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Article

2013

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How to cite

CATTACIN, Sandro, CHIARENZA, Antonio, DOMENIG, Dagmar. Equity Standards for Health Care Organisations: a Theoretical Framework. In: Diversity and equality in health and care, 2013, vol. 10, n° 4, p. 249–258.

This publication URL: <https://archive-ouverte.unige.ch/unige:40297>

Debate paper

Equity standards for healthcare organisations: a theoretical framework

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What is known on this subject

- Healthcare organisations face important challenges in accommodating differences among their users, adopting standards in response to these challenges and putting those standards into practice.

What this paper adds

- It argues that standards should not be target group oriented.
- It provides a theoretical and normative foundation for equity standards
- It offers a coherent set of difference-oriented equity standards.

ABSTRACT

In this article, we outline the conceptual assumptions that define the basic theoretical framework for the development of equity standards for healthcare organisations. We begin by critiquing current assumptions by healthcare organisations regarding gender, migration and disability. By challenging these assumptions through the interrelated concepts of intersectionality, origin and impairment, we introduce a way of modelling equity standards for healthcare organisations. *Intersectionality* is based on the assumption of multiple characteristics of discrimination; the origin of opposition to the cultural determination of differences and impairment of the reintegration of the body and suffering into the disability movement. The model of equity standards presented here has five domains that are intended to promote equity in policy, access, care

and participation. The model has been specified concretely through a set of substandards and measurable elements that have already been submitted to a large international audience of organisations in the healthcare sector. The use of these substandards allows for a broad review and consequently improvement of the specified preliminary standards. Because, in a pluralised society, the needs of people have changed, especially in terms of lifeworlds characterised by diverse biographies, experiences and representations of realities, these standards might be a first step towards providing an adequate framework for healthcare organisations faced with radical differences.

Keywords: equity, disability, gender, impairment, intersectionality, migration, standards

Introduction

Healthcare organisations today are confronted with a pluralistic world of users and with differentiated societies that force them to modify their structures

and behaviours accordingly. The development of standards is a way to reflect those new realities and to support these organisations' ability to face new

challenges. Standards often focus on specific target groups such as migrant populations, women or the disabled. This prioritisation runs the risk of creating inequalities and incoherence between certain target groups, and of stereotyping some of these groups more than others. Furthermore, in practice, problems arise from the need to both accommodate all categories of difference and acknowledge the realities of people who have more than one risk factor of discrimination. As Morten Kjaerum, Director of the European Union Agency for Fundamental Rights, has emphasised, individuals are complex, and that complexity has not always been acknowledged adequately:

Individuals are, however, complex; they share a number of characteristics that expose them to possible discrimination, including sex, ethnicity, age, disability, sexual orientation and any combination of these grounds. When people are denied equal treatment because of a failure to consider all the relevant facets of their individuality, they can be said to suffer multiple or intersectional discrimination.

(European Union Agency for Fundamental Rights, 2013, p. 3)

Indeed, for healthcare organisations to deal with all kinds of differences effectively, they need to focus not only on one, but on all of the often overlapping *grounds* or *layers of oppression* (Lazaridis, 2000). The aim of this article is therefore to challenge current ways of tackling inequalities in healthcare organisations by focusing on specific groups. Instead of this approach, we here refer to and focus on all kinds of differences. First, we present the main points of a theoretical framework that can shape equity standards for healthcare organisations in general. We then briefly introduce, as a specific example, a set of equity standards to which we have contributed in the developmental stages, their history, content and conceptual framework. Finally, we conclude with an overview of how these equity standards have been appraised by 45 healthcare organisations (largely hospitals) from around the world that were asked to participate in the first review of these preliminary equity standards.

From difference blindness to difference sensitivity

Since the original architects of the welfare state set up the healthcare sector, things have changed dramatically. The post-war period following the Second World War was characterised by the development of welfare states, a phase that combined a technocratic view with a dynamic conservatism (Schön, 1971), rather than a focus on users' needs. During these years of economic development, the focus was on infrastructural development in order to improve access to services for all.

The promotion of individual health and the fostering and enlargement of various institutions such as hospitals, outpatient clinics and social services were placed at the top of the political agenda. The goal of achieving excellence in all services gained importance based on a logic of *more of the same* rather than the inclusion of particularities and differences. This logic of *uniformisation* also entered into the healthcare sector, where 'difference blindness' became part of daily normality.

This logic has been challenged since the 1970s, first by feminists and then by Solidarity and other movements, all of which advocated for respect for particularities. Gender, migration and disability issues were probably the most important topics in a discussion that mainly criticised the *uniform model* for exercising violence against differences and particularities, and that was first formulated by pioneers such as Kate Millett (1971), Rudolf Braun (1970) and Michel Foucault (1972).

Intersectionality

The conceptual debate on complexity and intragroup differences, the *mapping of the margins* (Crenshaw, 1991), has always played a major role in challenging welfare-state practices. In particular, the debate on *intersectionality*, a term coined by Kimberlé Crenshaw (1991), has resulted not only in a criticism of uniformity but also in a more critical view of categories, such as man, woman or Italian, that had previously been interpreted as homogeneous. Intersectionality also means that 'difference and inequality are conceptualized as a set of processes' and not as the 'possessive characteristics of individuals' (Anthias, 2013a, p. 131). This view has a remarkable impact on the way in which societies and organisations are analysed because:

social categorizations are not equally salient at all times and our approach has to be historically sensitive as there are complex new emerging constellations of disadvantage.

(Anthias, 2013b, p. 15)

On the contrary, the homogenisation of social categories risks the possibility that those categories will be used to construct inclusionary or exclusionary boundaries that encourage various forms of discrimination:

In this way the interlinking grids of differential positionings in terms of class, race and ethnicity, gender and sexuality, ability, stage in the life cycle and other social divisions, tend to create, in specific historical situations, hierarchies of differential access to a variety of resources – economic, political and cultural.

(Yuval-Davis, 2006, p. 199)

Thinking in terms of intersectionality, by integrating all kinds of differences, as well as their effects on multi-discrimination, is one of the most important prerequisites for an equitable healthcare organisation.

Origin

In contrast to the trend in gender studies, which has focused on inter- and intracategorical complexity (McCall, 2005, p. 1773), health and social care organisations in the last few decades have focused mainly on the categories of migration and ethnicity, and these categories have become the main focus of attempts to accommodate vulnerable target groups. Furthermore, in order to simplify the complex realities that lie behind these categories of culture, specific ethnic and migrant groups have been essentialised and culturalised. This static essentialisation has often been based on the classic concept of culture formulated by Edward B. Tylor, who defined culture as:

that complex whole which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by man as a member of society.

(Tylor, 1871, p. 1)

This popular definition of culture has been used all over the world for decades to describe specific groups as complex wholes (for an overview, see Wicker, 1997). In consequence, healthcare professionals have also tended to construct boundaries of culture between different migrant and ethnic groups, and thus to stereotype individuals and culturalise social problems. To understand differences related to migration or affiliations, healthcare professionals have transformed origins into static cultures. The criticism of this classical conception of culture is not a new one. As early as 1973, Clifford Geertz, an advocate of interpretive anthropology, declared that:

doing ethnography is like trying to read ... a manuscript – foreign, faded, full of ellipses, incoherencies, suspicious emendations, and tendentious commentaries, but written not in conventionalized graphs of sound but in transient examples of shaped behaviour.

(Geertz, 1973, p. 10)

Two decades later, Arjun Appadurai (1996) argued against the continued use of the noun ‘culture’ because of its substantialisation, and instead argued for the use of the adjective ‘cultural’, a useful heuristic that includes aspects of similarity *and* difference between ‘all sorts of categories, as genders, roles, groups, and nations’, as a *situated difference*:

Culture is not usefully regarded as a substance but is better regarded as a dimension of phenomena, a dimension that attends to situated and embodied difference. Stressing the dimensionality of culture rather than its substantiality

permits our thinking of culture less as a property of individuals and groups and more as a heuristic device that we can use to talk about difference.

(Appadurai, 1996, p. 12)

According to Lorraine Culley, healthcare professionals, especially in nursing, give priority to the classic conception of culture in order to avoid dealing with their own prejudices or discriminatory practices:

An exploration of the ‘sensitive care of the culturally different user’ and the research needed to realise this practice is preferred to the theorisation of individual and institutional racist practices and their effects on users and colleagues.

(Culley, 2006, p. 145)

As a result, healthcare professionals tend to try to gain knowledge of other so-called cultures through static guidelines and checklists, convinced that this is the appropriate response to the diversity of their service users (Culley, 2006, p. 146). Although the critique of the classic conception of culture has begun influencing quite a lot of healthcare professionals in recent years and moving them in the direction of a more individualised, difference-oriented approach, the concept of culture still remains essential when it comes to shaping standards for an appropriate healthcare for migrant or ethnic groups.

Impairment

At the core of the disability movement in the 1980s was the desire not only to talk about but also to recognise and respect difference. The movement revolted against the biomedical model, which is based on the idea that disabled people primarily have to be cured, and it fought instead for a social model of disability, based on the view that it was mainly society that was disabling the disabled. The key issues were political rights and social inclusion (Oliver, 1990). The social model had an ‘enormous value in establishing a radical politics of disability’ (Hughes and Paterson, 1997, p. 326), but it also led to a Cartesian separation of mind and body. In order to escape this dualism, Bill Hughes and Kevin Paterson proposed a *sociology of the body* as a useful way of tackling the emerging ‘vibrations of difference’ within the ranks of the disability movement, ‘based on gender, ethnicity, sexuality, class, age or impairment’ (Hughes and Paterson, 1997, p. 338). In a similar vein, Michael Oliver emphasised the need to focus on *intracategorical differences*:

The crucial problem is that disabled people, regardless of the type or severity of their impairment, are not a homogeneous group that can be accommodated easily within a society that takes little account of their individual or collective needs. As with the whole population, disabled people differ widely in terms of ethnic background,

sexual orientation, age, abilities, religious beliefs, wealth, access to work, and so on. Clearly, their situation cannot be understood or, indeed, transformed by any policy based on narrow theories of conventional normality or uniformity.

(Oliver, 1998, p. 1448)

To underline this shift of view from disability to differences, the concept of *impairment* emerged in the social sciences. Impairment is:

a manifestation of processes of identity differentiation among disabled people. ... Identity is complex and problematic, and it is – in an individualistic and rapidly changing society – a precarious source of solidarity. Open recognition of this precariousness is useful. It mitigates against rather than encourages factionalism.

(Hughes and Paterson, 1997, p. 338)

With the concept of impairment, disabled people are no longer seen as categories, as kinds of disabilities, but as complex individuals. In order to provide appropriate support and solidarity for these complex individuals, different forms of care are needed to:

enable them to flourish and achieve their projects. One size will not fit all – either the historic form of residential care, or the current ideal of independent living. Whatever form of care and support is adopted needs to be based on respect for both parties – those who deliver care and support and those who receive it.

(Shakespeare, 2006, p. 160)

The concept of intracategorical differences introduced into the field of disability studies the issue of intersectionality and, together with the concept of impairment, which focuses on the body and suffering, the social aspects of disability.

Differences

In summary, making differences a category that, in today's lifeworld, links everybody in the same way, namely as an individual complex entity, seems to be the most promising way of providing adequate healthcare in a pluralist society. A focus on differences favours a case-by-case assessment of the needs of people who come into contact with healthcare organisations, regardless of which kinds of social characteristics they bring with them. The World Health Organization articulated a similar view in a **recent** World Health Report:

The growing reality that many individuals present with complex symptoms and multiple illnesses, challenges service delivery to develop more integrated and comprehensive case management.

(World Health Organization, 2008, p. 7)

However, before healthcare professionals can provide such integrated and comprehensive care, and in order to avoid arbitrariness and 'subalterns' speech' (Spivak, 1992), they need to have equity standards on which they can rely. In the remainder of this paper, therefore, we present a model of equity standards that tries to incorporate concerns about difference and intersectionality to help to tackle all forms of discrimination, including multi-discrimination.

Background with regard to the equity standards

Equity standards are a concrete answer to the challenges posed by pluralism to healthcare organisations today. The discussion on equity standards we present here starts with research conducted in the late 1990s by the European Migrant Friendly Hospitals (MFH) project into effective ways of providing health services to migrants (Karl-Trummer and Krajic, 2007). The Ludwig Boltzmann Institute for Sociology of Health and Medicine, University of Vienna, coordinated the MFH project and provided expert support to pilot hospitals (www.mfh-eu.net).

The MFH project involved 12 hospitals in 12 different European countries, and aimed to make hospitals more responsive to the needs of migrants and ethnic minorities. The novelty of this project was that it introduced the idea that, if we want to improve responsiveness, we must not only address measures to improve the knowledge and behaviour of individual patients and providers, but also improve the overall organisation of service delivery. The study was based on evaluations of the practices of the 12 hospitals involved, and included an assessment of service users' satisfaction. The result of these evaluations was a body of knowledge concerning the need to develop specific interventions, in particular:

- organisational development in the hospitals to improve *migrant friendliness* within core processes and services, and integrate *migrant friendliness* into the quality system of effective care
- the development or improvement of interpreting services
- the improvement of patients' health literacy and of the ways in which information and education are provided
- the enhancement of healthcare staff's *cultural competence* through training and personal development.

The MFH project produced three main results:

- a set of 12 national MFH models as examples of best practice for health services

- the Amsterdam Declaration, a political document containing a series of recommendations for European health services
- the creation of the Task Force on Migrant Friendly and Culturally Competent Health Care (TF MFCCH) as a tool to facilitate networks and cooperation between different European countries.

The TF MFCCH was established in 2005 as part of the international Health Promoting Hospitals (HPH) network with a specific mandate to continue the momentum created by the MFH project (see Box 1). The TF MFCCH was created to support the translation of the principles of the Amsterdam Declaration into practice, and is coordinated by the AUSL of Reggio Emilia (www.ausl.re.it/hph).

The TF MFCCH consists mainly of healthcare professionals and managers. From its inception, and through a number of meetings between 2007 and 2010, it established a strong alliance with researchers dedicated to the study of healthcare for migrants. The outcome of these meetings was the emergence of a consensus among professionals and researchers regarding the challenges that arise and the measures that are needed to:

- improve monitoring of the health of migrants and ethnic minorities
- improve entitlements to healthcare and access to services
- develop good practices to promote appropriate care and interventions
- improve the participation of migrants and ethnic minorities in the establishment of these standards.

These policy measures are well known, and there is a general consensus that they are required to enable healthcare organisations to accommodate diversity. However, many remaining obstacles prevent the transformation of this knowledge into action. A number of countries in Europe have adopted national policies on migrant and ethnic-minority healthcare, but the pace of implementation is very slow. In an analysis of

reports from health policy experts in 25 European countries, Mladovsky *et al* (2012) show that, by 2009, only 11 countries had progressed beyond establishing statutory or legal entitlement to care to national policies to improve migrants' health. These reports clearly demonstrate that, even in those few countries where policies have been translated into action, there is both a wide disparity in the policy measures adopted and very little evidence about which initiatives are actually effective. The idea of developing standards therefore originated from the need to acquire better evidence with regard to the effectiveness of policy measures that address the healthcare needs of migrants and ethnic minorities.

To accomplish this task, it was necessary both to define effective criteria for responding to diversity in the new context of pluralism, and to develop a tool for assessing the effectiveness of the criteria. The tool was developed through a cooperative process with input from members of the TF MFCCH and discussion in HPH-Network workshops. The goal was to develop a tool that made it possible for health service providers to monitor and measure their capacity to ensure equitable care and implement improvements.

Equity and differences

The use of equity as the general normative orientation towards the standards developed indicates that we do not adhere to an egalitarian view of society. Instead, we build from the assumption that differences are inherent to the relationships between service users and organisations. Consequently, equitable treatment has to be the main concern of any healthcare organisation. As John Rawls (1971, p. 47) argues in his second principle of justice, a fair society must ensure that people in the most disadvantaged positions are not discriminated against and can potentially access all positions. Amartya Sen, in his homage to Rawls, emphasises that arguing for a *just* society and not simply for a *fair* one, defined as a society that creates better conditions of life for those most in need as a result of deliberation and ranking, is not required by logical deduction but is instead something that can result from public reasoning and social choice (Sen, 2009, p. 106). In this way, Sen relates the argument of equity to the practical question of priorities (Sen, 2009, p. 95).

In the context of social and health services, this normative orientation requires that the disadvantaged be placed at the centre of concern and no longer at the periphery. This shift changes the orientation of the health sector and the welfare state from institutions for the middle classes to those for people with concrete difficulties and who are at risk of discrimination. As a

Box 1 The Health Promoting Hospitals (HPH) Network

The HPH Network is an international network established by the WHO Regional Office for Europe in 1989 with the aim of improving the quality of healthcare by incorporating health promotion activities for patients, staff and the community into routine hospital practice. Since 2008, the HPH network has broadened its scope to include health services more generally. Today, roughly 900 organisations in various countries and continents are part of the network.

consequence, healthcare professionals have to think about differences both between 'groups' and *within them*, as Culley puts it:

We need to recognise the importance of other identities or locations in structures of class, gender and generation, for example, and how these mediate encounters with health practitioners. We need an approach to educating healthcare workers that does not assume that there is a 'common cultural need' to learn about. Rather, there are heterogeneous groups with diverse social aspirations and interests and there are systemic processes that prevent fair treatment and equitable access.

(Culley, 2006, p. 151)

To develop this set of preliminary standards, we have identified five key domains for the creation of equity as a normative orientation in healthcare organisations, namely organisational policies, access to the organisations, the care relationship, participation issues and healthcare organisations' lobbying activities (for a detailed explanation of the standards, including examples for evaluation, see wwwold.ausl.re.it/HPH/FrontEnd/Home/Default.aspx?channel_id=38).

All five domains are logically interrelated and represent, from the standpoint of a healthcare organisation, the internal structural division of management: *the operational level, legal and technical issues, contact with service users, public participation and external activities* such as communication and marketing (Willke, 1978). Standards were formulated for each domain. Each standard has a set of substandards, and each substandard has one or more measurable elements against which the organisation is asked to assess services.

Equity in policy

The first standard, equity in policy, aims to promote equity by providing fair opportunities, reducing health inequities and delivering sustainable and cost-effective policies. This standard refers to the political acknowledgement of equity as a societal challenge. Even though organisations are normally not problem-oriented and would probably not voluntarily choose to focus on the poorest or least educated service users, government guidelines or legal rules intended to promote equity can force them to do so. Without such a high-level political framework, equity can hardly be implemented within the healthcare system, as the UK case clearly indicates (Schuster and Solomos, 2004). A society's choices can be made to enter into organisations, as Thomas Faist argues:

This insight is particularly relevant for the debates on diversity because, at first sight, it seems that the organizational level on which diversity programmes are conceptualized and implemented is a realm outside the civil sphere and thus democratic deliberation. However,

there is a nexus: it is only in this organizational and associational realm that the civil sphere can effectively take hold.

(Faist, 2008, p. 187)

In terms of the implementation of equity within a healthcare organisation, the top management has to be required to mainstream equity in all relevant strategic and organisational management instruments (Squires, 2005). However, this is not enough. It is also necessary to install reflexive processes through which it is possible to continually verify and review the consequences of the practices adopted. Thus all monitoring instruments and evaluation procedures have to be strictly related to the management instruments of equity policy.

Finally, management must also be required to focus on ongoing change in order to give the institution the space and time required for a deep organisational change towards equity. In particular, instruments that create awareness of the risks of discrimination, such as training or an employment policy that guarantees staff diversity at all levels, must be implemented (Stuber, 2002).

Equity in access

The goal of the second standard, equity in access, is to ensure equitable access to and equitable utilisation of the services provided. Here different kinds of access barriers are taken into consideration, and concrete actions are undertaken to overcome them. Physical accessibility and the geographical distribution of services and facilities, including outreach interventions for the most disadvantaged populations, have to be ensured. Communication and information must be improved. Although much has already been done to overcome language barriers, there is still a need to consolidate and maintain developments (Bischoff and Hudelson, 2010). Greater efforts are required to provide more information in different forms and with different tools, taking different levels of health literacy into account.

This standard also encourages healthcare organisations to address other barriers that are more difficult to overcome. Included here is the power imbalance in patient–doctor communication, the sick person's *mindful body* (Scheper-Hughes and Lock, 1987) in the healthcare relationship, and improvements in trust, respect, openness and empathy. Different meanings of the terms 'illness' and 'disease' (Garro and Mattingly, 2000), various ideas about interactional behaviour (Vanderminden and Potter, 2009) or just a lack of trust in the healthcare system in general (Krause, 1977) are quite challenging barriers for both service users and healthcare professionals. Legal and financial barriers such as the lack of formal entitlements or

insurance coverage are also difficult to overcome, and they depend on rules outside the healthcare organisations themselves. However, this standard encourages healthcare organisations to take action where eligibility rules compromise human rights by requesting that concrete solutions be provided to ensure that ineligible people receive appropriate information, care and support. This area is especially complicated because eligibility rules may actually discourage the individual in question from accessing the needed treatment, an issue that is particularly relevant in relation to illegal migrants (Björngren Cuadra, 2012).

Equity in quality of care

The third standard, equity in quality of care, is supposed to ensure that the organisation provides high-quality, person-centred care for everyone, always acknowledges the unique characteristics of the individual and the relational environment, and acts only on these considerations to improve individual health and well-being. The quality of care should not be assessed on the basis of the results of often standardised satisfaction questionnaires, but by measuring the capacity of the healthcare organisation to treat and care for people as unique individuals regardless of the differences they bring with them.

This standard focuses on individual lifeworlds and not on general categories such as migration, gender or disability. The idea of person-centred care also requires a focus not on culture or other stereotyped categories, but on the ability to 'notice and understand individual lifeworlds in a specific situation and in various contexts, and to infer appropriate ways of action from this' (Domenig, 2007, p. 29). 'Person-centred' here does not mean simply to 'reject cultural processes as one set of influences of health and health behaviours' (Culley, 2006, p. 150). It requires consideration of all other aspects of an individual's lifeworld, which are often even more important than the cultural dimension of daily life. As Culley argues, therefore, we need:

to think in terms of complexity and fluidity. We need to develop ways of avoiding essentialist assumptions about patients and clients from 'minority groups' and actively seek understandings that might be relevant to our healthcare practice.

(Culley, 2006, p. 150)

A prerequisite for such adaptive, needs-oriented care is to obtain the relevant information from service users. The aim is to ensure that healthcare providers are able to take individual *narrative-based* (Greenhalgh and Hurwitz, 1998) ideas and experiences into account in the co-construction of the care process from diagnosis to discharge. Therefore, in the case of migrants, for example, simple knowledge-based training,

in which providers are taught the customs and values of particular ethnic-minority cultures, cannot adequately prepare professionals to respond to the needs created by the intersection of differences. On the contrary, healthcare staff at all levels are encouraged to learn to work across differences and invest in the relationship with the user in order to produce knowledge. It is necessary to acknowledge that only the patient is uniquely qualified to help the healthcare provider to understand the relevance and impact of his or her uniqueness in relation to the represented illness experience.

However, users only tell their stories when healthcare professionals have succeeded in establishing a relationship of trust based on mutual respect and acknowledgement. Only such trustful interactions can create a safe environment, one of the most important conditions for being able to put person-centred care into practice.

Equity in participation

The objective of the fourth standard, equity in participation, is to ensure that the organisation develops equitable participatory processes that respond to the needs and preferences of all service users. This standard requires that they be seen as active participants rather than as passive recipients or consumers. Participation does not mean involving constructed communities or cooperating with community representatives who often do not really have the legitimacy to speak for others. Rather, the equity standards proposed here do not aim to culturalise or stereotype users by assigning them to certain categorical groups. The same approach should therefore be applied to the issue of participation. Furthermore, the concept of *community* should be viewed critically and employed only for practical purposes, not for ideological ones (Joseph, 2002). Even though standards concerning participation are regularly formulated at the group or community level, this is not how we have approached the issue of equity in participation, for two reasons. First, groups or specific communities cannot adequately represent intracategorical diversity. Secondly, specialised groups cannot adequately reflect the intersectional aspects of certain topics, such as specific diseases, disabilities or sexual orientations. Furthermore, groups can only be well organised when they represent a critical mass (e.g. migrant groups; see Moya, 2005, p. 844). When no such critical mass exists, therefore, representative groups are often ineffective or may not even exist, a situation that creates new injustices in the ability to represent certain realities.

In general, it is also difficult for organisations to reach certain groups because those groups exist out-

side the organisations' space and there are not enough resources to monitor the ongoing changes to the territory of reference and the radical differences that exist within it. Consequently, participation here means the involvement of concrete users of the services at an individual level in assessing how and whether the services work and meet the users' concrete needs, as well as figuring out new needs.

Promoting equity

The fifth standard, promoting equity, is intended to promote an understanding of the healthcare organisation as part of a wider social and political system in order to improve the sector's ability to influence the broader society. The aim is to encourage organisations to participate actively in networks, think tanks and research initiatives that promote equity, including partnerships to deliver innovative services to disadvantaged populations, and intersectoral collaborations to address the wider determinants of health (World Health Organization, 2011). This standard is the most important one because it is about addressing health inequalities in society in general. It is also the most difficult standard to implement, because these factors lie mainly outside the direct influence of healthcare organisations.

First insights from a pilot testing of the standards

These preliminary standards were piloted in 45 healthcare organisations (five in Australia, 10 in Canada, and 30 in Europe) between April and September 2012. In this article we intend just to present an overview of the results of the pilot test; a detailed analysis of the findings will be addressed in a separate article. The aims of this pilot test were to evaluate the comprehensiveness, importance and applicability of the standards and to assess the level of compliance with the standards among the pilot organisations involved. A review form was used to assess ratings of measurable elements and to collect comments and suggestions for improvement.

The overall evaluation of the standards was positive, but certain measurable elements proved to be somewhat problematic, in particular those pertaining to participation, equity in care and the promotion of equity outside the organisation. Some improvements to the wording (e.g. to clarify controversial terms) and the structure of the standards were recommended. Comments on the applicability of the standards provided important insights into the need to take into account national legislation, the organisation of each

health system and the socio-political context of local norms and values, current processes and resource restraints. These concerns included lack of favourable legislation or limitations imposed by current legislation, as in the case of collecting service user data, and:

- clashes with existing assessment systems
- clashes with influential health reforms
- the political climate.

It is not surprising that the level of compliance with the standards, in particular those of equity policy implementation, service user participation and the promotion of equity in the wider system, was low in a number of organisations. However, the pilot project indicated that organisations were aware that they had to accept complexity and avoid over-simplifications and generalisations, even if doing so required them to face the difficult task of providing person-centred care and take into account the interplay of different individual characteristics with other social variables. The TF MFCCH is now preparing a self-assessment tool including the standards, to assess structures, processes and complementary indicators to measure performance. The implementation of the self-assessment tool will be pilot tested in 2014.

Conclusions

We live in a pluralistic society, where differences in religious, philosophical and ideological positions, in lifestyles, in sexual orientations and in abilities and talents are at the heart of what Rawls called the *fact of pluralism*, which can only be denied by oppression (Rawls, 1971). Pluralism is, furthermore, strongly related to the long-term trend of singularisation (Martuccelli, 2002). We live in a society in which differences rather than similarities are promoted. All of us need to be different and to be *recognised* as different both in general and as users of healthcare services.

The equity standards that have been proposed by the TF MFCCH and which have been described here are, from a conceptual point of view, a comprehensive answer for organisations that are willing to react adequately to the fact of pluralism and the reality of the radical differences between people that characterise contemporary societies. They also answer demands for services that are more individualised and able to accept all kinds of differences as normal.

The standards contrast group-focused approaches without denying that individuals are always part of at least one group, in most instances, by choice. It is also their choice to select the groups they would like to include in the healthcare relationship. If this fundamental difference from community approaches is

accepted, it is without doubt possible to include experiences of these approaches coherently in the suggested equity standards. It would be an error to interpret these standards as a new way of handling health inequalities. They are more a new way of thinking about inequalities outside a fixed-group mentality, and of creating coherence between instruments based on groups and on different, often antagonistic logics. These standards state, as Jacques Donzelot would say, that individual rights come before community rights (Donzelot *et al*, 2001).

The normative aspect of these equity standards demands not only organisational adaptation but also political decisions and the need to acknowledge the necessity of changing existing practices that are potentially discriminatory and exclusive. Thanks to the pioneering organisations and, within them, the social innovators who have allowed their practices to be submitted to evaluation, informed policy decisions can be taken to help to diffuse these equity standards as a way of meeting the needs of people and organisations.

ACKNOWLEDGEMENTS

This is an original paper. The preliminary equity standards that we discuss in the second part of the paper were elaborated by a larger group composed of the authors and Elisabeth Abraham, Marie-Louise Essink-Bot, Manuel Fernandez Gonzales, Manuel Garcia-Ramirez, James Glover, David Ingleby, Christopher Le, Bernadette Nirmal Kumar, James Robinson, Conny Seeleman, Marie Serdynska and Ragnhild Spilker. Patricia Naegeli and Anna Weber provided critical comments on a draft of this text, and Daniel Moure revised the text. We thank the reviewers and the editors for their useful and constructive comments and suggestions concerning our manuscript.

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Received 24 June 2013

Accepted 7 August 2013