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FROM THE EDITOR

Building Ethical Global Health Care Systems

In 2015, 87 countries had less than 1 physician per 2,000 people [1]. And in 2014, 24 of 207 independent states had no medical school; 50 had only 1 [2]. Yet there are places where 1 in 4 people have HIV [3], where tuberculosis is resistant to almost all available treatments [4], and where the average person will never celebrate his or her 50th birthday [5]. The lack of a robust health care workforce is both a symptom and a propagator of these health inequities. Disparities in global health care reveal the most blatant violations of the rights to live, succeed, and be happy—because to do any of those things, one needs to have access to health care.

Two of the biggest questions confronting the global health community are these: Who should be leading the charge to build or rebuild health care systems in resource-poor countries? Given the diversity of populations and plurality of needs, what's the "right" way—in terms of policy and infrastructure design, for example—for a system to meet unmet health needs? In this issue of the *AMA Journal of Ethics*®, we explore these fundamental questions.

One major point of contention is top-down versus bottom-up models of developing health systems' capacities to respond to health needs. Does successful health systems strengthening come from national policies and wide-reaching programs that are implemented through intergovernmental collaboration? Or does it depend on the input of the very people it is meant to help by addressing—organically and incrementally—smaller, communal problems through a patchwork of different but interconnected projects? We seem to often fall somewhere in between these two camps. Ranu S. Dhillon, an expert in health systems design and advisor to the president of Guinea during the Ebola response, and Pranay Nadella examine this tension in their commentary on a case of a US physician working in Mozambique who is urged by state medical workers to join their strike for better wages and working conditions.

But do physicians and other health care workers from resource-abundant regions (the global North) who work in resource-poor regions (the global South) really know what is best for people whose backgrounds and health and illness experiences are unlike their own? Anita Chary and medical anthropologist Carolyn Sargent explore the need for cultural sensitivity in their commentary on a case of a US physician working in Thailand who seeks to change local healing practices that lack scientific support and might even be harmful.

Cases of physicians working abroad raise the question—which the poor living in the global North might well ask—Why do physicians volunteer or work abroad when we have so many of our own problems at home? Samuel G. Ruchman, Prabhjot Singh, and Anna Stapleton discuss how medical systems and innovations developed for resource-poor countries can improve health care delivery at home—and in turn pay dividends abroad—drawing on the second author's experience devising local health care solutions for resource-poor communities in New York City.

Strains on health systems in resource-poor countries are inevitable, given finite resources, but how we react to and address these strains is of utmost importance to building health systems that are ethically sound and just. South Africa's transition from "vertical" health systems development (focused on specific illnesses) to "horizontal" health systems development (focused on integrated infrastructure) illustrates the potential tradeoffs involved in building just health systems: in 2010, financial support for HIV/AIDS through the United States President's Emergency Plan for AIDS Relief was called into question [6]; this money was potentially to be used in more general health systems strengthening [7] to help prevent other illnesses that were killing as many people as HIV/AIDS (e.g., malaria, TB, diarrheal disease, malnutrition) and to improve maternal and child health [8]. Nicoli Nattrass, an HIV expert from South Africa and a leading activist in the HIV/AIDS movement, and her colleagues Rebecca Hodes and Lucie Cluver discuss the challenges of integrating HIV/AIDS programs with general medical care in sub-Saharan Africa and the importance of AIDS activist organizations in sustaining access to antiretroviral therapy in their commentary on a case involving conflicting obligations to individual patients and donors.

Strains on health systems, however, are not only a result of shifting funding priorities. The growing concern over brain drain, which describes the transfer of physician and health worker talent from the global South to the global North, shows that poor nations' health systems are weakened by forces beyond their own borders. What role do countries in the global North play in attracting physicians who are trained in the global South and desperately needed in their home countries? How can the tension between self-advancement and communal obligation be reconciled in a way that is ethically justifiable? I and my co-authors Daniel DeUgarte and Michele Barry analyze responsibility for and possible solutions to "brain drain"—one kind of which refers to migration of health care workers from the global South to the global North—in our commentary on a case involving a surgeon who has come to the US for skills training and is tempted to remain.

Although brain drain focuses attention on the loss of physician talent, this month's issue also examines a countervailing force: medical education and the creation of more physician leaders within the global South through the building of medical schools and

other developments that contribute to health workforce growth. Tracy L. Rabin, Harriet Mayanja-Kizza, and Asghar Rastegar discuss their ten-year experience with the Makerere University-Yale University (MUYU) collaboration in Uganda, an equity-focused global health education partnership. Similarly, Peter Drobac and Michelle Morse present the framework for a novel educational endeavor through Partners in Health in Rwanda, the University for Global Health Equity. These articles highlight the potential of global North-South partnerships to improve medical training and practice if we make equity a priority.

Health systems are also affected by global policies. Jing Luo and Aaron Kesselheim discuss the impact of the Trans-Pacific Partnership—a major trade agreement made between the US and 11 other countries in Asia and South America intended to promote trade and encourage innovation—on access to medicines, particularly for the poor, in signatory countries.

In addition to exploring many of the current tensions and hurdles facing health systems today, we also reflect on the past and the future of health systems strengthening. In her historical analysis, Helen Tilley shows that medical research and treatment programs in colonial Africa brought harm to participants. Recognitions of these harms can help motivate understanding of some patients' continued reliance on African therapeutics and resistance to Western biomedical models of care. This issue also looks forward: where are health systems headed in countries with limited resources, in places where the poor continue to die of diseases that don't kill the wealthy? In the podcast, Agnes Binagwaho, the minister of health of Rwanda and an international leader in health systems strengthening, outlines many challenges that Rwanda overcame to improve health outcomes significantly while highlighting that what worked well in Rwanda might not work elsewhere.

This issue of the *AMA Journal of Ethics* brings to bear the perspectives of several disciplines—law, public health, medicine, economics, philosophy, business, anthropology, and history—in presenting, framing approaches to, and addressing ethical problems of global health care systems. It forces us to ask: Are we building health systems ethically and justly? Are we fully demonstrating respect for the people they are meant to serve? Are the builders the right people? Could we be doing this better? The answer to this last question, most certainly, is yes, and we hope that this issue allows us to take one step closer to doing so.

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