New Global Health Directions for All Health Professionals

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Introduction

Significant changes in the way international health and development is approached and funded has seen the release of a host of major reports and policy documents[1-8]. Within these thousands of pages of evidence, policy and guidelines, lies the promise of a solution to a pressing puzzle; how can we, as developed world health workers, practically and effectively contribute to developing world healthcare?

These publications offer a welcome opportunity to develop a new evidence-based framework for cohesive and cooperative action towards improved global health. They also highlight challenges, both old and new -- how these are faced will dictate the success or failure of many of our collective efforts to improve global health over the coming decades. Focus is provided to those new to international health, and renewed direction for those distracted from the global health agenda.

The sheer volume of information included can, however, be off-putting. A distilled version of their contents, accompanied by a careful analysis of common themes and key guidance, stands to benefit the time-pressured health professional. This article aims to present an accessible summary review of these publications and their recommendations. It concludes with a realistic model for practical action that the globally aware health professional can easily apply.

21st Century Problems and Solutions

The over-arching theme connecting these reports is that of globalisation and its profound and novel effects on the health of populations. Within this, three consistent strands run through the entire corpus, reflecting the most pressing areas in which opportunities for progress can be seized or lost. They are grassroots involvement and the role of the individual, health worker migration and foreign policy.

Realising Your Potential

Highlighting the potential that individual developed world health professionals have to improve health in developing countries is central to many of these publications[1-3,6].

Consensus across the reports advocates strong institutional support to provide these health professionals with the guidance and material help they need to contribute to the best of their ability. In the UK, this support has become eroded in recent years through;

- *The introduction of the MMC run-through framework and is lack of flexibility.[8]*

- *Under-recognition of the value of doc-*

tors working abroad, both to developing world health system and NHS patients.[3,4,8,9]

• A lack of funding and will at deanery level for employment positions in global health, research or educational exchange programmes, such as those facilitated by NHS Links or for research.[3,4,8,10]

Undergraduate education and interest in global health has grown significantly in recent years, but postgraduate options remain limited for those in specialist training [1,4,10-12]. The funding necessary to create these posts could be sourced from the DoH and DfID, especially with the recent focus on development in the latest comprehensive spending review [13].

Figure 1: Ways in which individuals can take action to improve global health

Where funding is not forthcoming, alternative sources can and have been sought [11]. With the current groundswell of enthusiasm for these positions, lobbying and guidance needs to come from all levels, no more so than from the institutions who have set precedents in creating these opportunities. Promising schemes run by NHS Scotland [14] and the London Deanery [15] are already underway.

There must be a defined, well-organised, accessible structure for global health work opportunities within each aspect of postgraduate training. A global health curriculum should be developed to set standards of training in the area, be it as a public health sub-specialty or in general specialist training exams. These would provide elements of a 'one-stop shop', described and recommended by Lord Crisp[10,11]. With these elements in place, approaches can be made to local deaneries, Royal Colleges and PMETB/GMC, and local variations and specifics can be worked out based on these solid foundations.

Migration Matters

Health worker migration from the public to private-sector, rural to urban settings, and from the North to the South, has long been acknowledged to have a net negative effect upon the health of the world's poor [2,3]. Despite this, more work is needed to quantify the full extent of health worker flows [16].

Knowledge and expertise for human resource management is often lacking in source countries. Technical and financial assistance is required to develop broad human resource retention strategies and effective domestic governance to improve working conditions, provide targeted incentives to retain staff and

trainees and to address cultural pressures to work abroad [3].

Collaborative links between institutions, professional associations, trade unions, and individuals in the developed and developing worlds are increasingly important [17]. Through these partnerships, research, experiences, information, and best practise can be shared in a mutually beneficial way. Targets for lobbying should include the removal of disincentives for health professionals in the developed world to take part in such work; factors such as continuity of pension payments while overseas and lack of accreditation for training. Training and funding packages should be conceived with the goal of building capacity in mind [1,16].

The governments of recipient countries must be lobbied to develop more effective codes of practise for the ethical recruitment of health professionals from overseas. Recipient country health workforce needs to be better organised and strengthened to remove the necessity to employ from abroad, whilst aggressive marketing strategies in developing countries must be ended once and for all [18].

WHOse Foreign Policy?

Developed world foreign policy has great potential to directly and indirectly affect health in developing countries. Consideration of the vast interplay of factors such as trade, health protection and human resources is integral to challenging the broader determinants of today's borderless disease trends and is thus essential when devising an equitable foreign policy for sustainable development. The Oslo Declaration and, more recently, the 2007 World Health Report both identify key policy areas for international health security, underlining the growing awareness of developed world governments that poor health and security threats such as political instability, war and terrorism frequently share socioeconomic, environmental or social causes.

Crisp concluded that currently the most effective way for NHS staff to contribute to global health is through providing emergency health care in conflict situations, natural disasters, and infectious disease outbreaks [1]. However, the multitude of governments, organisations, and people providing support to developing countries are operating with considerable overlap and with poor inter-agency communication. Crisp discussed the need to develop, co-ordinate, and sustain a clearer framework for collaboration and used the example of an international database to match volunteers with relevant organisations.

In the UK, there are unified calls for the NHS, DoH, and DfID to develop an NHS structure linking health and development [1,4]. An inter-Ministerial group† has been convened to research strengthening health system capacity in developing countries, and Donaldson has proposed a strategic framework to facilitate inter-departmental co-operation within the British government [19]. This is indicative of the wider expressed need for an effective cross sector global policy and governance incorporating mechanisms for the coordination of multiple stakeholders to achieve the MDGs.

But who is best positioned to provide global governance over health? The creation of new, powerful actors in global health, such as the Bill and Melinda Gates Foundation and the Global Fund, have diluted the WHO's authority. With the WHO too poor to fulfil its mandate alone, strategic partnerships with private providers, borne of necessity, have allowed the private sector more control over health priorities. It is argued that this may promote increased competition and accountability and ultimately lead to stronger and more effective global health institutions.

Summing up

Global health is now mainstream. In Britain, medical schools have produced hundreds of graduates with additional qualifications in international health and Medsin UK have ensured its place on most curriculae. Health professionals take time out to study Masters and Diploma programmes. The presence of global health at the top of the political agenda from 2005 shows that government recognises that moves to address drastic international health and development inequalities can win votes.

There has been a clear shift of emphasis towards the role of the individual. More than ever before, individual health professionals have the means, and with it the responsibility, to increase awareness and action through teaching colleagues and themselves about global issues, informed lobbying of the government and international actors, forming and supporting global health pressure groups, volunteering and research. Now is the time to get stuck in.

† Consisting of input from the Department of Health, the Department for Education and Skills, HM Treasury, the Foreign and Commonwealth Office, the Home Office, DFID, The Northern Ireland Office, the Scottish Executive and the Welsh Assembly

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This article was written in January 2008. As a result, it does not take into account the financial implications of the global bankng crisis when discussing funding for global health projects. It has been one of the most read on the Alma Mata website and was linked to the South African Minstry for Health's website in March 2009.

Global Experiences

Dr. Kiran Jobanputra *was working with MSF in Somalia from October 2007 to February 2008, and here shares his daily experience as a medical doctor working for an humanitarian organisation.*

As you fly in to Somalia, you are struck initially by how normal everything appears. Gently dipping hills, great expanses of scorched red soil, and a total absence of movement – a very African environment. Likewise your first contact with Somali people – beaming young men, with Kalashnikovs swung over their shoulders like Mandolins, queuing up to shake your hand and ask you whether you support Man U or Celtic. This infamous land is populated by gentle young guys, who happen to have big guns.

On the way to the compound you notice for the first time that one of your guards has stuffed