

# Coordination the name of the game to improve health care provision

By **Belinda Lawton**

The [Lancet Commission on Global Surgery](#) has garnered a lot of health policy attention in the past six months. Last week, a formal regional symposium with delegates from 16 countries was held at the [Royal Australasian College of Surgeons](#) (RACS) in Melbourne.

The day-long public aspect of the symposium was refreshing for two reasons: it wasn't an Anglo-centric meeting lecturing on what could or should be done to strengthen health care provision in low and middle income countries (LMICs); voices from across the Pacific and Asia were actively heard with national nuances canvassed seriously. Secondly, it brought together a range of practitioners from beyond the surgical silo, with frank discussion around the need for better communication.

High income country health models are segmented. Each area of medical specialisation has its own rules, norms and associations and if a patient presents outside a specialist's specific area of expertise, there is someone else available for them to be referred to. And that is the way we teach medicine: after a general medical degree, to become an anaesthetist in Australia takes five years of training.

Yet in Myanmar, for example, there are about 200 trained anaesthetists for a country of approximately 60 million people. (See Zaw Wai Soe's [presentation](#) for more data.) The practical reality of this is that many patients undergoing emergency surgery have no anaesthesia delivered at all. For neurosurgery, the

reality is even grimmer. This year Myanmar hopes to raise its training program from zero to five neurosurgery graduates.

Even where specialists are available, the practical barriers of geography, cost and transport are often impenetrable barriers to access. Health posts refer people onward believing (often falsely) the next big facility will have the expertise and the equipment to provide care. Dr Paul Farmer has been quoted on the “myth of a referral” because [“chances are there is nothing on the other side.”](#)

One of the options to quickly upskill under-served populations is shortened, practical courses which give physicians enough knowledge and skills to treat the cases they are most likely to see. It is a numbers game; in the absence of any treatment at all, skilled assistance for the most prevalent conditions is better than the alternative.

Alarming though there is limited coordination between the medical silos in what is being delivered in this training in LMICs. In the region, emergency medicine specialists providing training in LMICs seem to be a uniquely cohesive group with good systems for information sharing; but that is by no means the norm. Often within specialties there are silos within silos; many of the relationships have developed organically, with specialists dealing directly with facilities outside their associations’ formalised structures. Most associations do not have a map of who is doing what outside their officially funded training activities.

So we have a situation where medical specialists from Australia are designing and delivering high-quality compressed training options to meet the immediate needs in LMICs, but there is little coordination between those various specialities and opportunities are being missed. The cowboys [herding cats video](#) is a fair assessment of the level of coordination in health care assistance for LMICs.

This symposium showed two very promising signs for rectifying this disconnect. The first was that RACS had specifically invited groups outside their normal membership including the [Royal Australian and New Zealand College of](#)

[Obstetricians and Gynaecologists](#), [Australasian Society for Emergency Medicine](#), [Australian and New Zealand College of Anaesthetists](#), [Australian Society of Anaesthetists](#), and [Royal Australasian College of Physicians](#).

The second was the broad willingness to work together and an acknowledgement that better information sharing across silos is needed. While there is a long journey ahead, that willingness and the start of open conversation between specialties can only be positive.

To improve the health care systems in LMICs coordination really is the name of the game. If the key training providers from Australasia can get together, strengthen their own links and coordinate their approaches, one further barrier to improving health care may well be overcome.

Presentations from the symposium can be [found here](#).

## About the author/s

### **Belinda Lawton**

Belinda Lawton is a PhD candidate at Crawford School of Public Policy researching not-for-profit, non-government hospitals and clinics in fragile countries in Asia. Belinda is a communications specialist who has worked with several health-related NGOs in Timor-Leste, Bangladesh and Thailand.