Editorial

Sustainable Health Equity—Can It Be Secured in a Post-COVID World?

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The recognition of disparities in healthcare within and between countries has led to efforts to develop programs and service delivery systems with the stated goal of health equity (Lawson, 2018). The World Health Organization (WHO) defines Health Equity as the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. Health inequities therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms (WHO, 2021). A characteristic common to groups that experience health inequities—such as poor or marginalized persons, racial and ethnic minorities, and women—is lack of political, social, or economic power (WHO, 2021).

The health equity debate has been highlighted in milestone international reports, urging governments, and the global community to consider the means to achieve universal coverage of healthcare (Cotlear et al., 2015; Gwatkin & Ergo, 2011; WHO, 2014). When assessing equity impacts, both the distribution of benefits and the distribution of opportunity costs are important; complex compromises and choices must be made to enable a more equitable healthcare system (Cookson et al., 2017). Yet we continue to see growing disparities in life expectancy between the wealthy and the poor, and worsening inequities between many countries (Gaffney & McCormick, 2017). Historically, pandemics have also been experienced unequally with higher rates of infection and mortality among the most disadvantaged communities—particularly in more socially unequal countries (Bambra et al, 2020)

The COVID-19 pandemic has highlighted the impact of health inequity within countries and between countries and has challenged healthcare professionals when unequal or unfair distribution of healthcare occurs due to social and political factors (Chiriboga et al., 2020).

Early reports of ethnic inequalities in COVID-19, from England found that compared to the White population Black males were 3.9 times and Black females were 3.3 times more likely to die from COVID-19, similarly Asian males were 2.5 and Asian females 2.3 times more likely to die than White counterparts (Public Health England, 2020). Racial inequalities in COVID-19 infections and deaths in Chicago, USA (in the period ending January 14, 2021), found that around 70% of COVID-19 deaths were among Black and latino residents and the COVID-19 mortality rate for Black Chicagoans was 213 per 100,000 population compared to 101 per 100,000 population among White residents (Chicago Department of Public Health [CDPH], 2021). Underlying these COVID-19 statistics are longstanding social, economic, and political inequalities—even before the

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COVID-19 pandemic, life expectancy amongst the poorest groups was already declining in the UK and the USA and health inequalities in some European countries had been increasing over the last decade (Forster et al., 2018). Despite the alarming consequences of health inequities in the aforementioned countries, the health inequities between these first world countries and low-middle income countries (LMICs) are considered to be much worse (Chiriboga et al., 2020). For critical care services globally, we will continue to receive victims of inequity. People who belong to disadvantaged communities being more likely to require critical care services at younger ages or at advanced stages of their disease, not just during times of COVID, but more broadly. The burden of disease suffered by the communities and the unnecessary burden to the critical care system may in turn further reduce access to critical care for many in these communities who need it... a vicious and dangerous cycle!

Further concerns surrounding health equity is the availability of a COVID-19 virus vaccine. Countries with immediate access to the vaccine are almost exclusively first world countries. *The Lancet* reported on estimates as of Dec 2, 2020, suggesting direct purchase agreements have allowed high-income countries to secure nearly 4 billion confirmed COVID-19 vaccine doses, compared with 2 · 7 billion secured by upper and lower middle-income countries and that public confidence in many countries is low when it comes to trusting government policy to protect the most vulnerable with the vaccine (Burgess et al., 2021). Meanwhile, GAVI the vaccine alliance, have projected that 92 LMICs will be able to vaccinate one in five citizens in 2021 while high-income countries which represent 14% of the world's populate have already secure enough vaccine for their entire populations (Gavi, 2020). Yet these actions appear to be contrary to the World Health Assembly COVID-19 Response of May 18th 2020 which:

> Calls for the universal, timely and equitable access to and fair distribution of all quality, safe, efficacious and affordable essential health technologies and products including their components and precursors required in the response to the COVID-19 pandemic as a global priority, and the urgent removal of unjustified obstacles thereto; consistent with the provisions of relevant international treaties including the provisions of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement and the flexibilities as confirmed by the Doha Declaration on the TRIPS Agreement and Public Health. (World Health Assembly [WHA], 2020)

The World Federation of Critical Care Nurses (WFCCN) constitution (Section 4.1) cements its role as supporting and advocating for critical care nurses and their patients without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origins, property, birth, or other status on a global basis (WFCCN, 2021). To this end, WFCCN was invited as a founding partner in the Sustainable Health Equity Movement (SHEM; 2021). SHEM is a worldwide collaboration and movement comprising multiple professional organizations and individuals that are concerned with health equity and the failure of successive governments and global entities to make meaningful change in health systems to address health equity concerns for many disadvantage groups (SHEM, 2021).

SHEM is calling for a transformational change of global governance and economy so as to bring together all international actors and efforts towards sustainable equity between and within countries and emerge from this pandemic with a new world order, which is safer and fairer for all, including coming generations. Early actions of SHEM have included a letter to the Secretary General of United Nations (UN), outlining the ongoing concern of health inequity that is expected from COVID-19 in many countries and especially those LMICs. SHEM members proposed a multisectorial Task Force that may catalyze global knowledge and resources to confront

the impact of the present COVID-19 pandemic and its foreseen lasting effects on deeper inequities in the health, social, and economic dimensions; and pledged to work with WHO and other global actors to align efforts in order to advocate for a more sustainable and equitable healthcare system. The authors of this editorial represent WFCCN on SHEM.

In July 2020, a global online launch of SHEM invited founding organizations to articulate their vision and plans for supporting the sustainable global health equity movement, Adriano Friganovic presented the WFCCN vision titled "Frontiers of critical care nursing: Aspects of global equity." Other noted speakers included Dr. Tedros Adhanom Ghebreyesus—Director General WHO, and Dr. Michelle Bachelet, High Commissioner for Human Rights, UN.

At a global level, WFCCN provide knowledge, experience, organizational recourses, and global networks to be a conduit between the discussions at the UN/WHO/SHEM level and critical care nursing organizations, as well as nurses throughout the world as we work together to secure sustainable health equity as a universal human right. It is our role as patient advocates to be a voice for the protection of human rights of our patients and the communities we serve.

Through our partnership with SHEM, WHO, the UN, and many other like-minded and committed organizations, WFCCN and the global critical care nursing community have an opportunity to create a better, more equitable, and sustainable healthcare system.

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