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Education and practice

Global health equity

Every decade or so, it seems, there is a major shake-up in medical education. The current one revolves around topics with which many medical educators are unfamiliar or uncomfortable: health as a human right and the growing disparities of outcome between well-to-do and poor patients.

The burden of disease is growing disproportionately in precisely those regions most commonly afflicted by “the brain drain”. From Africa and the poorer regions of Asia and Latin America, doctors and nurses who cannot make living wages flee rural areas for cities, then make their way to industrialised countries. A decade ago, there were more Haitian psychiatrists in the city of Montreal, Canada, than in all of Haiti.¹ A more recent survey in a Kenyan teaching hospital showed that most trainees were contemplating quitting their jobs; many met clinical criteria for major depression.²

Here is the irony: more and more trainees in affluent nations seek to dedicate at least part of their working lives to benefit the world’s destitute sick,³ while the brain drain draws culturally and linguistically competent clinicians away from their home countries. What is our pedagogic plan? How can medical schools and teaching hospitals respond, with conscience and pragmatism, to the goodwill of trainees from rich countries desiring to serve in the settings that endure the exodus of their own health professionals?

Growing inequalities are at the heart of this irony. Medicine is developing evidence, but has no equity plan: we lack a rights-based

approach to its distribution. Medicine and public health goods are still parochial, limited to a few beneficiaries. We have developed no compelling strategy for medicine to exert the same global reach as, say, finance.

According to economists such as James Galbraith, there has been a sharp upturn in global inequality since about 1980.⁴ Regardless of their origins, social and economic inequalities are reflected

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epidemiologically: disparities of outcome in and between countries are now major challenges in medicine and public health. If health is ever to be construed as a human right, such disparities must be seen as the chief challenge for medical education.

What matters most, for those training the next generation of health workers, is not improved curricula in international health or tropical or geographical medicine. None of these terms captures the dilemma so well as does “global health equity”.⁵ Too much conventional international health education shrinks from acknowledging the social roots of grotesque inequalities. Too many in

medicine are unwilling or unable to confront the complexities by which, for example, financial institutions exhort poor countries to cap spending on health and education. Above all, too many of us are slow to incorporate rights into our health and teaching practices.

As medical educators, we can turn away from these complexities, shrug them off, delegate them to economists or policy-makers. However, more and more students and trainees are now eager to span the worlds of the rich and poor—which also means reducing the divide between clinical medicine and public health. Thus, we are launching, at Boston’s Brigham and Women’s Hospital, a global health equity residency. It will enable residents in internal medicine to train in public health and work to address inequalities of access and outcome. It will be underpinned by a rights-based approach to responding to growing inequalities in health. We close with a question: why only internal medicine? The same inequalities exist in surgery, psychiatry, obstetrics and gynaecology, radiology, and paediatrics. What branch of medicine or public health is not forced to confront the growing outcome gap that promises to shield the privileged, while the world’s bottom billion continue to die from readily preventable or treatable disease?

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- 4 Galbraith J. A perfect crime: global inequality. *Daedalus* 2002; Winter: 11–26.
- 5 Foege W. The wonder that is global health. *Nature Med* 2001; **7**: 1095–96.