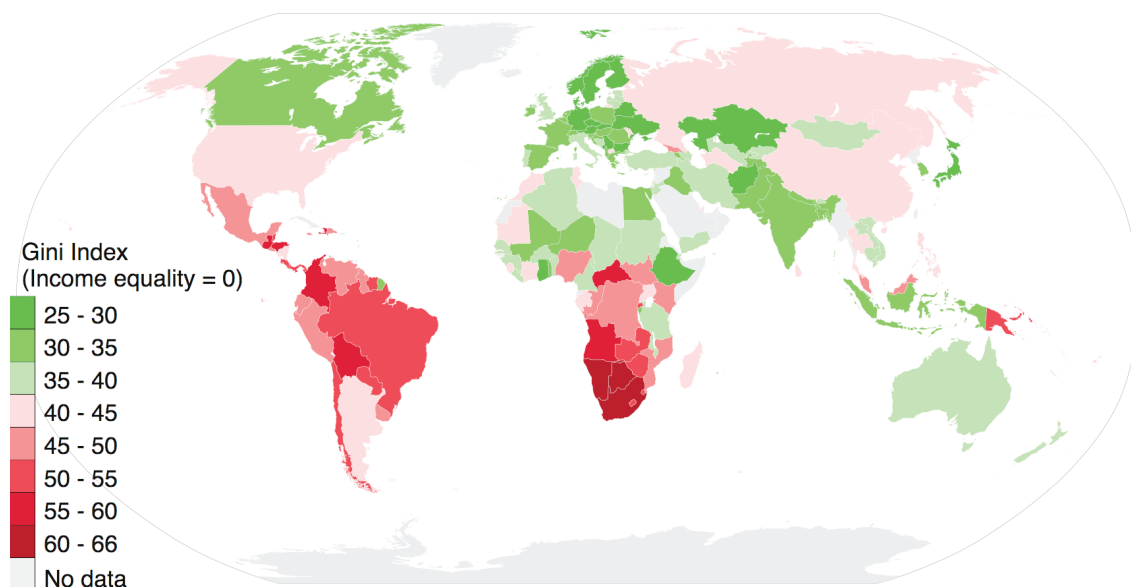


Figure 4 - Global Gini Coefficient Perspective.

Source: (WHO, 2014).

This inequality is all the more striking in the case of the Gender Inequality Index^(b), which captures the disadvantages of women and the loss of potential for development in three dimensions that reflect the HDI: reproductive health, empowerment (autonomy), and economic activity.

Based on the indicators presented it will be easy to establish relations between them and understand how much of an influence they have either negative or positively.

The scenario presented here can be summarized as follows:

A rich, developed northern hemisphere with high standards of health and well-being as opposed to a poor, underdeveloped and poorly developed southern hemisphere with poor standards of health and well-being, but mainly with a combination of unfavourable factors that contribute to the perpetuation of the current scenario. This combination of unfavourable factors led the UNDP to propose the adoption of the concept of vulnerability defined as “risk exposure and risk management, including shock prevention and diversification of assets and sources of revenue”⁽¹⁾.

(b) Reflects inequalities based on gender in three dimensions - reproductive health, autonomy and economic activity. Reproductive health is measured by maternal mortality and fertility rates among adolescents; autonomy is measured by the proportion of parliamentary seats held by each gender and the achievement of secondary or higher education by each gender; and economic activity is measured by the rate of labour market participation for each gender.

In turn, the concept of human vulnerability was introduced as a way of describing situations of deterioration of individuals' capacities and possibilities of choice⁽¹⁾.

This stark inequality and vulnerability concern us whether we consider the ethical point of view or health from a global perspective and consequently the global economy.

Ethical-moral dimension and health policy

Each person is unique, irreplaceable, endowed with dignity; In other words, human dignity is inherent in the person, precedes and underpins human rights - as Habermas asserts, rights (as a whole and in relation to each other) must "satisfy politically the moral promise of respecting human dignity"^(c).

From human dignity we usually deduce the protection of life and, from it, integrated and inherent, the protection of health. It may thus be thought that the desideratum of the *highest level of health* is as much a matter of justice and humanism as an obligation of States. Therefore, the State is required to ensure and undertake the protection of the right to health care.

It is understood that for the full realisation of human existence in the sphere of health, both the creation of conditions and their realization are relevant. Hence, access to health care and health information are not only related to the legal framework of the country but depends substantially on political will, i.e. on health policies and on how care processes and practices are developed.

In a broad approach to capacities, Amartya Sen distinguishes between 'functioning' as an acquisition of the person, what he or she can do or be, the use of the resources at his disposal, and capacity as a skill to achieve a certain 'functioning' - from which it follows that capacities emerge from the application of all available uses of available resources and reflect the real opportunities a person has to choose between possible lifestyles for themselves. Therefore, "capacities are the potential 'functionings' of people. Functioning refers to being and doing [...] all capacities, together, correspond to the freedom to lead the life that the person has reasons to value"^(d).

(c) Habermas, Jürgen (2010) La idea de dignidad humana y la utopía realista de los derechos humanos. *Annals of the Francisco Suárez Chair*, 44, 105-121. "los derechos fundamentales sólo podrán satisfacer políticamente la promesa moral de respetar la dignidad humana de cada uno, si actúan conjuntamente y de manera equilibrada en todas sus categorías" ("Fundamental rights can only satisfy politically the moral promise of respecting the human dignity of each person, if they act together and in a balanced way in all their categories") (italics in original) p.110.

(d) Robeyns, Ingrid (2003) Sen's capability approach and gender inequality: selecting relevant capabilities. *Feminist Economics*, 9 (2-3), p. 61-92. cit p. 62: "Capabilities are people's potential functionings. Functionings are beings and doings. The difference between a functioning and a capability is similar to the difference between an achievement and the freedom to achieve something, or between an outcome and an opportunity. All capabilities together correspond to the overall freedom to lead the life that a person has reason to value."

Health is fundamental for the realization of life projects, and therefore access to health care is a human right - let us understand human rights as a moral implication of the principle of a minimum threshold for all. Health is considered a personal asset and individual resource, which influences quality of life and can also be seen as a result of a set of conditions and lifestyles, being determined by multiple factors (which have been designated by health determinants). Hence, the aspiration of the best level of health for all has arisen^(e) - however, this intentional universality is faced with complex details, dynamic profiles of individual needs, associated with the life cycle and life processes, ageing, increasing chronic diseases, in an environment that exerts strong influences upon us, from economy to culture, from the life of the groups to the work conditions.

Understanding that health gains are “positive results in health indicators, and include references to their evolution”^(f) is expected to translate into “gains in years of life, by reducing disease episodes or shortening their duration, by reducing temporary or permanent disability, by increasing physical and psychosocial functionality, and by reducing avoidable suffering and improving quality of life related to or conditioned by health”^(g). Of course, health gains depend on the ability to intervene, either by preventing, controlling or resolving causal factors, where known - and, consequently, health gains also depend on knowledge management, accurate identification of health needs and correct allocation of existing resources.

We will all generally agree that health policies have to be based on clear principles and values - in fact, in our reality, what is not missing are statements of rights or texts about the health situation, which (being a relevant indicator) is different to implementing health systems that effectively ensure “universality, access to quality care, equity and solidarity”^(h), reducing health inequalities.

Reforms in the health system have pointed to accessibility and equity as central axes, with access to health care being “one of the health determinants [...] dynamically interlinked with social determinants, with literacy, with attitudes towards health services and health status”⁽ⁱ⁾, factors that intersect with the characteristics of the care system and influence the use of health care. Considering that one of the fundamental pillars of health policy is

(e) The Declaration of Alma-Ata (1978) assumed health as a fundamental human right. Reaching the highest level of health in all nations corresponds to the most important social goal in the world.

(f) Portugal. Plano Nacional de Saúde 2012-2016. 4.1. Objetivo para o Sistema de Saúde - Obter Ganhos em Saúde, p.2.

(g) Idem, p.2.

(h) Idem, p. 3.

(i) Furtado, Cláudia; Pereira, João (2010) Equidade e Acesso aos Cuidados de Saúde. Escola Nacional de Saúde Pública. Universidade Nova de Lisboa. p. 8.

access to care, it seems clear that, at the most basic level, this access depends on the provision of care, that is, the availability of health care for people to access; and this availability is directly related to the organization of services and the existence of (more or less) barriers to utilisation, as well as the adequacy of the response to citizens' needs. In this sense, it is "inseparable from the issue of equity in the health system"^(j).

The basic premise, conveyed by the WHO, is that all people should be able to reach their maximum health potential, with health equity defined as "the absence of avoidable, unjust and changeable differences in the state of health of population groups of diverse social, geographic or demographic contexts"^(k). Health policies and health care, at their various levels, as a health system, aim at an ultimate objective, namely "to improve the health status of all citizens"^(l). Here, then, a universal concern arises (all citizens) and, in ethical terms, the common good of each and every member of a community is easily evoked.

There is persistent talk of public goods with a global dimension as goods that "tend towards universality, in the sense that they can benefit all countries, population groups and generations"^(m) - the benefits of these goods extend to a broad range of populations, meeting the needs of the present without endangering future generations. That is, public goods contribute to increasing the possibilities and opportunities of each person to live the life that they choose to live.

Some examples of our everyday life: the public good of scientific knowledge, materialized in vaccines, has enabled millions of people to protect their lives from certain diseases; or, in another example, a public service hotline that provides fast and qualified health advice, provides citizens with tools for self-care and reduces the use of emergency services, allowing the public system to function better as a whole; or, in another case, a free and effective emergency service on the ground, immediate life support or emergency and resuscitation support, that everyone can access quickly is a public commodity that seeks to preserve life or reduce sequelae.

It is argued today that the actions of health systems must be aligned with other systems and policies, such as education, environment and work. Moreover, there are areas in which the states of the European Union "cannot act alone in an effective way, and cooperation at

(j) *Idem*, p. 4.

(k) Plano Nacional de Saúde 2011-2016. Estratégias para a Saúde. p.2.

(l) Portugal. Plano Nacional de Saúde 2012-2016. 4.1.Objetivo para o Sistema de Saúde - Obter Ganhos em Saúde, p. 2. Available at: <http://pns.dgs.pt/files/2012/02/OSS1.pdf>

(m) Deneulin, Séverine; Townsend, Nicholas (2006) Public goods, global public goods and the common good. WeD - Wellbeing in Developing Countries. Working Paper 18.

community level is indispensable. These include major threats to health and issues with cross-border or international impact, such as pandemics and bioterrorism (...). In order to fulfil this function, it is necessary to develop cross-sectoral work.”⁽ⁿ⁾

Health and economic development

With regard to the economic dimension, the problem can be seen in two complementary perspectives. First, the development of humanity cannot be achieved, under penalty of being extremely fragile, increasingly digging the gap between the most developed and the least developed; Secondly, the fragility is manifested, among other things, by the pressure that is placed on the borders that separate developed regions from less developed regions (e.g., the southern border of Europe and the southern border of the United States), creating dramatic humanitarian situations that are often out of control. This pressure has had recent developments with intense, dramatic and degrading migratory phenomena.

Given the above, the attitudes of developed countries have varied over time between greater or lesser rigor in the control of migratory movements, especially at the pressure points mentioned above. This variability is clearly related to the economic cycles and the labour needs of the richer countries. Note that this pressure has also contributed to fuelling human trafficking networks and illegal emigration, as well as illegal networks that are often under subhuman conditions. The prevalence of these networks also contributes to the total absence of control of any disease situation, as well as its permanence and even degradation in the host country since, as illegal workers, they do not have access to the health system.

At the same time, developed countries have contributed through donations and/or programme funding, both through public funds and through philanthropy, the impact of which little is known, and there are doubts as to the real beneficiaries of these gestures. This raises the question: how does one define a development strategy? What role do nurses play in this strategy, from conception to short-, medium- and long-term interventions?

Looking for answers

Assuredly the answers to such complex problems are not simple, much less miraculous. Nor is change expected to occur suddenly. The possible changes will occur if there is a great diversity of variables that favour them, many of them with a high degree of unpredictability such as those resulting from the political instability that often leads to destructive conflicts of human lives and all the infrastructures that sustain development.

(n) Livro branco Juntos para a saúde: uma abordagem estratégica para a UE (2008-2013), p.2.

Therefore, what we propose here does not translate into an exercise of futurology, but only in a delineation of a strategy that can bear fruit in the medium-/long-term. We will do so by stating two fundamental pillars - health in all policies and a health policy implemented through local health strategies - and consequently the contribution of nurses in this whole process.

Health in all policies

Do nurses, like all health professionals, have a key role to play as agents of change and improvement in health care, and of health responses, in a systematic service of joint support to the populations and the community organizations, which necessarily requires training adapted to these objectives?

This new approach, which starts from the centrality of the initiatives of the citizens and the communities, creates breakdowns and simultaneously stimulating opportunities for the work of nurses, who will have to change their long-established practices and establish new professional relationships, where the partnerships with the users and community organizations, will become more prominent. Also, the use of new technologies to help solve “old” problems, will be a given in the daily life of nurses.

Endowed with solid scientific knowledge and leadership skills, nurses will play a strategic role in the implementation and monitoring of Health in All Policies and as agents of change and transformational leaders that promote the improvement of the health of populations and communities through continuous cooperation with all community sectors and political players of governance⁽³⁾.

The realization of this new role to be performed by nurses requires more than changes in training models, a solid reconfiguration and flexibility of roles and a strong investment in teamwork where information sharing supports all the bases of action.

Taking a strategic and political position in the defence of people’s health has associated the challenge of a new role but also requires that governments recognise and reinforce the nursing professionals’ new role.

Increasing average life expectancy, quality of life, improved levels of education and health knowledge, have increased citizens’ expectations in the care system and its possibilities, requiring more and better health. We are then faced with perspectives that refer to an innovative (re)formulation of both the concept of health and public policies and their role in society⁽⁴⁾, which encourages and values the importance of negotiation and collaboration, allowing individuals to be informed and guided (empowered) to make decisions in a free and conscientious way in favour of health.

Playing the role that the current health conditions of the countries demand, introduces training to the nurses that values and reinforces public and communitarian health. In this formative context, it is imperative to retake and deepen all the WHO strategic guidelines that the most hospital-centric vision of health in Portugal has always referred to for a secondary plan, in the training of health professionals and especially nurses.

In this framework, the importance of Health in All Policies is emphasized. More than a political strategy of intersectorality in health, it is based on the conviction that health gains are inseparably dependent on the lifestyles of each individual and the environment in which they are inserted.

Health in all Policies is also a guarantee that health is integrated into policy initiatives in other areas, which should be consistent with health policy priorities⁽⁵⁾. Health as a Resource, central to the development of countries, regions and populations, is also a configuration that underlies all health policies. Both the first and the second are operationalised through the Social Determinants of Health, which combine the principles derived from these two perspectives.

In this context, it is never too much to remember or recall the principles that should underpin training, rather than action/intervention in health, and which are based on the assumptions of the World Conference on Social Determinants of Health⁽⁶⁾:

- All planned interventions must be health-driven across all policies (stressing the importance of the relationship between health and broader economic and social goals, by improving the health of the population and reducing health inequalities as an integrated policy response)⁽⁷⁾;
- All planned interventions must be coordinated and coherent with each other (each level of action needs to act according to its own priorities and conditions);
- All planned interventions must be sustained on a medium-/long-term basis through continued implementation of campaigns;
- All planned interventions should be based initially on empowering individuals and communities on health inequalities and health determinants;
- All planned interventions should be based on an assessment of health inequalities and the main factors associated with the social determinants of health, in the context in which it is intended to intervene;
- All planned interventions should follow the principles of intersectorality⁽⁸⁾;

- All interventions must work according to the moral imperative underlying human rights that everyone should have equal opportunities for health^(9,10);
- All planned interventions should develop and institutionalise mechanisms for effective participation of populations by providing objective information and working directly with communities throughout the process⁽¹¹⁾;
- All planned interventions should promote continuous monitoring and create mechanisms for assessing planned interventions, monitoring health inequalities, social determinants, and the impact of policies pursued^(12,13);
- All planned interventions should pay particular attention to the creation, collection, dissemination and availability of information on the social determinants of health and related policies;
- All planned interventions should establish methodologies for obtaining monitoring and evaluation data. This data collection (on education, housing, employment and access to health), based on population-based surveys and at regular intervals, will provide the minimum necessary basis for supporting and sustaining policy-making⁽¹²⁾;
- All planned interventions should include the definition, construction and selection of indicators to support action on health determinants. These indicators must comply with criteria of comparability, harmonisation and accessibility^(13,14);
- All planned interventions should prioritize models focused on the cultural context, value systems, and individuals' goals and expectations (as opposed to the traditional epidemiological model)⁽¹⁴⁾;
- All planned interventions should take a multidisciplinary approach reflecting the full spectrum of sectors involved⁽¹⁴⁾ (Stiglitz, Sen and Fitoussi, 2009);
- All planned interventions must be coherent and coordinated, meaning that different sectors can contribute to health by simply doing their own work well;
- All planned interventions should express coherence between social and economic policies;
- All planned interventions should avoid operating as a project or programme that is simply performed. In this sense, political action must always be based on knowledge about the health determinants⁽¹⁵⁾;

- All planned interventions should adopt governance as a core concept. This concept is fundamental to mediate how governments and social organizations interact and relate to citizens, to clarify the role of different actors and sectors, and to foster consensus among different sectors^(16,17);
- All planned interventions should provide for accountability for decisions made, in relation to common goals identified, linked to health and equity in health;
- All planned interventions should have a strategic direction and vision, based on a medium-/long-term commitment. Short-term campaigns often lead to fast but inadequate implementation of measures;
- All planned interventions should provide assurances of good performance in both processes and results, making the best possible use of resources in terms of the common goals identified;
- All planned campaigns should be based on transparency, both for decision-makers and those responsible for implementing the policies and results achieved, ensuring that responsibilities are and always remain clear;
- All planned campaigns must resort to equitable processes, as this is the only way to reduce health inequalities;
- All planned campaigns should promote the evaluation of the impact of health-driven policies. This evaluation allows the modification or adaptation of policies, plans or strategies for health promotion and reduction of inequalities. The values that support the use of impact analysis in decision-making are democracy, equity, sustainable development and the ethical use of evidence^(o).

In an era in which health problems are increasingly complex, health promotion and the implementation of campaigns to combat social and health inequalities emerge as decisive conditions for ensuring economic and social development and, above all, to ensure the inclusion of all groups in society. In achieving these goals, nurses are central and indispensable actors. To do this, they must be able to rescue the critical dimension that allows them not only to shed new light on old problems but to essentially shed new light on new

(o) An example of an impact assessment tool is the Urban Health Equity Assessment and Response tool, called Urban HEART (<http://www.who.or.jp/urbanheart.html>). It is a tool developed by the WHO (and already tested) that systematically incorporates the issue of health equity into the planning cycle, especially in urban settings. Also, audits focused on health equity can be used to assess whether the distribution of services and resources - given the health needs of different groups and regions - is fair, as well as to identify priority areas for action.

problems through a comprehensive and interactive view of social and health issues, in accordance with the complexity of these areas and the current society itself⁽¹⁸⁾. Nurses cannot continue to ignore or live on the fringes of the political elements that ground and shape the social context that defines their professionalism. Without critical awareness of the profession, health and the world, nursing action has no meaning. Therefore, action and social and political consciousness must be in equilibrium and harmony⁽¹⁹⁾.

A health policy and strategy

Regardless of the health system model adopted by any given country, it is understood that it will be a promoter of development, provided it meets the criteria of universal coverage, accessibility and equity. It is then necessary for each country to adopt a health policy that implements the aforementioned principles. In addition, and considering the transnational perspective underlying this text, there is a need for alignment and cooperation between country-defined health policies and WHO guidelines.

However, we believe that this is insufficient to respond adequately to the health needs of the population. In order to achieve this, we understand that national health policies and programs should be combined with a wide range of other orientations from different sources (scientific societies and other knowledge-promoting entities), converging them into a local campaign involving all actors. This perspective is called the Local Health Strategy and is defined as the set of health goals, social partners (committed), activities (effective in the achievement of these goals) and resources (existing or deployable) capable of improving the health status of the community, in a context of high complexity. The local health strategy is the main (but not exclusive) instrument for achieving the major objectives of any Health Plan at a local level. Local Health Strategies and the opportunities for citizenship promotion that they provide are the cornerstone in managing health changes. A set of abilities needed in the leadership of Local Health Strategies it is also pointed out, namely:

- Analytical ability - “understanding the world around us” (Local Health Observatory: “diagnosis” and “evaluation”).
- Ability to negotiate goals based on (a) the estimation of the “base values” and “time trends” of the situations in question, (b) analysing the effectiveness of the measures necessary to achieve the goals, the recognition of existing or deployable resources to achieve them, or the SWOT analysis applied to those specific circumstances.
- Ability to manage the partnerships and “social networks” needed to develop local health strategies.

- Ability to plant and fertilise small projects - it is important to mobilise the structures for tangible projects, which can create a sense of belonging, essential in the dynamics of participation; these have the advantage of being inexpensive, can start without significant organizational modifications, and provide a starting point for the development of other goals.
- Ability to promote innovation; achieving success through innovation depends on creating a climate conducive to change.
- Motivation to “change things” while maintaining the interest and energy needed to initiate and support the various impacts of the change process.

Local health strategies correspond to a population-based instrument, led by health services and involving different community partners. In each local health strategy, health services and their partners should define a limited and well-selected set of health gains targets that incorporate some of the major national priorities, adding local specificities.

Local Health Strategies should be the “cornerstone” of the development of the health system, since they are the main instrument for the implementation of a National Health Plan or any other instrument that defines health policy. They aim to bring change and innovation to citizens and professionals, taking the referred Plan as reference and incentive. Its implementation provides an opportunity to modify the relationship patterns among the various social actors in the community and strengthen the instruments for promoting citizenship, healthy public policies, equity and adequate access to health care.

All these aspects will allow health gains, comparability of data and good practices, which is also part of a national and international research-action policy, with the possibility of applying to different financing programmes, to be demonstrated.

Given the above, which strategies are the most appropriate for nurses to be leaders at the most diverse levels and participate proactively in transformation processes, thus contributing to human development?

Nursing responses to health in the 21st century - some thoughts

The sustainability of countries and communities requires healthy people. Health systems capable of delivering sustainable responses, to ensure that people remain healthy, require adequate, affordable and quality human resources.

The evolution of the industrial society to the knowledge society, the demographic and epidemiological transition that ageing and mass mobilisations of the masses will produce are major challenges facing health systems and their human resources.

In the 21st century, human resources in health will be essential to guarantee the satisfaction of individual needs, but above all to promote health and human development, so that each person can live their life with dignity.

Achieving the goals for sustainable and equitable development implies that governments and policies focus on equity and universality of access and coverage, which will only be achieved through an investment effort in human resources, particularly in nurses, but also in the training of other providers for the resolution and follow-up of problems and situations that are less complex and outside the “usual” institutions. This implies thinking today about the supply of professionals for the future needs of the populations.

The challenges facing countries, related to the global shortage of human resources in health combined with ageing populations and epidemiological transformations as well as north-south inequalities and human mobility, require a reassessment of the effectiveness of the models and measures that have been taken in the past, focusing very much on disease diagnosis and pharmacological treatment.

Meanwhile, the demand for more human resources will lead to greater employment opportunities and hence greater economic development.

The improvement of health care, coverage and outcomes depends on the supply of human resources, their availability, accessibility, acceptability and quality. But how can we guarantee that everyone, in any country or region, has access to a competent, motivated and supported professional by an organized and sustainable health system?

The first thing to do, according to UN experts, is to start thinking about human resources not as an expense, but as an investment in people's health, which is the best investment that governments can make.

A substantial part of the GDP of low- and middle-income countries is a result of the population's health levels and the opportunities that this generates.

We are therefore in a complex and imbalanced scenario. On the one hand, a changing epidemiological pattern with different population structures that will put pressure on health systems and human resources to act more closely to people living in states of chronic illness and non-communicable diseases; on the other hand, an epidemiological pattern characterized by infectious diseases affecting people of very low resources, living in countries with or without weak political and economic structures, and others with scarce human resources but that are subject to mobility, either by escaping the difficult conditions that affect them or as victims of human trafficking.

This scenario will confront countries with increasingly complex challenges that require them to respond simultaneously to the needs of a population in demographic and epidemiological transition and the needs of another that, occupying the same geographic space or remaining in their places of origin, remain in a former epidemiological pattern.

At the same time, access to information will cause the existing imbalance between provider and consumer to collapse, leading consumers to require more personalised care and more person-centred systems. Access to information will also make known what each professional group provides, how it provides and what results can be obtained from what they provide.

What are the responses to these scenarios?

At the same time, the responses will have to make the most of the resources we already have and start a reform that will prepare responses that are better suited to the challenges set forth here.

With regard to the first part of the above statement, there is now an enormous diversity of nursing education in the European area and even more globally, as well as the diversity of socio-occupational profiles. However, some common traits seem to persist, namely that the socio-professional profile is systematically marked by the socio-political representations of the various professions, with assumed supremacy of the medical profession; this has as a consequence, among other things, the artificial limitation of nurses' skills. Despite this and in certain circumstances, these manifest themselves in an extensive way with evident gains for the people who need care. This finding led a number of experts, under the auspices of the Institute of Medicine⁽²⁰⁾ to recommend that nurses should practice throughout their education and training. We feel that this is a particularly appropriate recommendation for our country, since a remarkable evolution in the level of training of nurses did not correspond to the same evolution in the skill profiles required in a clinical context. In other words, the evolution in the formation and regulation of skill profiles did not correspond to the development of political and organizational spaces. Therefore, let us highlight the feasibility, both normative-legal and political, of full development in a clinical context.

With regard to the necessary reform for global health in the 21st century, we propose:

A profound change in the training profile including:

- Training for inter- and transdisciplinarity as well as for inter- and trans-professionalisation^(20,21) - this requires joint training of the various health professionals, thus preparing them to work together, in the certainty that many of the problems that

arise will require responses at a transdisciplinarity and transprofessionality level, and that training is essential for interdisciplinary teamwork learning.

- Training for leadership and innovation and social entrepreneurship - A team needs leaders who are able to identify who is best placed to respond effectively to the desired ends at any given time. The need for leadership and for establishing leaders is essential, regardless of which professional group they come from. On the one hand, the lack of leaders hinders decision-making, organization and accountability. On the other hand, care proximity strategies (e.g., ELS) require the capacity for innovation and social entrepreneurship to work together with local actors to find solutions to the health problems of populations.
- Training for political intervention - Being and participating in the life of society means developing political action. It is urged that each person be proactively political and intervene in the name of defending a health policy that promotes the development of people;
- Training for lifelong learning that articulates the development of skills, systematically based on evidence, materialised in the interventions and monitored by results in health, such a movement will promote a new professionalism based on the excellence of skills;
- Training for cultural diversity and unpredictability - the fast mobility of people increasingly confronts us with cultural diversity. In turn, the nature of the problems we deal with but also the nature of the social context we are in, require us to have skills that allow us to deal with unpredictability;
- Maximum use of Information and Communication Technologies as a way to promote learning, as a support for clinical intervention, and for the infinite possibilities it offers for the collection, storage and analysis of information.
- Systematic review aimed at adapting curricula skills to respond to fast changes in needs, rather than being dominated by static curricular units. Skills must be adapted to local needs while relying on global knowledge⁽²¹⁾.
- Changing the concept of School/College by replacing it with the concept of "qualifying contexts," or academic systems as Frenk calls it⁽²¹⁾, which include schools/colleges as well as health organizations, in a truly committed dialogue on developing new professionals' skills.

At the level of clinical practice contexts:

- Provide person-centred care - Respect for identity and values; Prioritising the relief of pain and suffering; Continuous integrated care; listening, communication and education skills; capacity for decision-making and shared management⁽²²⁾.
- Identify and remove barriers to a practice that fully demonstrates the training and skills that nurses have⁽²⁰⁾;
- Create and take advantage of all opportunities for nurses to lead processes in a collaborative and people-centred way⁽²⁰⁾;
- Work in interdisciplinary teams - Cooperate, collaborate, communicate and integrate care in teams to ensure that this care is continuous and reliable⁽²²⁾.
- Strengthen practice based on evidence and values - Integrate the best research with clinical expertise and client values for excellent care, and participate in learning and research activities to increase and expand this evidence⁽²²⁾;
- Apply continuous quality improvement processes - Identify errors and hazards in care; understand and implement basic safety principles; systematically measure quality in terms of structure, process and results⁽²²⁾;
- Acting as agents of change and transformational leaders that promote improved public and community health through continued cooperation with all community sectors and political players of governance⁽³⁾;
- Act as promoters of self-care;
- All planned interventions should:
 - be based initially on the empowerment of individuals and communities on health inequalities and health determinants;
 - be based on an evaluation of health inequalities and the main factors associated with the social determinants of health, in the context in which it is intended to intervene;
 - develop and institutionalise mechanisms for effective participation of populations by providing objective information and working directly with communities throughout the process⁽¹¹⁾ (Valentine et al., 2008).

- promote continuous monitoring and mechanisms for evaluating planned interventions, monitoring health inequalities, social determinants and the impact of policies pursued^(12,13);
- give special attention to the creation, collection, dissemination and availability of information on the social determinants of health and related policies;

At research level:

- To promote clinical PhDs and to increase the number of PhDs in clinical contexts;
- Create, based on the qualifying contexts or academic systems referred to above, research communities that collect and systematically analyse information, translate knowledge immediately and promote innovation;
- Develop research based on innovative methodologies that emphasize complex and multi- and transdisciplinary approaches;
- Develop socially and politically committed research, that is, concerned with solving community health problems and providing a basis for public health policies;
- Develop new health indicators that demonstrate the dimensions associated with self-care;
- As stated in the report “The future of nursing”, “Now is the time to eliminate outdated regulations and organizational and cultural barriers that limit nurses’ ability to practice to the fullest extent of their education, training and competence”^(p).

(p) “Now is the time to eliminate the outdated regulations and organizational and cultural barriers that limit the ability of nurses to practice to the full extent of their education, training, and competence. (...) Scope-of-practice regulations in all states should reflect the full extent not only of nurses but of each profession’s education and training. Elimination of barriers for all professions with a focus on collaborative teamwork will maximize and improve care throughout the health care system” Institute of Medicine. The future of nursing, 2010, p. 24.

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Correspondence: mjl@uevora.pt