Global Health Capacity and Workforce Development: Turning the World Upside Down

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KEYWORDS

• Global health • Health workforce • Codevelopment

Throughout this article the author distinguishes between *International Health* as a description which has traditionally been used in talking about the health of others—of people and peoples in countries other than our own—and the concept of *Global Health*, which embraces all those aspects of health shared by us all around the world. There are many of these shared concerns, as we shall see, from global pandemics to climate change and the availability of medicines, and together they reveal how interdependent we all are now in terms of our health.

This article discusses the vital importance to us all of building up the health workforce globally—as just such an example of this interdependence—and argue, further, that those of us living in the richer and more powerful countries of the world have a great deal to learn from people in low-income and middle-income countries who, without our resources and our baggage of history and vested interests, are innovating and developing new ways of tackling the spread of disease and improving health. We need, as argued by the author in the book *Turning the World Upside Down*,[1] to set aside our inbuilt assumptions and unconscious prejudices and see the world differently. We are dependent on each other and we can learn from each other.

INTERDEPENDENCE

Our most obvious interdependence is our shared vulnerability to infectious diseases and the ease with which these can now be transmitted around the world. In the fourteenth century the Black Death took 3 winters to cross Europe, in this century SARS

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(severe acute respiratory syndrome) took 3 days to spread across continents. We are all at risk and therefore, one might think, must fight such diseases together. However experience and the emergence of new diseases have shown us that this isn't at all as straightforward as it might seem. Our shared vulnerability has brought into focus issues of equity and rights.

Globally we need to share our knowledge; this also means sharing the tissues and specimens from ill and deceased people from which we can develop vaccines and treatments. However, as we have seen from recent cases, countries may not be willing to share such materials from their people if they do not believe that their citizens will share in the benefits of the drugs or vaccines developed from them. There is a real and understandable concern that these drugs or vaccines will only be available and affordable in the richer countries and that poorer countries will not get their share of the payback from a joint endeavor. The behavior of governments in both poorer and richer countries comprise test cases of whether countries can work together to counter shared threats, and a test of the will of those in the World Health Organization (WHO) and elsewhere charged with the global governance and improvement of health.

This high-profile and emotive issue can mask a low-profile and equally difficult issue. As readers of this Journal know better than anyone, the diseases that may in time become great pandemics are more likely to arise and gain a foothold from which to spread to areas and countries that have the least developed health and surveillance systems. There is more chance that they will be undetected for longer, possibly misinterpreted and perhaps, even, deliberately hidden. Moreover, there is a greater chance in such relatively weaker and less regulated health systems that our defenses against such diseases will be compromised, with uncontrolled use of drugs allowing multidrug-resistant strains to arise.

In these circumstances we all have an interest in supporting and strengthening the health systems of our neighbors. Our own self interest, let alone any moral sense or feeling of natural justice, means that we can no longer ignore the health problems of the most disadvantaged areas of the world. Issues that might previously have been seen as part of the substance and subject matter of International Health, and worthy subjects for charity and aid, have become real Global Health concerns for us all.

Our interdependence goes far beyond this. Professor Julio Frenk, the former Minister of Health for Mexico and now Dean of the Harvard School of Public Health, has identified 7 different types of interdependence, all of which need to shape our understanding of Global Health and our response to our shared problems.[2] Here it is worth drawing out 4 categories that go beyond infectious diseases. The first group are the environmental aspects of climate change, pollution, the loss of natural resources and habitats, and overpopulation, which affect us directly in many ways and can, in turn, lead to mass migration, conflict, and disease. The second is the growing incidence of noncommunicable disease, which is increasing in many countries alongside rising wealth and the accompanying change in lifestyles—itself fed by a more global culture that influences our habits—as part of an "epidemiologic transition." The third is the way in which resources which are costly and in short supply—whether they are trained health workers, equipment, or drugs—are distributed, unequally, around the world.

Sitting alongside these 3 is a fourth category, which has received less attention as yet. It concerns our scientific and medical knowledge and the way in which the traditions of Western Scientific Medicine have been, and are being, shaped and spread around the world by the interests of commerce and academia. The important point here is not criticism, far less repudiation, of science and scientific medicine.