EDITORIAL

Happy returns: reflections on a further visit

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Following my first trip to São Paulo in 2006, I wrote about how much I looked forward to future visits(1), and have been very fortunate to return on two more occasions. In 2010, apart from consolidating the Memorandum of Understanding that had been signed between the respective Schools of Nursing in the University of São Paulo (USP) and King's College London (KCL), we celebrated that there is now a formal, university-wide collaboration between the two organisations. In recognition of this, earlier this year, KCL and FAPESP (Fundação de Amparo à Pesquisa do Estado de São Paulo) made available some funding to develop links between the two universities. Professor Emiko Yoshikawa Egry and colleague academics in the Department of Collective Health Nursing at USP were jointly awarded a funding grant with my self representing the Florence Nightingale School of Nursing at KCL, to further develop research about health needs assessment in the two countries. We were very proud to see our names and respective schools of nursing listed alongside the other grant six award winners, who were all biomedical *hard scientists*. Can this be seen as a marker of the success of nursing science? We think so.

Working so closely together means we have each developed a high level of respect for the different histories of our Schools of Nursing, and for one another's expertise in the present. The School of Nursing at USP had been established for 65 years when I visited in 2007, and the Department of Collective Health Nursing was then 20 years old. That is really impressive, and much longer than the university department and School of Nursing at King's College London. Our Department of Nursing Studies was first established in 1977, with undergraduate students being admitted that same year. However, at that time, British nurses did not have to have a degree to be registered; our university was one of the innovators. We have continuously offered degrees at King's, adding Masters and Doctoral education since then, but as a country, we have only just reached the point of requiring all registered nurses to have a university degree. The UK regulator, the Nursing & Midwifery Council, published new degree-level standards in September 2010. Until now, students have been able to qualify at sub-degree level, although all education moved from hospital-based schools of nursing into universities in the 1990s.

In 1996, the Nightingale School, which had been founded at St Thomas's Hospital in 1860, became fully integrated into King's College London. Now, we use our founder's name in full, in the Florence Nightingale School of Nursing and Midwifery. This marks the change, whilst still honouring the history and background, which is very much in mind as we celebrate this year's 150-year anniversary(2). Florence Nightingale encouraged the dissemination of her methods and training by sending her nurses overseas, both to establish new nursing programmes (in Australia and Canada) and to reform military hospitals in Egypt. She was also a keen and knowledgeable advocate of public health. So, the collaboration between KCL and USP schools of nursing, focusing on public health, is firmly following in her footsteps.

It seems likely that, if Nightingale were around today, the state of public health in our two countries would be exercising her mind as much as it did in the nineteenth century. The exponential economic growth in Brazil is excellent news for the population, but it is also the cause of considerable social change and disruption, often causing distress for families and much work for primary care and public health nurses. The sharp increase in migration from rural to urban areas means that 86% of the Brazilian population now live in towns and cities, up from 75% in 1990(3); a 10% increase in less than 20 years. Often, this migration is associated with families moving into poor quality housing or slum accommodation, which is a major threat to health, or at best may mean the separation of different generations of families. This means the natural first port of call for help and support is harder to access, leading to a greater need for professional services.

Although within-country differences are still rife, infant mortality rates have improved dramatically in Brazil over the last two decades, from 46 per 1000 live births in 1990, to 18 in 2008(4). In 2006, 39.8% of infants were exclusively breast fed for the first six months in Brazil, the 28th best of 124 countries reporting to the World Health Organisation's global health observatory(4). Less than 1% of British babies receive their mother's milk for this long, so we could certainly learn from the Brazilian experience! How much of this is due to grandmothers supporting their daughters? It is something to keep a close eye on, as families get scattered through migration, to avoid a reduction in this health-protecting activity.

Health inequalities are improving rapidly, but are still marked in Brazil, with a United Nations Gini coefficient of 55 in 2007(5) and 52 in 2008(1). In this scale, 0 corresponds with perfect equality (where everyone has the same income) and 100 corresponds with perfect inequality (where one person has all the income, and everyone else has zero income). In the UK, the figure was 36 in 2007, but is not improving. The former Labour government had a strong

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commitment and policies to reduce health inequalities, but succeeded only in stabilising the headline figures[6]. Although improvements were made in some areas, we have had a change of government this year, and with the worldwide economic downturn, inequalities seem likely to worsen again.

The index of health and social problems includes 10 key indicators, which show how closely social conditions affect health. These are:

- life expectancy
- math and literacy
- infant mortality
- homicides
- imprisonment
- teenage births
- trust (in neighbourhood)
- obesity
- mental illness, including drug and alcohol addiction
- social mobility

This index is always worse (sometimes much worse) in unequal countries, and is not related to income in rich countries[7], which explains why it is so important to drive down health inequalities. As in my first visit to São Paulo[1], I was impressed by efforts made in the Family Health Program to bring medical and nursing services to the most deprived areas. The near-universal coverage of these primary care services, particularly the work of Community Health Agents, has been cited as the most likely reason for improvements to infant mortality, always a key marker of public health[8].

The next challenge is to move to a more nuanced form of universal provision, which will take account of the need for everyone to have some services, but for those who need more to receive extra. This was called *progressive universalism*[9], by our former government, who set out a plan for different types and levels of services, depending on the population needs, as assessed at a local level. Unfortunately, this plan remained aspirational, and was not fully implemented. Perhaps in São Paulo, you will have more success? The needs assessment research project that first brought me to Brazil is now complete, and shows that it is clearly possible to identify different levels of health needs in different neighbourhoods. Therefore, the shape and size of teams in the family health centres could be adjusted to better match and meet local needs. There is so much enthusiasm and expertise in the service, that I am confident progress will be made before my next visit, which I am anticipating with pleasure.

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