# What is global health and how do we measure it?

Patricia M. Davidson RN, PhD

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@nursingdean

- Define global health and globalization
- Discuss epidemiological transitions
- Identify old and new emerging threats
- Outline metrics for improved performance

# Improving health and achieving health equity for all people worldwide

*Beaglehole and Bonita (2010)*

# Definition of *globalization*

: the act or process of globalizing : the state of being globalized; *especially* : the development of an increasingly integrated global economy marked especially by free trade, free flow of capital, and the tapping of cheaper foreign labor markets

http://www.merriam-webster.com/dictionary

In most countries...

# Nurses & Midwives

## ARE MORE THAN HALF TOTAL HEALTH WORKFORCE*

Nurses & Midwives bring **people-centred care** to the communities where they are needed, helping to improve health outcomes and deliver cost-effective services.
An estimated **18 million more health workers**, primarily in low-resource settings, will be needed to attain high and effective coverage to ensure healthy lives for all by 2030.

## Global strategies to strengthen Nursing & Midwifery

Education, collaboration & ongoing professional development

Effective policy, planning, leadership & governance


Strong regulation and scope of practice

Investment in workforce development

## * Vision for Nursing & Midwifery towards #Workforce2030

"Progress towards universal health coverage and the UN Sustainable Development Goals (SDGs) by ensuring equitable access to health workers within strengthened health systems"

United Nations Commission on **Health Employment & Economic Growth**


**HEALTH FOR ALL**

**UNIVERSAL HEALTH COVERAGE**

**Click on logos and mouse icon for interactive links**

## THE GLOBAL NETWORK OF WHO COLLABORATING CENTRES FOR NURSING AND MIDWIFERY

is an independent international not-for-profit network of Collaborating Centres from WHO's six regions, focusing on nursing and midwifery. Founded in 1988, the Network supports WHO's efforts toward universal health coverage.

GLOBAL NETWORK NURSING AND MIDWIFERY WHO COLLABORATING CENTRES

**UTS:**
**WORLD HEALTH ORGANIZATION COLLABORATING CENTRE FOR NURSING, MIDWIFERY & HEALTH DEVELOPMENT**

Follow WHO CC UTS on Twitter
Michele Rumsey @whoccmichele

- Rapid epidemiological transitions
- Integration of economies and trade
- Economic trading blocks and corporate domination
- Changes in social norms and values
- Trade versus aid and economic support
- Move to structural and institutional changes

# *Our ancient genes and modern world have collided*- Kaufman

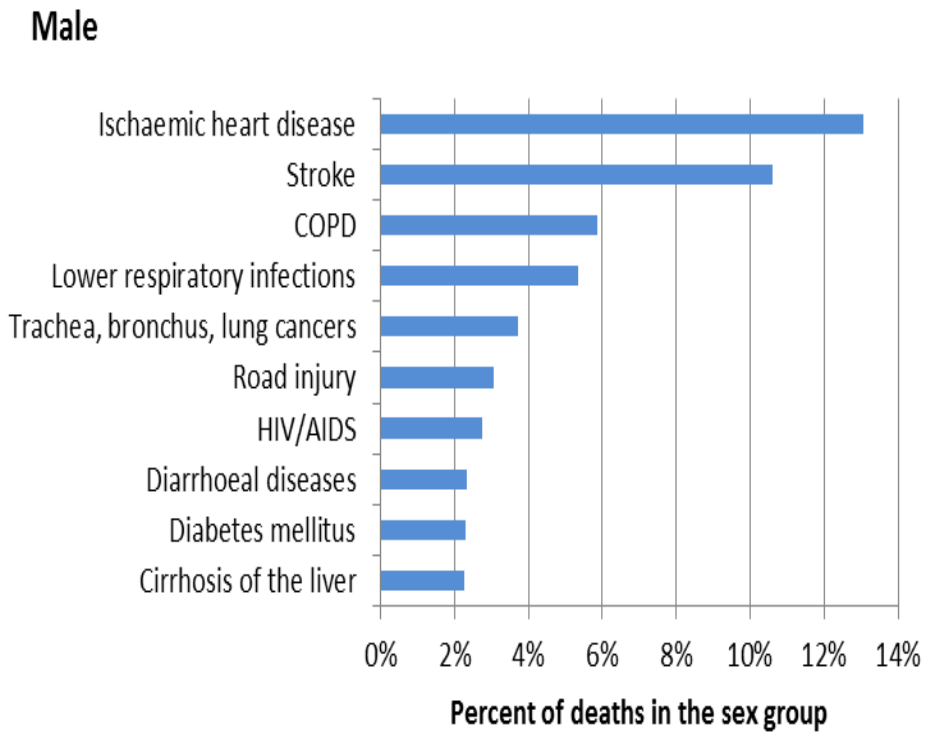
NASA

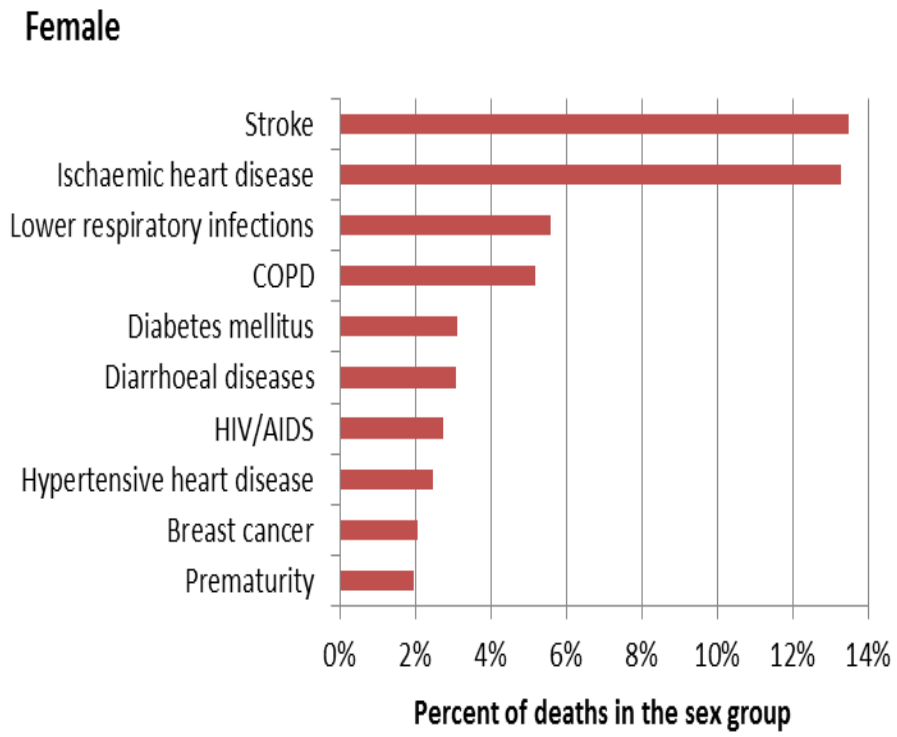
www.discoveringfossils.co.uk/royalty_free_photos_fossil_hunting_collecting.jpg


Photograher- Bobbi-lee Hille

- Non-communicable diseases cause 60% of all deaths globally
- 35 million people die every year
- Social, political, economic and cultural factors

Global Burden of Disease Study 2013 Collaborators; *Lancet*, 386, (9995): 743–800




**The 10 Leading Causes of Death by Sex, Global ( 2012)**

EXCLUSIVE THE HIT MAN HUNTING OSAMA

www.ninemsn.com.au/bulletin
MARCH 16, 2004 $5.50 INC GST NZ $6.50 INC GST

# The Bulletin WITH Newsweek

SPECIAL HEALTH REPORT BY TONY WRIGHT

## 100
(THE NEW 80)

## 80
(THE NEW 60)

## 60
(THE NEW 40)

**Australians are living longer. One in three children will reach 100. How we're turning back the years.**

Olive Riley, 104 years old

PRINT POST APPROVED PP255003005555

LEO SCHOFIELD

THE GREAT UGHH! BOOT DEBATE


What is GLOBALISATION ?
...That's when a woman in New York...
... a man in Hobart...
... a child in Oslo
... a canary in Milan
... an old lady in Peru, a dolphin off the coast of Madagascar...
... all share the same anxiety and the same despair for the same reason at the same time.
Lowry


THE TIMES
SATURDAY
Only £1.50
Weekend Newspaper of the Year
Brexit earthquake
Prime minist
es resignation
Vote to leave threatens break-up of UK


BREAKING
Since 1883
YOUR NUMBER ONE SOURCE FO
ZIKA VIR
SPREAD
EXPLOSIVE PANDEMIC EXPECTED
Zika virus is spread to people through mosquito bites. The most common symptoms of Zika virus disease are fever,
LEVEL 2 TRAVEL ALERT ISSUED
The outbreak in Brazil led reports of GB syndrome are pregnant women giving birth to babies with birth defects and poor pregnancy outcomes.See your healthcare provider if you


Ankara, Turkey
10:47 PM
Getty Images/Sunday
Ankara, Turkey
SUPER TUESDAY 3 COVERAGE BEGINS
25 12 33
TERROR IN TURKEY
11 SUSPECTS IN CUSTODY IN CONNECTION WITH BOMBING
Arwa Damon | CNN Senior International Correspondent
CNN
4:47 PM ET
THE LEAD


The Boston Globe
Tuesday, April 16, 2013
Marathon terror
3 killed, 130 hurt by bombs at finish line; area locked down

- Human health is increasingly perceived as the integrated outcome of its ecological, social-cultural, economic,  and structural factors
- Interaction of humanity with our planet
- Geopolitical instability and emergence of non-state based actors
- Enablers communication, global imperative for engagement

The ROCKEFELLER FOUNDATION THE LANCET

## The Rockefeller Foundation–*Lancet* Commission on planetary health

# Safeguarding human health in the Anthropocene epoch: report of The Rockefeller Foundation–*Lancet* Commission on planetary health

*Sarah Whitmee, Andy Haines, Chris Beyrer, Frederick Boltz, Anthony G Capon, Braulio Ferreira de Souza Dias, Alex Ezeh, Howard Frumkin, Peng Gong, Peter Head, Richard Horton, Georgina M Mace, Robert Marten, Samuel S Myers, Sania Nishtar, Steven A Osofsky, Subhrendu K Pattanayak, Montira J Pongsiri, Cristina Romanelli, Agnes Soucat, Jeanette Vega, Derek Yach*

International Journal of Nursing Studies 53 (2016) 1–2

Contents lists available at ScienceDirect

International Journal of Nursing Studies

journal homepage: www.elsevier.com/ijns

Editorial

## Rockefeller Foundation-Lancet Commission report: A call to action for human health

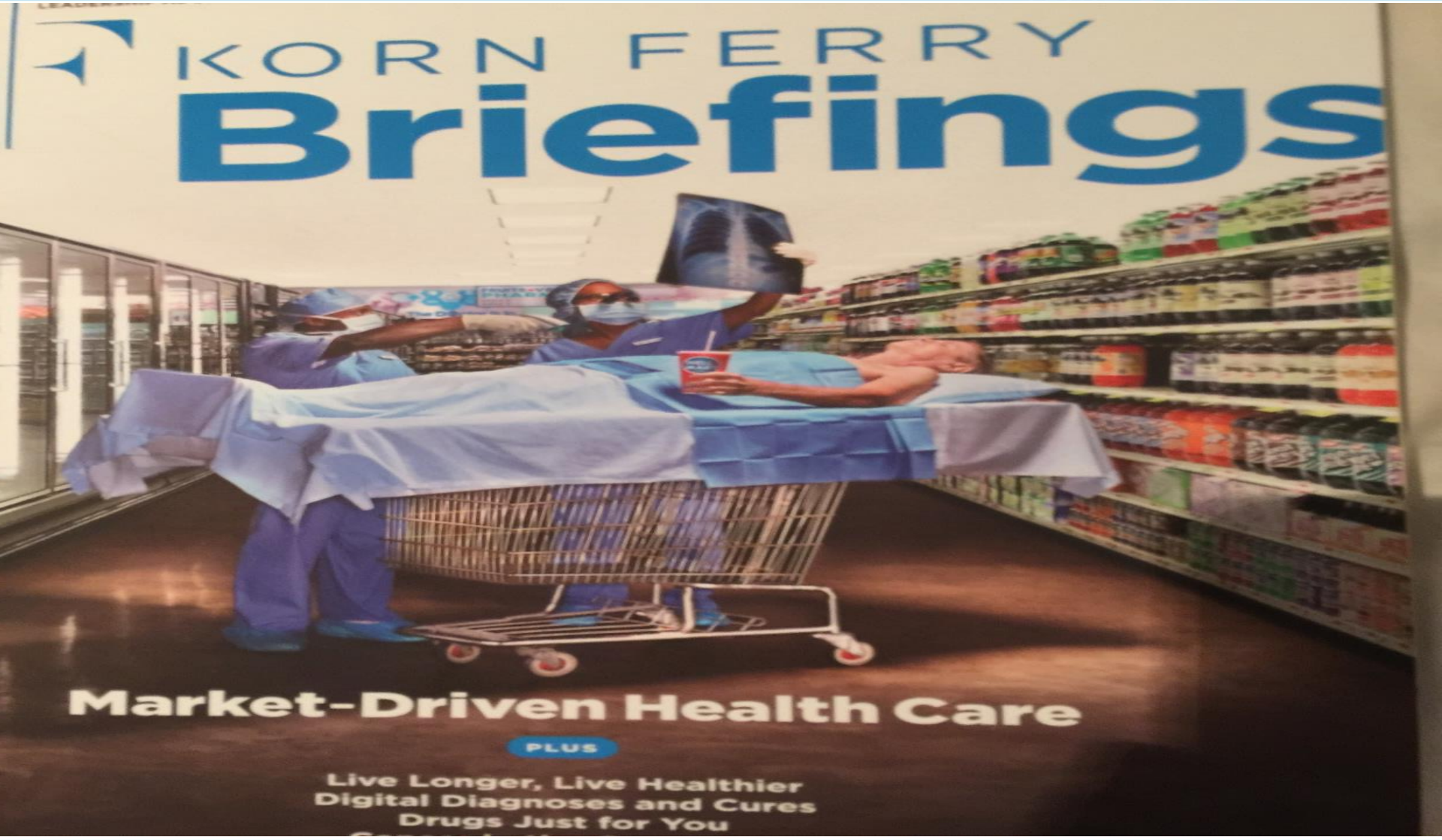
# Marketing

- *"The truth could never be more damning: Smoking is the world's leading preventable cause of death today. So, for the tobacco industry to survive, it has to replace smokers it kills or those who quit.* ***This it does by hooking new customers—often targeting teenagers and young adults.***
- *Unless urgent measures are undertaken, smoking could kill one billion people, 80% of these deaths in developing countries, during the 21st century "*

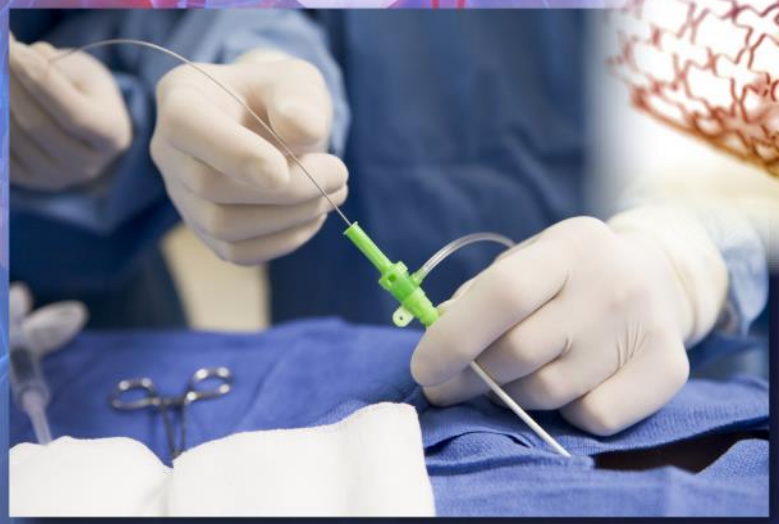

CAMPAIGN for TOBACCO-FREE Kids™

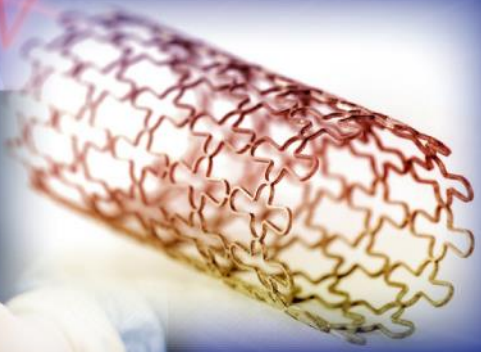
Break the tobacco marketing net — WHO

PUBLISHED ON JULY 25, 2008 AT 9:12 AM


KORN FERRY
Briefings
Market-Driven Health Care
PLUS
Live Longer, Live Healthier
Digital Diagnoses and Cures
Drugs Just for You


EMERGENCY
Main Entrance





AHA Scientific Statement

# Social Determinants of Risk and Outcomes for Cardiovascular Disease

## A Scientific Statement From the American Heart Association

Edward P. Havranek, MD, FAHA, Chair; Mahasin S. Mujahid, PhD, MS, Co-Chair; Donald A. Barr, MD, PhD; Irene V. Blair, PhD; Meryl S. Cohen, MD, FAHA; Salvador Cruz-Flores, MD, FAHA; George Davey-Smith, MA(Oxon), MD, BChir(Cantab), MSc(Lond); Cheryl R. Dennison-Himmelfarb, RN, PhD, FAHA; Michael S. Lauer, MD, FAHA; Debra W. Lockwood; Milagros Rosal, PhD; Clyde W. Yancy, MD, FAHA; on behalf of the American Heart Association Council on Quality of Care and Outcomes Research, Council on Epidemiology and Prevention, Council on Cardiovascular and Stroke Nursing, Council on Lifestyle and Cardiometabolic Health, and Stroke Council

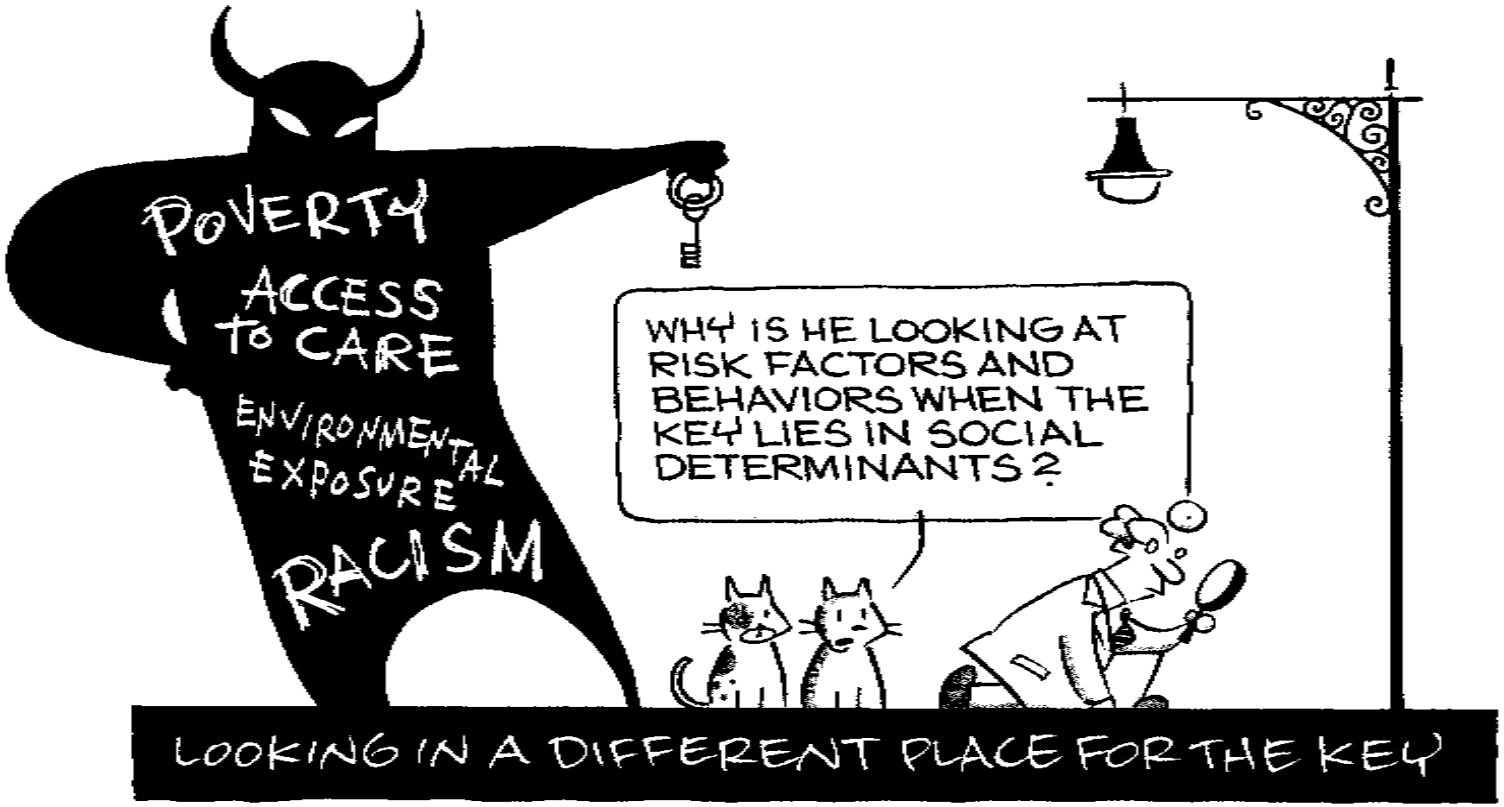
An Institute of Medicine report titled *U.S. Health in International Perspective: Shorter Lives, Poorer Health* documents the decline in the health status of Americans relative to people in other high-income countries, concluding that "Americans are dying and suffering from illness and injury at rates that are demonstrably unnecessary."[1] The report blames many factors, "adverse economic and social conditions" among them. In an editorial in *Science* discussing the findings of the Institute of Medicine report, Bayer et al[2] call for a national commission on health "to address the social causes that have put the USA last among comparable nations."

Although mortality from cardiovascular disease (CVD) in the United States has been on a linear decline since the 1970s, the burden remains high. It accounted for 31.9% of deaths in 2010.[3]

There is general agreement that the decline is the result, in equal measure, of advances in prevention and advances in treatment. These advances in turn rest on dramatic successes in efforts to understand the biology of CVD that began in the late 1940s.[4,5] It has been assumed that the steady downward trend in mortality will continue into the future as further breakthroughs in biological science lead to further advances in prevention and treatment. This view of the future may not be warranted.

The prevalence of CVD in the United States is expected to rise 10% between 2010 and 2030.[6] This change in the trajectory of cardiovascular burden is the result not only of an aging population but also of a dramatic rise over the past 25 years in obesity and the hypertension, diabetes mellitus, and physical inactivity that accompany weight gain. Although there is no consensus on the precise causes of the obesity epidemic, a dramatic change in the underlying biology of Americans is not postulated. More likely culprits are changes in societal and environmental conditions that have led to changes in diet and physical activity. At the same time, there is increasing awareness that the benefits of advances in prevention and treatment have not been shared equally across economic, racial, and ethnic groups in the United States. Overall population health cannot improve if parts of the population do not benefit from improvements in prevention and treatment.

The purpose of this statement is to increase awareness of the influence of social factors on the incidence, treatment, and outcomes of CVD; to summarize the current state of knowledge about these factors; and to suggest future directions in research, particularly research on effective interventions to attenuate or eliminate these adverse social influences. The statement is not intended to be a comprehensive review;


POVERTY
ACCESS TO CARE
ENVIRONMENTAL EXPOSURE
RACISM
WHY IS HE LOOKING AT RISK FACTORS AND BEHAVIORS WHEN THE KEY LIES IN SOCIAL DETERMINANTS?
LOOKING IN A DIFFERENT PLACE FOR THE KEY

BRIEFING PAPER NO. 10
SARAH ROACHE, LAWRENCE O. GOSTIN, DAN HOUGENDOBLER AND
ERIC FRIEDMAN



10.02.14

# LESSONS FROM THE WEST AFRICAN EBOLA EPIDEMIC: TOWARDS A LEGACY OF STRONG HEALTH SYSTEMS

**O'NEILL INSTITUTE**
The O'Neill Institute for National and Global Health Law at Georgetown University was established to respond to the need for innovative solutions to the most pressing national and international

The West African Ebola epidemic is an international public health crisis, representing a threat to international peace and security. UN Secretary-General Ban

- Since 1976, more than 20 Ebola outbreaks in sub-Saharan Africa
- World was unprepared for the tragedy
- Broken health system, public distrust, fragmented and uncoordinated response
- Contingency fund, a reserve corps, a health systems fund, and innovative international law

https://theconversation.com/africas-growing-and-neglected-cancer-problem-we-will-all-suffer-61545

https://theconversation.com/hospital-life-in-sierra-leone-after-ebola-61030

*The country has been devastated by the Ebola outbreak, but of course the roots of the epidemic are in poor health infrastructure, inadequate resources and a lack of trained staff; none of these has improved enough since the time of the civil war." His voice trails off thoughtfully. "Even before Ebola, being born in Sierra Leone your life expectancy was 45."* Dr. Paddy Howlett

Hospital life in Sierra Leone after Ebola https://theconversation.com/hospital-life-in-sierra-leone-after-ebola-61030. Accessed June 23rd 2016.

*"As a global community, it is to our moral, financial, and security detriment not to invest in health systems"*

*Roache et. al 2014*

# So how do we move forward?

# EXHIBIT ES-1. OVERALL RANKING

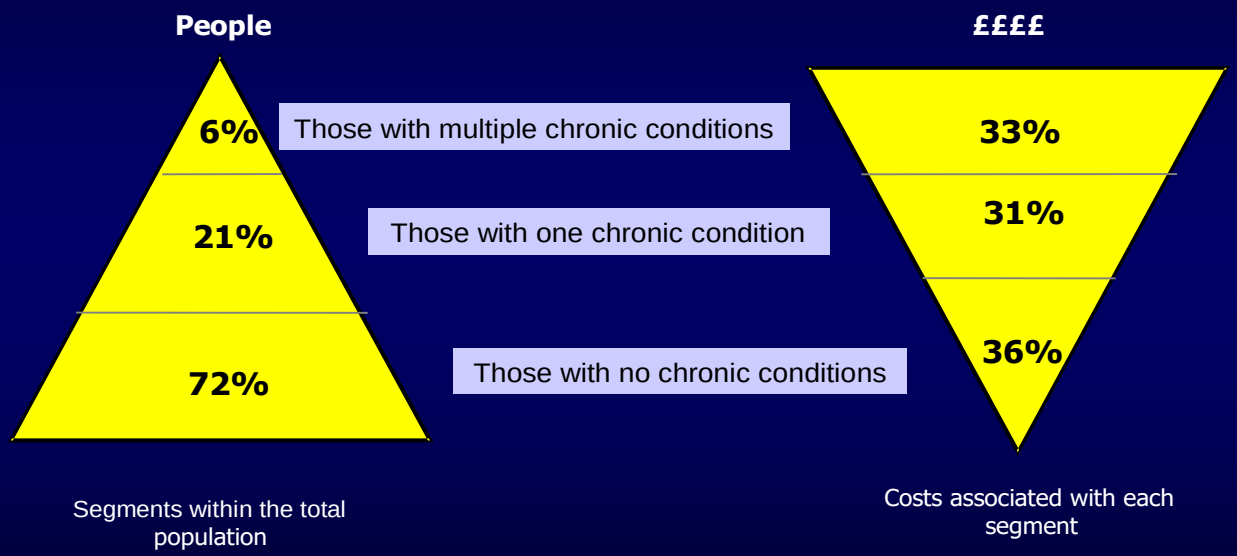
**COUNTRY RANKINGS**

Top 2*
Middle
Bottom 2*

| | AUS | CAN | FRA | GER | NETH | NZ | NOR | SWE | SWIZ | UK | US |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **OVERALL RANKING (2013)** | 4 | 10 | 9 | 5 | 5 | 7 | 7 | 3 | 2 | 1 | 11 |
| **Quality Care** | 2 | 9 | 8 | 7 | 5 | 4 | 11 | 10 | 3 | 1 | 5 |
| Effective Care | 4 | 7 | 9 | 6 | 5 | 2 | 11 | 10 | 8 | 1 | 3 |
| Safe Care | 3 | 10 | 2 | 6 | 7 | 9 | 11 | 5 | 4 | 1 | 7 |
| Coordinated Care | 4 | 8 | 9 | 10 | 5 | 2 | 7 | 11 | 3 | 1 | 6 |
| Patient-Centered Care | 5 | 8 | 10 | 7 | 3 | 6 | 11 | 9 | 2 | 1 | 4 |
| **Access** | 8 | 9 | 11 | 2 | 4 | 7 | 6 | 4 | 2 | 1 | 9 |
| Cost-Related Problem | 9 | 5 | 10 | 4 | 8 | 6 | 3 | 1 | 7 | 1 | 11 |
| Timeliness of Care | 6 | 11 | 10 | 4 | 2 | 7 | 8 | 9 | 1 | 3 | 5 |
| **Efficiency** | 4 | 10 | 8 | 9 | 7 | 3 | 4 | 2 | 6 | 1 | 11 |
| **Equity** | 5 | 9 | 7 | 4 | 8 | 10 | 6 | 1 | 2 | 2 | 11 |
| **Healthy Lives** | 4 | 8 | 1 | 7 | 5 | 9 | 6 | 2 | 3 | 10 | 11 |
| **Health Expenditures/Capita, 2011**** | $3,800 | $4,522 | $4,118 | $4,495 | $5,099 | $3,182 | $5,669 | $3,925 | $5,643 | $3,405 | $8,508 |

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

# Chronic Illness Drives Medical Care Costs




Source: Kaiser Permanente Northern California commercial member ship, DxCG methodology, 2001.

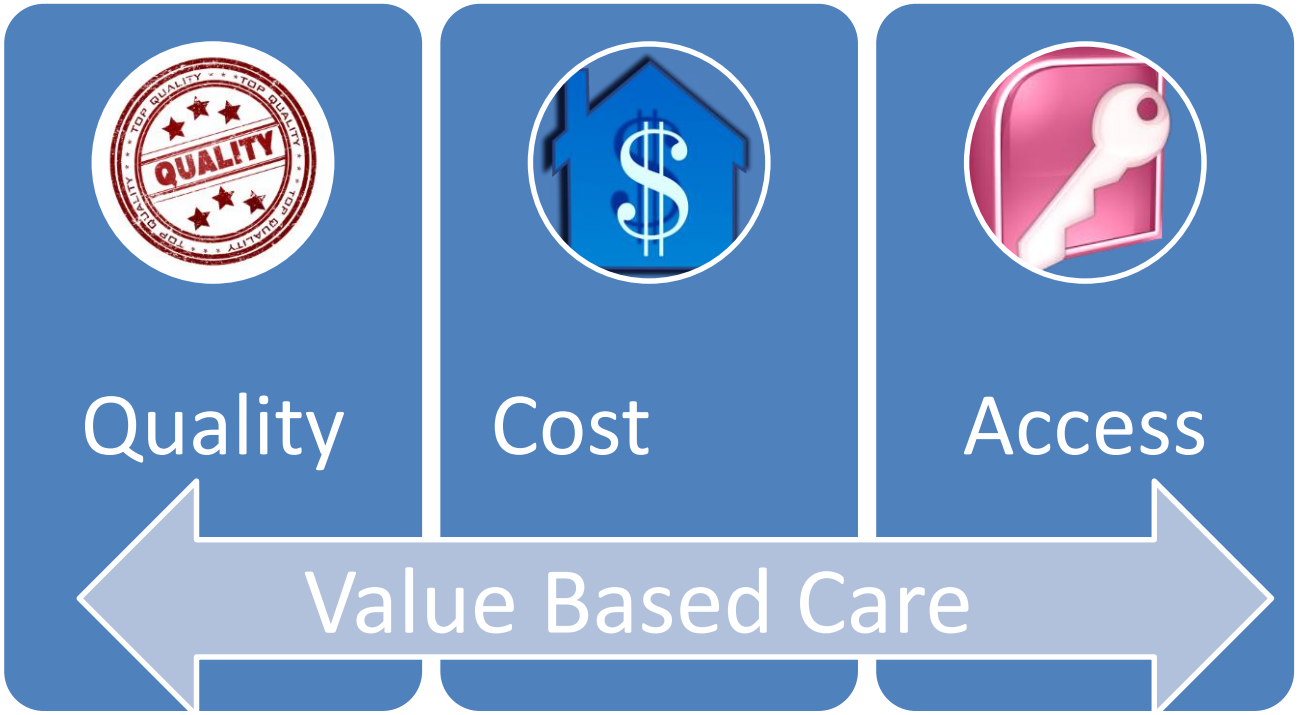
Source: Towards Managed Care - Information Exchange Event. Dr HF Macintyre
17th September 2004, Effingham Park Hotel, Copthorne Accessed at http://www.natpact.nhs.uk/cms/363.php.

Improved health


Enhanced experience of care

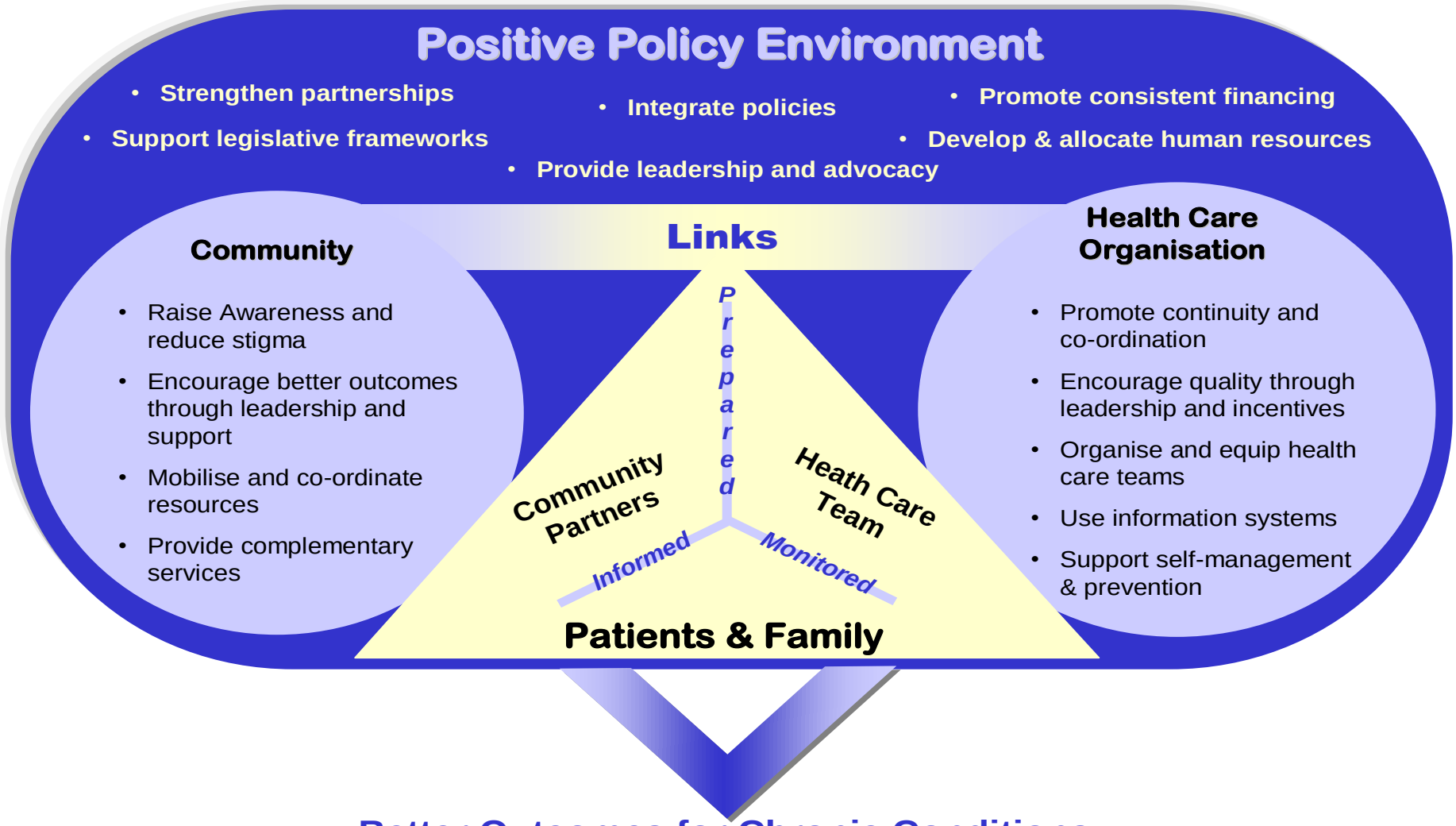

Reduced costs per capita

Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: care, health, and cost. *Health Affairs*, *27*(3), 759-769.

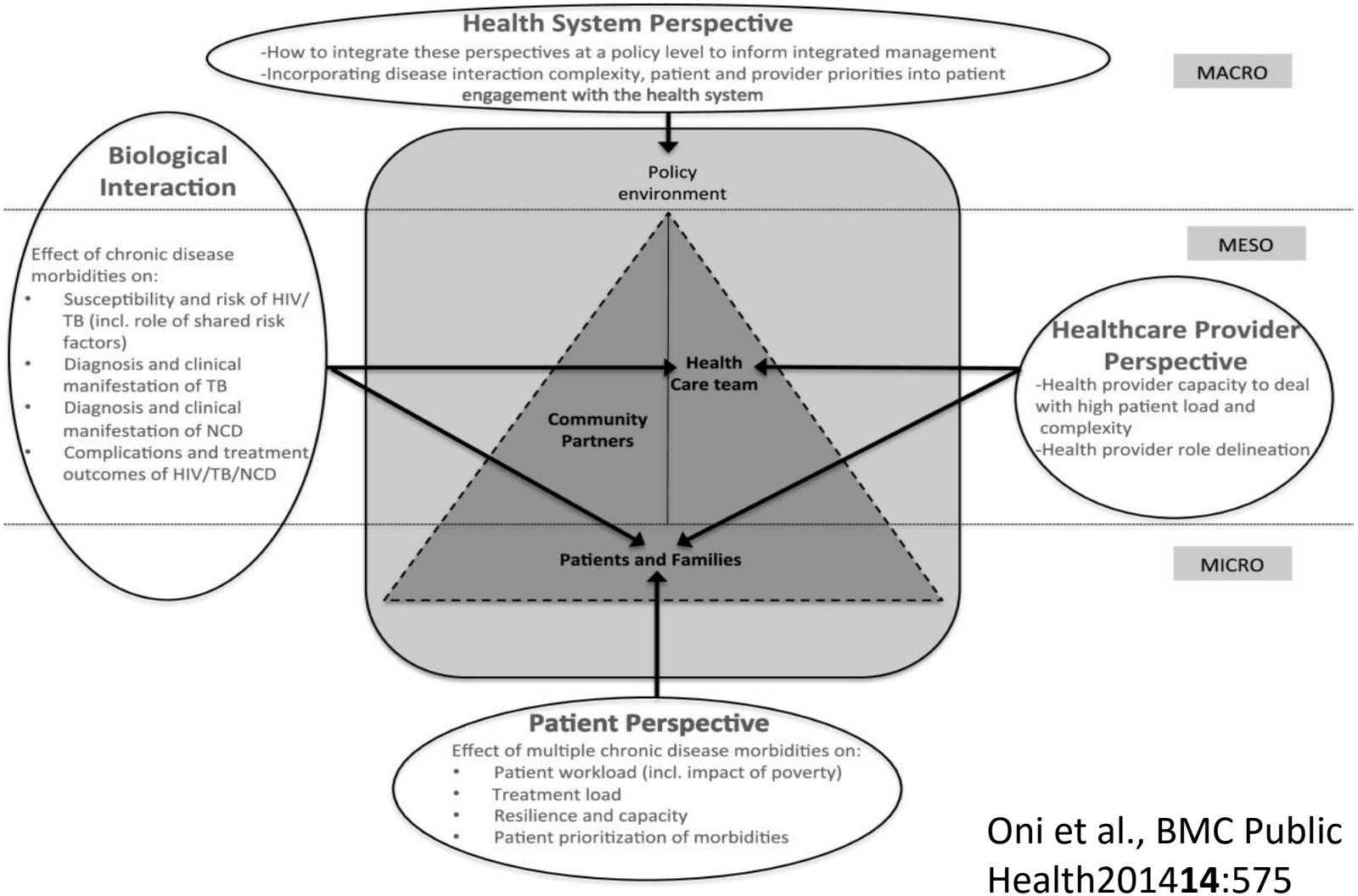



Porter, M. E. (2009). A strategy for health care reform—toward a value-based system. *New England Journal of Medicine*, *361*(2), 109-112.

# Innovative Care for Chronic Conditions Framework



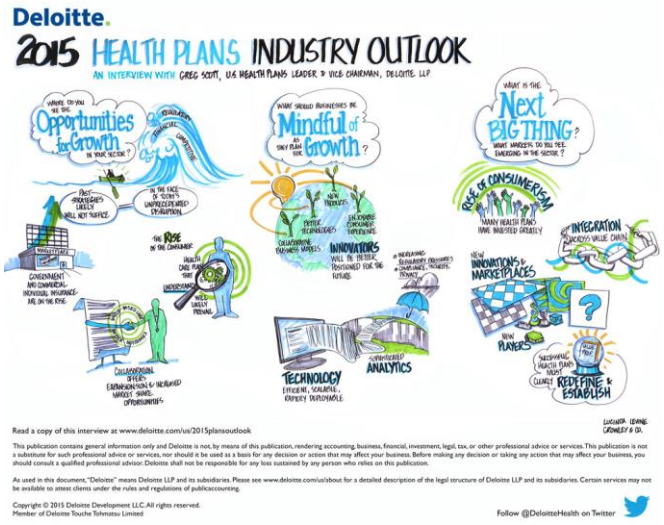

*Building Blocks for Action Innovative Care for Chronic Conditions: Global Report. World Health Organisation 2002.*




Oni et al., BMC Public Health2014**14**:575

# Health care as an ecosystem

- Macro- social, political and economic agenda
- Meso- organizational factors
- Micro- individual factors



# Challenges

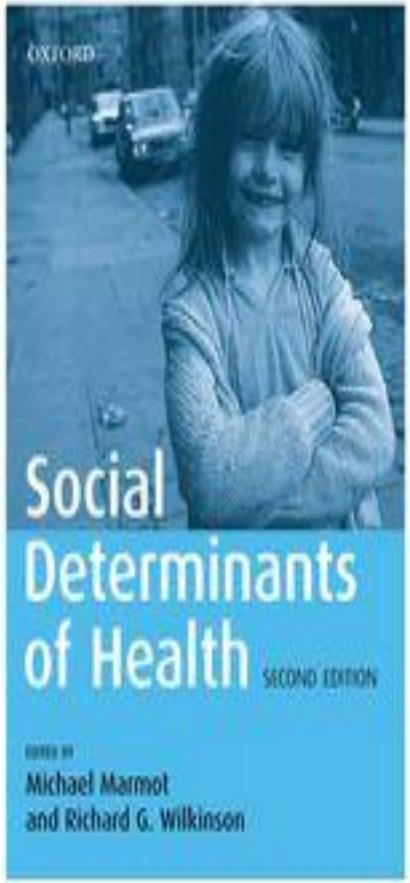
- Multiple actors, silos and competing agendas
- Political and funding challenges
- Workforce within a global context
- Push and pull of migration forces
- Nursing labor considered as a cost not a value
- Faculty shortage and cost of programs
- Diversity and inclusion
- One size fits all solutions

# Global challenges for nursing and midwifery

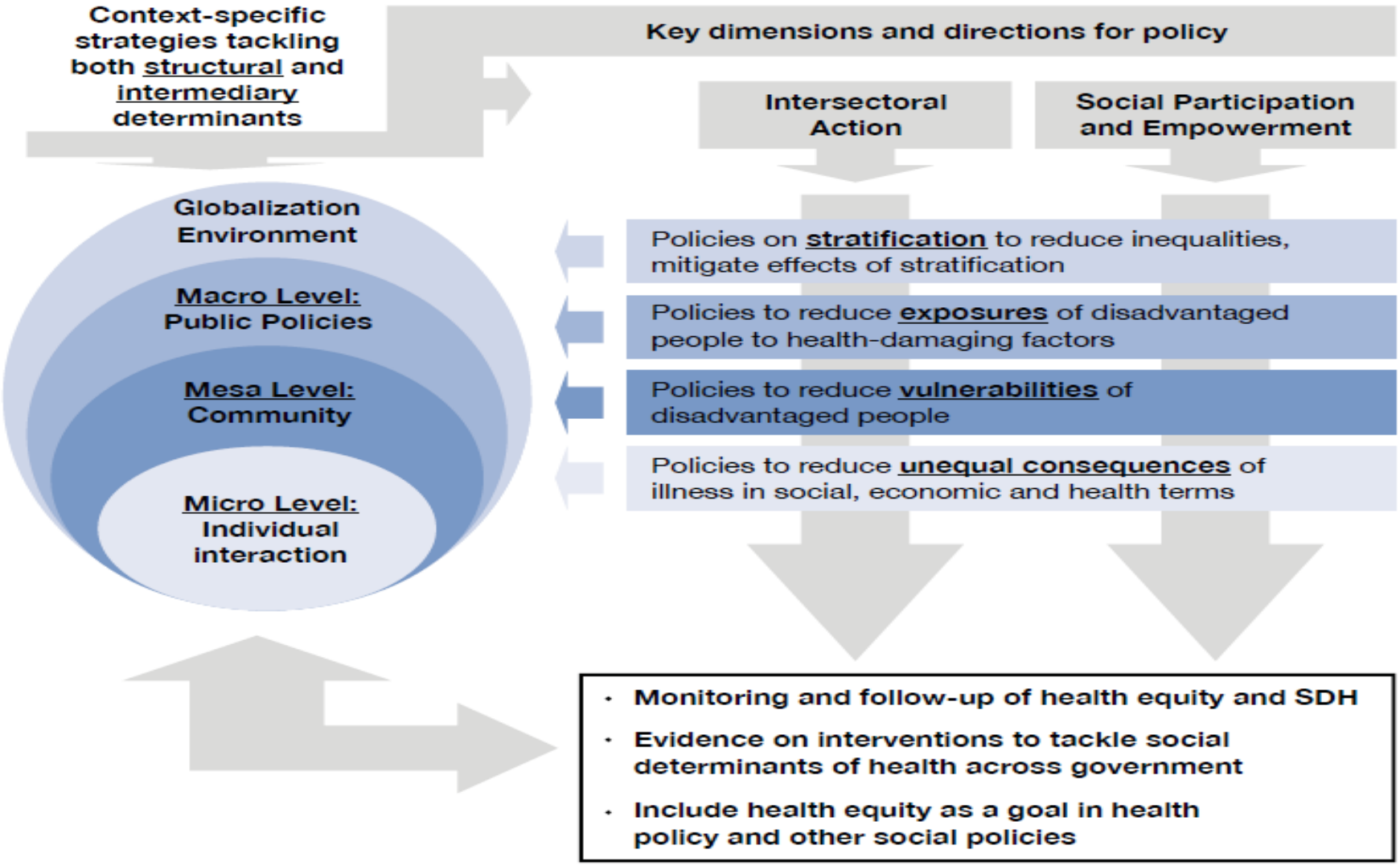
- Securing and maintaining adequate investment in development of high quality nursing education programs
- Achieving consistency in standards for nursing role development and pre-licensure curricula given the mobility of the registered nurse workforce
- Responding effectively to nursing workforce demand and supply challenges
- Forging new innovative, contemporary models for preparing registered nurses which take account of the changing patterns of health and health care
- Addressing the international shortage of well prepared nurses for research and/or teaching roles in the higher education sector
- Lobbying governments and health policy decision makers and increasing awareness of the vital contribution that nursing as a profession makes to health care

- Davidson et al 2003; Boland et al 2008; Daly et al 2008

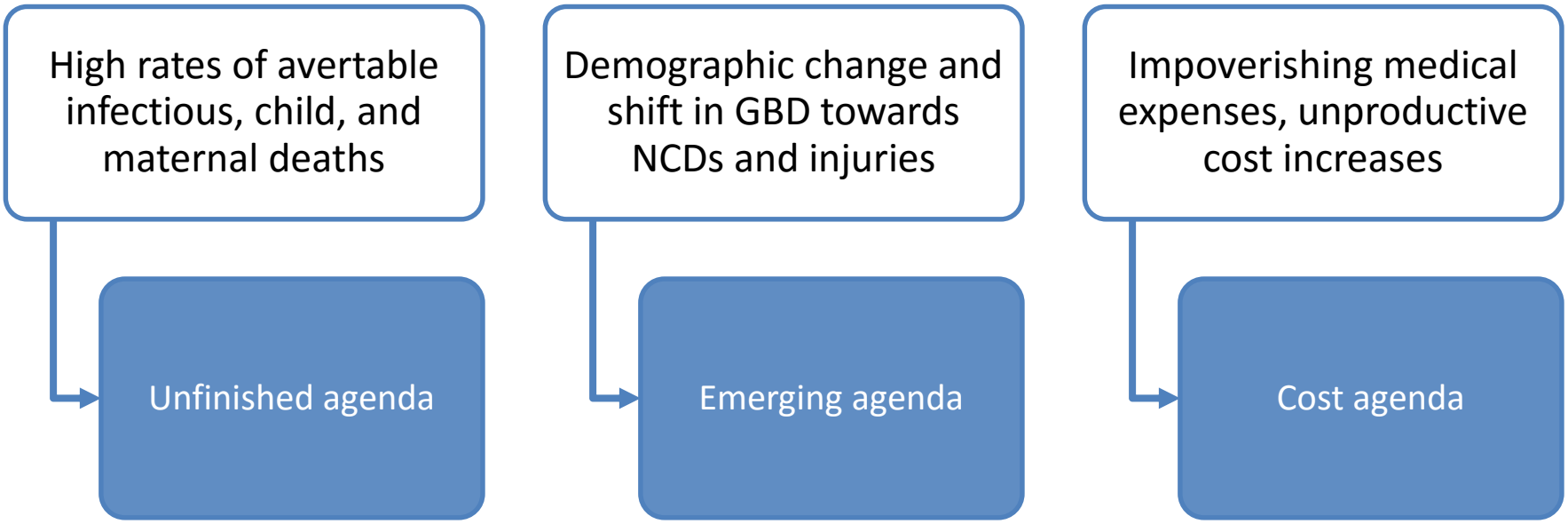
- Income inequality
- Education
- Race/ethnicity/gender
- Built environment
- Stress
- Social support
- Early child experiences
- Employment
- Housing
- Transportation
- Food environment
- Social status



Ben-Shlomo Y, Kuh D. A life course approach to chronic disease epidemiology: Conceptual models, empirical challenges and interdisciplinary perspectives. *International Journal of Epidemiology*, 2002, 31:285-93.


Context-specific strategies tackling both structural and intermediary determinants
Key dimensions and directions for policy
Intersectoral Action
Social Participation and Empowerment
Globalization Environment
Macro Level: Public Policies
Mesa Level: Community
Micro Level: Individual interaction
Policies on stratification to reduce inequalities, mitigate effects of stratification
Policies to reduce exposures of disadvantaged people to health-damaging factors
Policies to reduce vulnerabilities of disadvantaged people
Policies to reduce unequal consequences of illness in social, economic and health terms
Monitoring and follow-up of health equity and SDH
Evidence on interventions to tackle social determinants of health across government
Include health equity as a goal in health policy and other social policies

# Three Domains of Health Challenges 2015-2035




Lancet Global Health 2035

*"It is clear that nurses are the backbone of most health care teams... In virtually all countries, nurse constitute the largest health provider group… they always provide the human touch that is essential for healing"*

Dr Gro Harlem Brundtland, Director General, World Health Organisation

- End era of secret nurses language and a separatist agenda
- Importance of interprofessional frameworks and teamwork
- Having a voice at the table because of knowledge and capabilities
- Move to health systems strengthening is a compelling agenda for a nursing


Policy
Research
Practice
Education

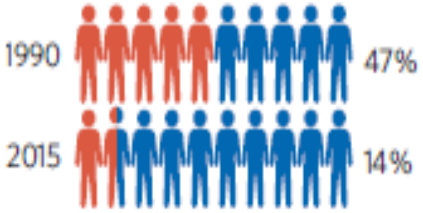
# The Millennium Development Goals Report 2015

UNITED NATIONS

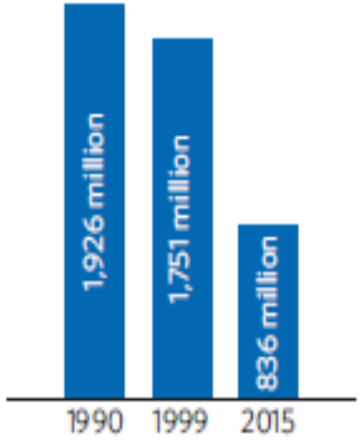
Summary

# GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

**Extreme poverty rate in developing countries**



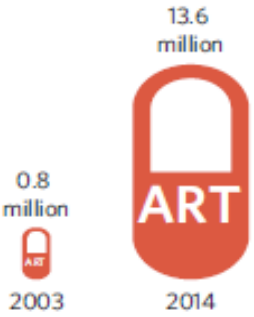

**Global number of extreme poor**




- Extreme poverty has declined significantly over the last two decades. In 1990, nearly half of the population in the developing world lived on less than $1.25 a day; that proportion dropped to 14 per cent in 2015.
- Globally, the number of people living in extreme poverty has declined by more than half, falling from 1.9 billion in 1990 to 836 million in 2015. Most progress has occurred since 2000.
- The number of people in the working middle class—living on more than $4 a day—has almost tripled between 1991 and 2015. This group now makes up half the workforce in the developing regions, up from just 18 per cent in 1991.
- The proportion of undernourished people in the developing regions has fallen by almost half since 1990, from 23.3 per cent in 1990-1992 to 12.9 per cent in 2014-2016.

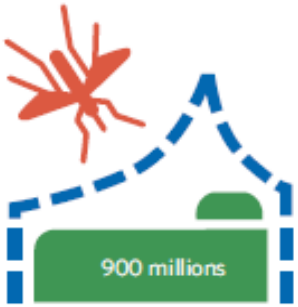
## GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

**Global antiretroviral therapy treatment**




- New HIV infections fell by approximately 40 per cent between 2000 and 2013, from an estimated 3.5 million cases to 2.1 million.
- By June 2014, 13.6 million people living with HIV were receiving antiretroviral therapy (ART) globally, an immense increase from just 800,000 in 2003. ART averted 7.6 million deaths from AIDS between 1995 and 2013.
- Over 6.2 million malaria deaths have been averted between 2000 and 2015, primarily of children under five years of age in sub-Saharan Africa. The global malaria incidence rate has fallen by an estimated 37 per cent and the mortality rate by 58 per cent.

**Number of insecticide-treated mosquito nets delivered in sub-Saharan Africa, 2004–2014**



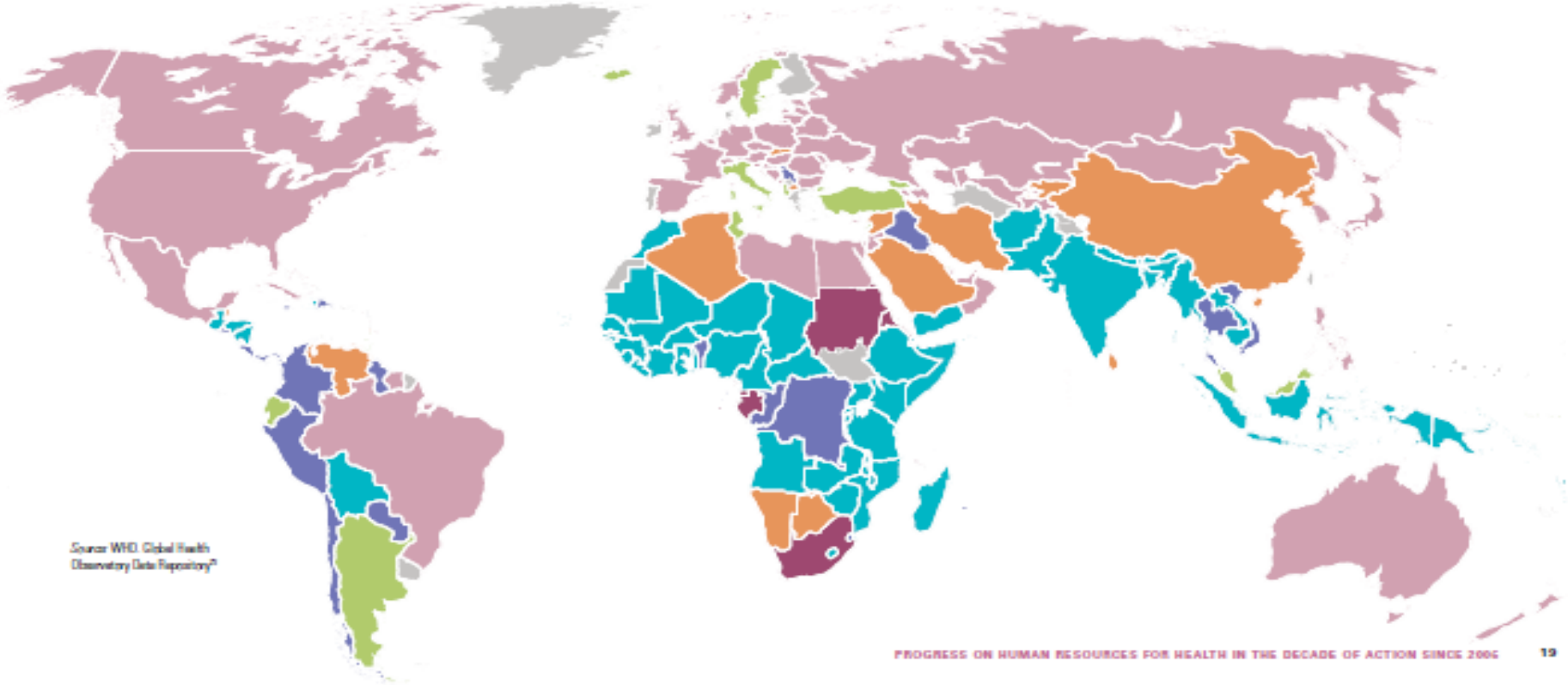

- More than 900 million insecticide-treated mosquito nets were delivered to malaria-endemic countries in sub-Saharan Africa between 2004 and 2014.
- Between 2000 and 2013, tuberculosis prevention, diagnosis and treatment interventions saved an estimated 37 million lives. The tuberculosis mortality rate fell by 45 per cent and the prevalence rate by 41 per cent between 1990 and 2013.


## A UNIVERSAL TRUTH:

# NO HEALTH WITHOUT A WORKFORCE

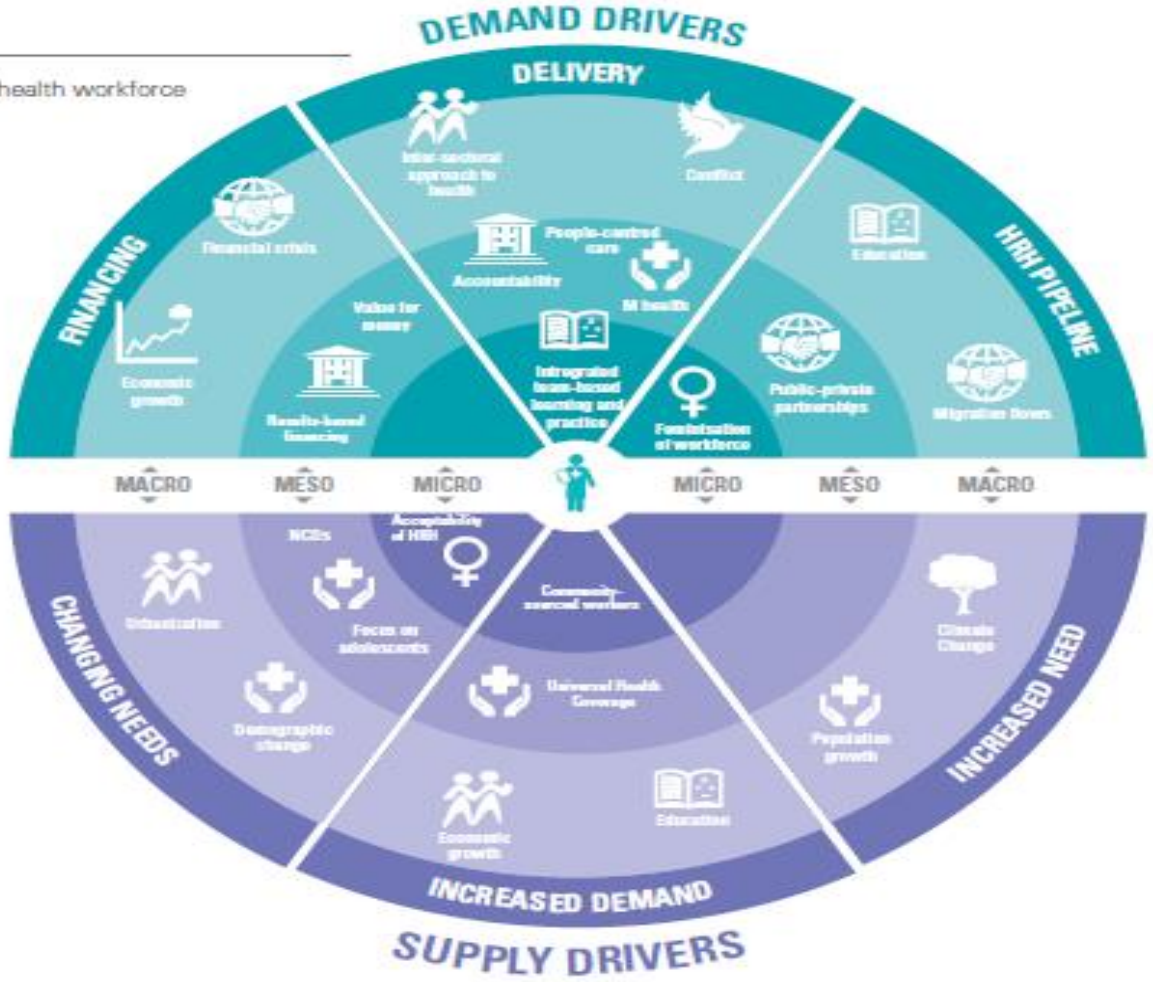
**FIGURE 4** Workforce to population ratios for 186 countries

- **Group 1:** density of skilled workforce lower than 22.8/10 000 population and a coverage of births attended by SBA less than 80%
- **Group 2:** density of skilled workforce lower than 22.8 /10 000 population and coverage of births attended by SBA greater than 80%
- **Group 3:** density of skilled workforce lower than 22.8/10 000 population but no recent data on coverage of births attended by SBA
- **Group 4:** density is equal or greater than 22.8/10 000 and smaller than 34.5/10 000
- **Group 5:** density is equal or greater than 34.5/10 000 and smaller than 59.4/10 000
- **Group 6:** density is equal or greater than 59.4/10 000



Source: WHO Global Health Observatory Data Repository[9]

**FIGURE 9** Drivers of change for the health workforce



# Data Attracts Targeted Action

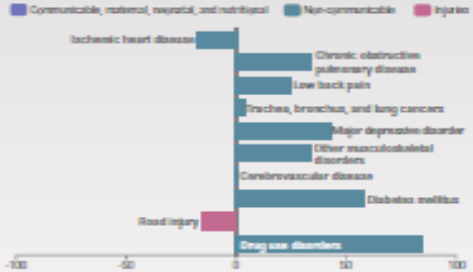
# UNITED STATES OF AMERICA

In 2011, private expenditure comprised 54% of total health expenditure, of which about 21% was out of pocket. About 84% of the population has some insurance coverage, of whom 66% through their employer or personally, and the other 22% under various federal programmes. These are administered by states that are required to offer mandatory benefits; they can add other benefits such as dental services and prescription drugs. They can charge premiums and copayments. Medicare, the programme for people older than 65 years, covers about 50% of the costs of visits and surgeries, and supplies, but not long-term care or dental care. There is a 3.9 nurses-to-physicians ratio and a 24.2 per 10 000 population density of physicians with major variation between and within the 50 states and federal district. There are programmes to attract health workers to underserved areas. Shortages are expected to be high for general practitioners and for nurses, which may continue to stimulate recruitment abroad. Regulation of professional practice is state-based and therefore varies.

## POPULATION AND HEALTH

| | | |
|---|---|---|
| Population (all (000s); proportion under 15 (%); proportion over 60 (%)) | 312.2; 20; 18 | (2010) |
| Average annual rate of population change (%) | 0.8 | (2010-2015) |
| Population living in urban areas (%) | 82 | (2011) |
| Gross national income per capita (PPP int. $) | 48620 | (2011) |
| Population living on <$2 (PPP int. $) a day (%) | .. | |
| Total expenditure on health as a percentage of gross domestic product (%) | 17.9 | (2011) |
| General government expenditure on health as a percentage of total expenditure on health (%) | 46 | (2011) |
| External resources for health as a percentage of total expenditure on health (%) | .. | |
| Life expectancy at birth (years) (all; female; male) | 79; 81; 76 | (2011) |
| Total fertility rate (per woman) | 2.1 | (2010) |
| Neonatal mortality rate (per 1 000 live births) | 4 | (2011) |
| Infant mortality rate (per 1 000 live births) | 6 | (2011) |
| Under-five mortality rate (per 1 000 live births) | 8 [7-9] | (2011) |
| Maternal mortality ratio (per 100 000 live births) | 21 [18-23] | (2010) |
| Births attended by skilled health personnel (%) | 99.4 | (2010) |
| Antenatal care coverage - at least one visit (%) | .. | |
| Antenatal care coverage - at least four visits (%) | 97.4 | (2009) |
| Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) | 94 | (2011) |
| Postnatal care visit within two days of birth (%) | .. | |

### Top 10 causes of morbidity and mortality (DALYs)




Disability-adjusted life years (DALYs) quantify both premature mortality (YLLS) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in 2010. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

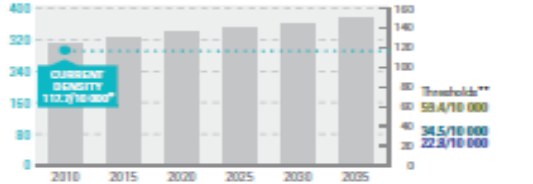
## HUMAN RESOURCES FOR HEALTH

### AVAILABILITY

Feasibility of achieving thresholds: Most likely | Somewhat likely | Least likely

| TO MEET THRESHOLDS BY 2025, REQUIRES: | FEASIBILITY | POPULATION (MILLIONS) |
|---|---|---|
| 0% increase to meet 22.8/10 000 threshold | | |
| 0% increase to meet 34.5/10 000 threshold | | |
| 0% increase to meet 59.4/10 000 threshold | | |

DENSITY OF SHPs (Skilled Health Professional) PER 10 000 POPULATION (Estimated 2010)




### ACCESSIBILITY

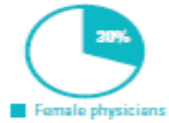
GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS (density per 10 000 population)

| SUB-NATIONAL LOW | NATIONAL AVERAGE | SUB-NATIONAL HIGH |
|---|---|---|
| — Physicians | 24.2 Physicians | — Physicians |

### ACCEPTABILITY

The ratio of nurses to physicians is ABOVE the OECD average.

3.9 Nurses TO 1 Physician




### QUALITY

*Is there evidence that the country has mechanisms in place to:*

| ACCREDIT training institutions for: | | REGULATE: | | LICENSE/RE-LICENSE: | |
|---|---|---|---|---|---|
| Dentists | ✓ | Dentists | ✓ | Dentists | ✓ |
| Midwives | ? | Midwives | ? | Midwives | ? |
| Nurses | ✓ | Nurses | ✓ | Nurses | ✓• |
| Pharmacists | ✓ | Pharmacists | ✓ | Pharmacists | ✓ |
| Physicians | ✓ | Physicians | ✓ | Physicians | ✓ |

## HRH GOVERNANCE

*Is there evidence that the country is adopting recommended good practices on HRH:*

### Leadership and Partnership

| | |
|---|---|
| Is there government leadership on health workforce policy and management? | ✓ |
| Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? | ? |

### Policy and Management

*Is existing health workforce policy and human resource management:*

| | |
|---|---|
| related to population health needs? | ✓ |
| informed by data and strategic intelligence? | ✓• |
| addressing pre-service education? | ✓ |
| addressing geographical distribution and retention? | ✓ |
| addressing health workforce performance (e.g. competence, responsiveness and productivity)? | ✓ |
| addressing international mobility of health workers, and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? | ✓ / ✓ |

### Strategy/Plan and Finance

| | |
|---|---|
| Is there a national HRH strategy/plan resulting from the above mechanisms? | ✓• |
| For which period? | 2010-2015 |
| Does the strategy/plan account for the financial costs and resource requirements to implement it? | ✓ |

✓ – Yes ✓• – Partial ✗ – No ? – Insufficient data

*Equal to the total of physicians (N= 748 566, 2009), licensed practical nurses (N= 510 000, 2008) and registered nurses (N= 2 477 000, 2005) divided by the 2010 population (N= 312 247 000). Source: (WHO Global Health Observatory - http://apps.who.int/ghodata/view.main)

**See Annex 1 for full explanation on country profile methods and sources.

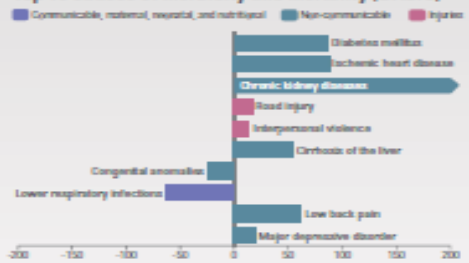
# MEXICO

The health system comprises different subsystems with access linked to employment status. The contributory subsystem, funded by employers and employees, is mandatory for salaried workers and covers 47% of the population. The non-contributory subsystem (Seguro Popular-SP) covered 64% of the uninsured population in 2011 and has enabled some progress in access to services in poorer and rural regions and among the indigenous population, even though further improvements are possible. Out-of-pocket payments represent up to 49% of total health expenditure. The burden of some communicable diseases is high, and despite good progress towards meeting the health Millennium Development Goals, there are still challenges regarding maternal mortality and gender equality. There are various strategies for health workforce planning but no formal plan for human resources for health. There is important variation in the density of physicians among regions. The ratio of nurses to physicians is below the OECD average at 1.9. There are mechanisms for regulation and licensing health workforce that differ between types of health workers.

## POPULATION AND HEALTH

| | | |
|---|---|---|
| Population [all (000s); proportion under 15 (%); proportion over 60 (%)] | 113 3; 29; 9 | (2010) |
| Average annual rate of population change (%) | 1.2 | (2010-2015) |
| Population living in urban areas (%) | 78 | (2011) |
| Gross national income per capita (PPP int. $) | 15280 | (2011) |
| Population living on <$1 (PPP int. $) a day (%) | <2 | (2008) |
| Total expenditure on health as a percentage of gross domestic product (%) | 6.2 | (2011) |
| General government expenditure on health as a percentage of total expenditure on health (%) | 49 | (2011) |
| External resources for health as a percentage of total expenditure on health (%) | 0.0 | (2011) |
| Life expectancy at birth (years) [all; female; male] | 75; 78; 72 | (2011) |
| Total fertility rate (per woman) | 2.3 | (2010) |
| Neonatal mortality rate (per 1 000 live births) | 7 | (2011) |
| Infant mortality rate (per 1 000 live births) | 13 | (2011) |
| Under-five mortality rate (per 1 000 live births) | 16 [14-18] | (2011) |
| Maternal mortality ratio (per 100 000 live births) | 50 [44-56] | (2010) |
| Births attended by skilled health personnel (%) | 95.3 | (2009) |
| Antenatal care coverage – at least one visit (%) | 95.8 | (2009) |
| Antenatal care coverage – at least four visits (%) | -- | |
| Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) | 97 | (2011) |
| Postnatal care visit within two days of birth (%) | 54.9 | (2009) |

### Top 10 causes of morbidity and mortality (DALYs)




Disability adjusted life years (DALYs) quantify both premature mortality (YLLS) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in 2010. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

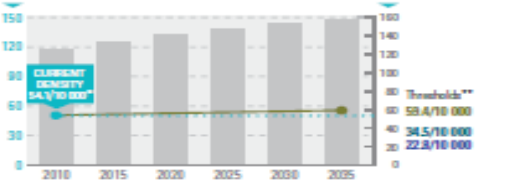
## HUMAN RESOURCES FOR HEALTH

### AVAILABILITY

Feasibility of achieving thresholds: Most likely | Somewhat likely | Least likely

| TO MEET THRESHOLDS BY 2035, REQUIRES: | FEASIBILITY |
|---|---|
| 0% increase to meet 22.8/10 000 threshold | |
| 0% increase to meet 34.5/10 000 threshold | |
| 39% increase to meet 59.4/10 000 threshold | |

POPULATION (MILLIONS) — DENSITY OF SHPs (Skilled Health Professionals) PER 10 000 POPULATION (Estimated 2010)




### ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS (density per 10 000 population)

| SUB-NATIONAL LOW | NATIONAL AVERAGE | SUB-NATIONAL HIGH |
|---|---|---|
| — Physicians | 19.6 Physicians | — Physicians |

### ACCEPTABILITY

The ratio of nurses to physicians is **BELOW** the OECD average (2.8:1).

1.9 Nurses TO 1 Physician


### QUALITY

*Is there evidence that the country has mechanisms in place to:*

| ACCREDIT training institutions for: | | REGULATE: | | LICENSE/RE-LICENSE: | |
|---|---|---|---|---|---|
| Dentists | ✓• | Dentists | ✓• | Dentists | ✓• |
| Midwives | ✓ | Midwives | ✓• | Midwives | ✓• |
| Nurses | ✓ | Nurses | ✓• | Nurses | ✓• |
| Pharmacists | ✓ | Pharmacists | ✓• | Pharmacists | ✓• |
| Physicians | ✓ | Physicians | ✓ | Physicians | ✓ |

## HRH GOVERNANCE

*Is there evidence that the country is adopting recommended good practices on HRH:*

### Leadership and Partnership

| | |
|---|---|
| Is there government leadership on health workforce policy and management? | ✓ |
| Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? | ✓ |

### Policy and Management

*Is existing health workforce policy and human resource management:*

| | |
|---|---|
| related to population health needs? | ✓ |
| informed by data and strategic intelligence? | ✓ |
| addressing pre-service education? | ✓ |
| addressing geographical distribution and retention? | ✓ |
| addressing health workforce performance (e.g. competence, responsiveness and productivity)? | ? |
| addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? | ? / ✓ |

### Strategy/Plan and Finance

| | |
|---|---|
| Is there a national HRH strategy/plan resulting from the above mechanisms? | ✓• |
| For which period? | 2013-2018 |
| Does the strategy/plan account for the financial costs and resource requirements to implement it? | ✓ |

✓ – Yes ✓• – Partial ✗ – No ? – Insufficient data

*Equal to the total of physicians (№ 219 582; 2009), auxiliary/assistant nurses (№ 271 319; 2006), enrolled nurses (№ 36 373; 2006) and registered nurses (№ 108 073; 2006) divided by the 2010 population (№ 117 886 000). Source: (WHO Global Health Observatory - Global Health Workforce Statistics – 2013 update - http://apps.who.int/ghodata/#view,main)

**See Annex 1 for full explanation on country profile methods and sources.

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World Health Organization

# Global strategic directions for strengthening nursing and midwifery 2016–2020

- Ensuring an educated, competent, and motivated nursing and midwifery workforce within effective and responsive health systems at all levels in different settings
- Optimizing policy development, effective leadership, management and governance
- Working together to maximize the capacities and potential s of nurses through intra and interprofessional collaborative partnerships, education and continuing professional development
- Mobilizing political will to invest in building effective evidence based nursing and midwifery workforce development

  – http://www.who.int/hrh/nursing_midwifery/global-strategy-midwifery-2016-2020/en/

- Achieving a power base- moving from the informal to formal
- Education and measures of credibility are key
- Communication of achievements
- Engagement with political process
- Assume our position based on our value proposition

# Vale Jo Cox

- *"deeply enhanced by immigration, be it of Irish Catholics across the constituency or of Muslims of Gujarat in India or from Pakistan, principally from Kashmir"…"We have far more in common with each other than things which divide us"*


https://theconversation.com/we-are-entering-a-new-era-of-migration-and-not-just-for-people-48650

the Lowitja INSTITUTE

Australia's National Institute for Aboriginal and Torres Strait Islander Health Research

*Incorporating the Cooperative Research Centre for Aboriginal and Torres Strait Islander Health*

- socially created problems can likely be socially transformed

O'Donoghue 2003

# Eliminating Disparities is the Pathway to Equity



Adapted from http://themetapicture.com/equality-vs-justice

This is Disparity

This is Equality

This is Equity

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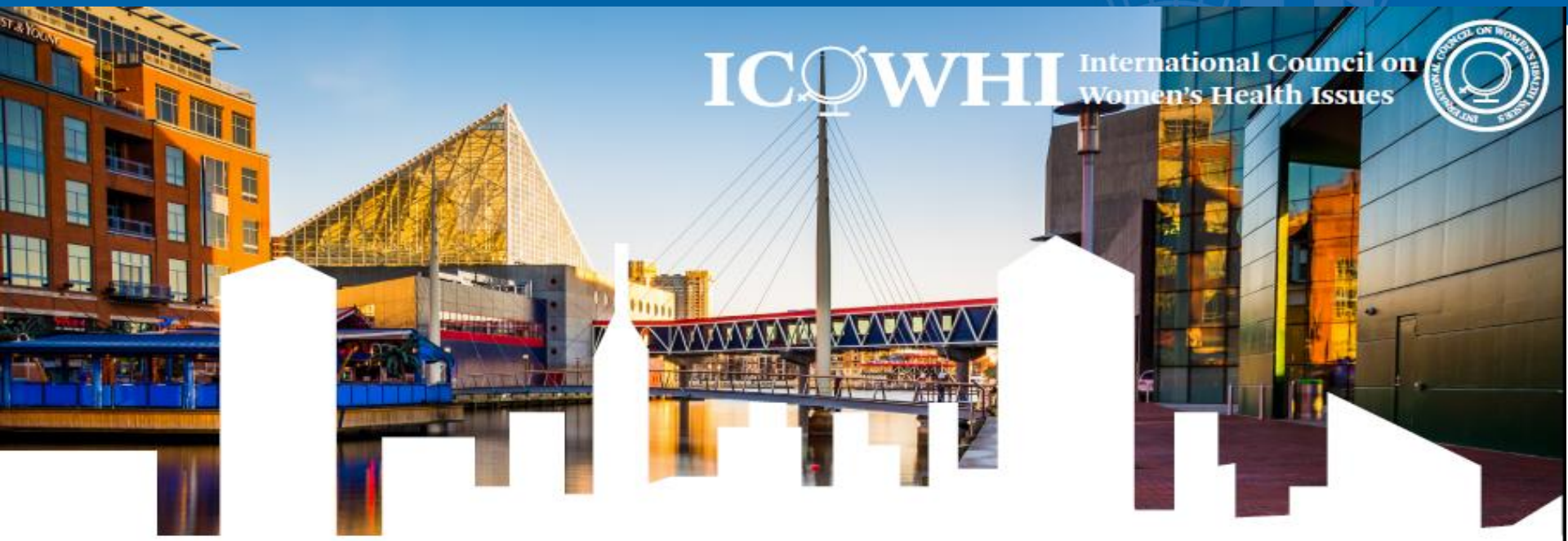


# SAVE THE DATE
## NOVEMBER 6-9, 2016

21ST BIENNIAL CONGRESS

# SCALE AND SUSTAINABILITY:
## MOVING WOMEN'S HEALTH FORWARD

FOUR SEASONS HOTEL | BALTIMORE, MARYLAND

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A place where exceptional people discover possibilities that forever change their lives and the world.