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The changing face of international medicine

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I am delighted to introduce a new international content strand in *Clinical Medicine*, and myself as the international editor. Although as a group we are UK-based, it may surprise readers to learn that 18.6% of fellows and members of the Royal College of Physicians (RCP), and more than half of *Clinical Medicine*'s non-RCP-member subscribers, are currently located beyond our borders. The RCP has a flourishing programme of international work streams, with recent highlights including a partnership with the West African College of Physicians to strengthen medical education, a project on clinical guidelines in Oman and facilitating clinical training placements in the UK for around 100 international medical graduates each year. As such, we are already an international college and journal. This new strand will reflect the diversity and constantly evolving nature of international medicine, which is traditionally underpinned by discussions of inequality to healthcare access in the developing world. We now must also acknowledge and embrace the expanding influence of globalisation, medical tourism and changing demographics to fully appreciate the impacts abroad, as well as here in the UK, and we hope that this content will bring an exciting, innovative and novel element to *Clinical Medicine*.

Over recent decades, global health has begun to occupy a key position within debate at the highest levels (the World Economic Forum, United Nations (UN) summits, G8 and G20), centring on the global burden of disease and the recognition of global epidemics of both communicable and non-communicable diseases (NCDs). While globalisation has had some positive influences in low and middle income countries, with better infrastructure and increased GNP, it has also led to some unexpected deterioration of healthcare in certain areas and populations, as demonstrated by the (possibly inevitable) failure of many developing countries to meet the Millennium Development Goals by 2015.[1] The cause of this failure is multifactorial, but it is in part related to uneven distribution of resources, including food, infrastructure and human resources. Migration of healthcare workers leading to 'brain drain' in critical areas is also a problem, particularly in remote regions where the need is greatest. This is not only a problem in low-income countries; it is also evident nearer to home in central and eastern Europe.

A further health effect of globalisation is the rapid spread of diseases across borders, with examples including the influenza pandemic and severe acute respiratory syndrome (SARS). A coordinated international effort is now essential to maintain disease control worldwide. I write this editorial in the lead up to the Olympics, where tight outbreak control strategies have been integral to the public health preparedness effort to prevent the rapid spread of transmissible diseases that can occur at such mass gatherings of large numbers of people from around the world, confined in both time and space.

The UN summit on NCDs in 2011 reiterated the need for universal access to affordable, high quality care and essential medicines for NCDs. Importantly, all four diabetic drugs on the World Health Organisation (WHO) essential medicines list are now available at low cost in generic form. Similarly, after World Trade Organisation agreements on intellectual property were addressed some ten years ago, antiretroviral drugs are becoming available globally, although in reality access to these drugs in the areas where they are most needed remains grossly hindered for many reasons, including cost. Indeed, even in wealthy nations patented drugs are a strain on an overstretched healthcare budget, highlighting that for very different reasons an international perspective on the consideration of drug usage would be beneficial. In a different context, international policies on antibiotic usage are needed to limit rapidly expanding drug resistance patterns; this is particularly topical in relation to multidrug-resistant tuberculosis. In addition, significant health harms are associated with alcohol and tobacco, yet there is a distinct lack of international policy. Tobacco policy has had some success in the developed world in reducing smoking rates, but, worryingly, advertising campaigns for alcohol and tobacco are now focussing on middle- and low-income countries with growing economies, where trade policies are often under-regulated. The challenge is to reduce these harms by strengthening policies and their implementation locally, nationally and globally.

Nearer to home, there is a demographic dimension to health inequalities. Population movement around the world is increasing and the UK has an increasingly diverse ethnic population. This has had two major effects: differing health profiles across different ethnic groups within the population and changing infectious disease epidemiology. First, there is a complex interrelationship between health, ethnicity and socioeconomic status, which first emerged in surveys carried out in the 1840s by Frederick Engels, which recorded the poor health and high mortality of the Irish population in England. Today, across many developed countries, there is a multitude of evidence showing that black and ethnic minority (BEM) populations have poorer health outcomes and poorer access to healthcare than white populations. The BEM population is increasing in the UK and services to close this health gap and specifically address these populations are needed. 'Project London' is a programme run by Doctors of the World, which helps vulnerable people access NHS services. However, cultural and linguistic barriers add to the

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complex challenge of achieving equitable access across these groups. Secondly, migrants have different health needs. A Health Protection Agency report on migrant health in 2006 showed that most of the burden of certain infectious diseases (including TB, HIV and malaria) was within a group of people who were not born in the UK.[2] It is important to ensure that we can identify and appropriately treat these patients rapidly, in order to prevent further transmission.

The consideration of healthcare systems outside the UK presents an opportunity for raising clinical standards, both in terms of high quality clinical practice and service improvement. With the government leading the most radical changes the NHS has seen since its inception in 1948, the identification of good practice within other healthcare models can potentially suggest mechanisms for cost-effective improvements. Many healthcare systems have survived significant service redesign or reconfiguration in response to economic and other pressures, and an understanding of the successes and pitfalls may be instructive. Canadian healthcare was reconfigured during the recession of the early 1990s, while the high-performing German healthcare system has seen recent policy moves to contain costs and strengthen competition. The question at the heart of the debate for every healthcare system is how universal, high quality health services can be maintained, while keeping costs down. UK health spending accounted for 9.6% of GDP in 2010,[3] approximately equal to the OECD average, although this is one of the lowest expenditures in the developed world. The proposed reconfigurations are scheduled at a time of a 4% health budget cost saving and therefore present a previously unmet challenge. Despite this, the NHS is upheld as a shining beacon of socialised healthcare, free at the point of access for every person.

Another strand which can be studied across international systems is the financial model of healthcare provision – whether involving public funding, private investment, insurance, or a mixed economy. In the UK, the role of the private sector in supporting NHS services will be evaluated in recently outsourced private units (such as providers of hip replacements) and the private takeover by Circle of a Cambridgeshire NHS Hospital. In the USA, Kaiser Permanente is a private sector, non-profit healthcare organisation primarily based in California. This model provides an example of a truly integrated approach, which is physician-led and patient-centred. Kaiser is exceptionally well regarded by many and heralded as a model of high quality, cost efficient healthcare, which many systems may try to emulate. In resource-limited settings, the private sector has an important role, with private foundations supporting global health initiatives; for example the Bill and Melinda Gates Foundation, other public-private partnerships and major pharmaceutical companies making drug donations. A novel model is run by the independent non-profit organisation ColaLife, which aims to utilise Coca Cola's virtually universal distribution network to deliver 'social products' where they are needed the most. They have designed 'aid pods' which fit in the unused space between the bottles in the transportation racks and therefore 'social products', such as oral rehydration sachets, can reach remote areas.

With the apparent inability of the global health agenda to adequately address the healthcare burden within the developed and developing world, international considerations and collaborations will help to address some of the urgent issues nationally and internationally, both now and in the future. Innovation often comes from unexpected sources and I look forward to commissioning articles and welcoming contributions on a broad remit of topics touching on this diverse range of international issues. In the words of Margaret Mead 'Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has'. I'm not suggesting we change the world, but creative, committed clinicians could change the face of healthcare worldwide!

References

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