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White Paper on International Hospital Partnerships

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Introduction

There is increasing recognition that we are part of a global community. The U.S. healthcare system is well positioned to join other nations in working to enhance the capacity of health services in underserved areas of the world. The purpose of this white paper is to present a case as to why collaborations between healthcare leaders in high-income countries (HIC) and low-income countries (LIC) are important. We will demonstrate potential partnership models distributed at multiple resource levels and explore possible roles for organizations in their support of international hospital partnerships (IHP).

For the purpose of this paper, partnerships are defined using a definition co-developed within African Partnerships for Patient Safety (APPS), a partnership program at World Health Organization (WHO). A partnership is a "collaborative relationship between two or more parties based on trust, equality and mutual understanding for the achievement of a specified goal. Partnerships involve risks as well as benefits, making shared accountability critical" (WHO, 2009).

The importance of establishing IHPs is currently recognized by governments and institutions worldwide. As seen in many countries, creating a nationally organized and cohesive means of support for IHPs produces a greater positive impact compared with establishing partnerships on an individual basis.

Why Are International Hospital Partnerships Important?

It is too late to say no to globalization. Our destinies in the world are unquestionably shared. Major global concerns include security interests, disease patterns, dramatic imbalance in the availability of health services, restructuring of work, pressure for resources (energy, food, water), global financial system and unsafe, unsustainable and unfair gaps between the rich and the poor. It is an incredible opportunity and a global citizenship responsibility that we find ways to participate in the solution to these issues.

The U.S. healthcare system has a rich tradition of service in LICs. This has often taken the form of medical mission outreach, typically led by a physician who has a strong commitment to providing service in the LIC. One of the most notable pieces of U.S. history in developing IHPs is the creation of the American International Health Alliance (AIHA) in 1992. AIHA was established "by a consortium of major healthcare provider associations and professional medical education organizations to help the nations of the former Soviet Union build much-needed health system capacity" (AIHA, n.d.). This remarkable and highly functioning partnership model focused on facilitating IHPs funded through agreements with USAID. Over the years, the AIHA has transitioned to focusing on academic partnerships, but the efforts that were made in the early 1990s show that numerous U.S. hospitals can come together to facilitate IHPs. This partnership model was both rewarding and helped lead to sustainable healthcare systems in places such as Georgia, Kyrgyzstan, Russia, Ukraine and Uzbekistan.

In addition to sustaining tradition, these partnerships are well placed to serve as a platform for sharing best practices. Research has found "partnerships are important because they allow an organization to come out of isolation, to think together and to transfer technology" on a global scale (Loutan, 2010). And equally as important as helping organizations expand and grow in knowledge sharing, these partnerships are rewarding for the individuals involved, allowing them to "expand the horizons of their specialty" and "build soft leadership skills, such as communication and self-knowledge" (Eastwood, Plange-Rhule, Parry, & Tomlinson, 2001; All-Party Parliamentary Group on Global Health, 2013).

The awareness of global healthcare needs is expanding, and this challenges healthcare leaders to think more broadly about their duty to community and the opportunities to fulfill each hospital's mission on a more global scale. It has become evident that "a disease incubated in one country can be around the world

in 24 hours," so "all of us…are dependent on there being sound health surveillance systems in every country" (Crisp, 2010). IHPs are able to help contribute to disease surveillance and also to have an impact on the current exponential growth of noncommunicable diseases and influence healthcare outcomes by improving the quality, education and delivery of healthcare worldwide (Blanding, 2012).

How Does Each Partner Benefit?

LIC Partner

The LIC partner benefits in four major ways. First, these partnerships help fulfill the healthcare needs and improve the care of the patients in LICs. It is clear to many people involved in these partnerships that "we already have sufficient scientific knowledge and resources available in many low and mid-income countries to save thousands of lives each year. We just do not have the systems in place to deploy this knowledge and resources effectively" (Crisp, 2010). Second, IHPs provide an opportunity for clinicians and healthcare providers to build international relationships that can help enhance care through mutual understanding and collegial friendship. Third, these partnerships can help the LIC partner educate healthcare professionals, helping to create a long-lasting and viable healthcare environment within the LIC. And fourth, "a healthier workforce is a more productive workforce," so putting partnerships in place to give healthcare providers the tools to provide better care in their community is another building block in helping LICs develop their economy (Blanding, 2012).

HIC Partner

The HIC partner also gains substantial benefits from being involved in IHPs. The first is the intangible or "soft" elements that employees gain from being involved with IHP efforts. We have heard from places such as Massachusetts General Hospital that clinicians have tremendous interest in IHP projects, and the opportunity to be involved becomes a selling point for these hospitals (P. Firth, personal communication, October 10, 2013). Caregivers want to work at institutions that focus on IHPs, which in turn increases satisfaction, engagement and retention of their workforce. Involvement in these partnerships has the potential to draw staff and physicians together in ways not otherwise seen in most institutions.

In addition to providing a means to engage employees, IHPs have the potential to increase markets and provide opportunities for the HIC partner to expand its business reach in the future. Studies have shown "many developing countries are growing fast economically and becoming important emerging markets" (Crisp, 2013). And even within current markets, multiple opportunities exist to affect care and expand business lines with "foreign governments and health systems increasingly seeking out partnership with American and international health systems to improve their quality of care" (Dunn, 2011). In addition to creating and serving the needs of these new markets, some current partnerships have discovered the value of being able to conduct needed research in a foreign partner's service area (ACHE & AHA, 2011). And, in the United Kingdom (where there are many established IHPs), some organizations have been able to draw "a connection between their work in developing countries and subsequent commercial activities in richer parts of the world" (All-Party Parliamentary Group on Global Health, 2013).

Another unique aspect of developing IHPs is the concept of "reverse innovation"—the flow of ideas from LICs to HICs (DePasse & Lee, 2013; Syed et al., 2013). Structured IHPs allow innovations in LICs to flow to HICs and can inform solutions to present-day healthcare challenges (Syed et al., 2012). Some areas where the United States can capitalize on the concept of reverse innovation and learn from LIC partners are as follows:

- *Population Health*. Due to limited resources, LICs have had "to learn how to engage patients and communities in their own care and how to prioritize promoting health" (Crisp, 2010). The methods

currently used in LICs to deliver healthcare to people in rural settings provide health education for disadvantaged communities, revolutionize the technology for mobile phone use for telemedicine and induce social change that can be brought to the United States as models that can be adapted to improve our current focus on population health (Crisp, 2010).

- *Workforce Shortage*. To combat the current pervasive fear within the United States of a healthcare workforce shortage and make meaningful changes, "workforce planners may benefit from utilizing LIC models for worker substitution, mobilization, recruitment and retention" (Syed et al., 2012). Places such as Pakistan and Malawi have dealt with their own workforce shortages, training "cadres of community workers" and focusing on the specific healthcare needs of the community through targeted training (Crisp, 2010). This narrowed focus allows healthcare workers to make substantial contributions to address local healthcare needs without having to train an overwhelming number of people.
- *Best Practices.* LICs "produce efficient and effective substitute health products and treatments" that HICs now use (Syed et al., 2012). Some of these innovative health products and treatments include homemade spacers to manage asthma in children, oral rehydration therapy to treat diarrhea, lenses used in cataract operations, care for chronic diseases such as HIV/AIDS and kangaroo mother care to regulate newborn body temperature (Syed et al., 2012; Crisp, 2010).
- *Payment Models*. As healthcare reform continues to face challenges in providing healthcare coverage to the majority of the population across the U.S., we will need to continue thinking of new and innovative ways to raise additional funds to meet current and future healthcare needs. "Assessing experiences from low- and middle-income countries can help draw lessons for policymakers who seek ideas on resource diversification" and has the potential to provide "ideas and inspiration to the often stalled efforts" of our current government (Syed et al., 2012; Berwick, 2004).

What Are the Key Lessons Learned from Current Partnerships?

Over the years the various models of IHPs have provided many opportunities for learning. Some of the most common lessons learned from current partnerships are as follows:

For LIC Industry Partner	For HIC Industry Partner	Barriers	Enablers
Simplify everything (Berwick, 2004)	Take relationship seriously (All-Party Parliamentary Group on Global Health, 2013)	Strictly HIC-to-LIC funding leads to donor–client relationship rather than one based on equality (Doyle & Kelly, 2013)	Establish mutual trust, understanding, objectives, and ownership (European ESTHER Alliance, 2013; WHO, 2013)
Take teams seriously (Berwick, 2004)	Be sensitive to the environment and culture (Longstaff, 2012)	Lack of infrastructure and support from leadership (Berwick, 2004)	Expand partnership beyond time-bound projects (Doyle & Kelly, 2013)
Be pragmatic about measurement (Berwick, 2004)	Consolidate goals and build a sustainable infrastructure (Berwick, 2004)	Mismatched expectations between partners (European ESTHER Alliance, 2013)	Customize partnership to serve both partners (Richards & Tumwine, 2004)
Manage the political interface wisely (Berwick, 2004)	Understand the similarities between LICs and HICs and capitalize on that shared knowledge and goals (Crisp, 2007)	Implementation of solutions from HICs without adapting to local context (European ESTHER Alliance, 2013)	Sufficient project budget with a funder who appreciates the value of incremental change (European ESTHER Alliance, 2013)
Start now (Berwick, 2004)	Measure outcomes and be willing to adjust as needed (P. Firth, personal communication, October 10, 2013)	Communication issues and/or language barriers (Berwick, 2004)	Realistic expectation about achievable results (European ESTHER Alliance, 2013)
Spread in stages through a well-thought-out system (Berwick, 2004)	Look for opportunities to learn from the LIC partner	Patient needs can be different in different contexts. (European ESTHER Alliance, 2013)	Integration of partnership into everyday operations (European ESTHER Alliance, 2013)

What Partnership Models Can US Hospitals Consider?

IHPs can be structured in many ways. Although determining where to start can be overwhelming, many current partnerships began with a low resource commitment and have expanded to larger and more intricate models over the years. While these partnerships do require some resources upfront, the purpose is to build capacity and mutual benefit for both partners. Additionally, no matter what the aim or resources available, each successful IHP includes a shared vision, joint planning, ownership, relationships, strong communication and a systematic process to get work done (Syed & Kelley, 2013). Some examples of current IHP models (based on their different resource levels) include:

Low Resource Commitment

- Hartford Hospital's partnership with Qilu Hospital-University of Shandong (established 1987) (ACHE & AHA, 2011). Hartford is helping to help provide healthcare services, assist in educating healthcare professionals, provide a cross-cultural experience for its staff, conduct needed research within Qilu's service area, and fulfil Hartford's mission (ACHE & AHA, 2011). Click here to learn more about this partnership.
- Gillette Children's Specialty Healthcare's partnership with Teleton Hospital in Santiago, Chile (established 2006) (ACHE & AHA, 2011). Gillette Children's initiated this partnership to help Teleton educate healthcare professionals, provide a cross-cultural experience for Gillette Children's staff and educate themselves on Teleton's care system for children with disabilities (ACHE & AHA, 2011). Click here to learn more about this partnership.

Moderate Resource Commitment

- Massachusetts General Hospital's outreach program with Mbarara University of Science and Technology (MUST) in Uganda (established 2011). Surgeons and anesthesiologists at Massachusetts General Hospital work together to provide educational resources and empower anesthesiologists at MUST by creating a sustainable perioperative training model (Massachusetts General Hospital, 2011). Improved training can have a cascading effect on patient health by creating a more functional surgical environment, improving the likelihood that anesthesiologists will stay in their local community leading to a greater capacity to perform more complex surgeries, resulting in better outcomes for patients (P. Firth, personal communication, October 10, 2013). Surgical diseases are a major problem and providing academic support to train more anesthesiologists is a key component to improving care delivery in LICs (P. Firth, personal communication, October 10, 2013). Click here to learn more about this partnership.
- African Partnerships for Patient Safety (APPS) in Switzerland (launched in 2009) is a "WHO Patient Safety Program building sustainable patient safety partnerships between hospitals in countries of the WHO African Region and hospitals in other regions." Click here to learn more about this program.
- ESTHER Alliance in Europe (established 2002) is a network of 12 European institutions. Since its founding, it has developed more than 260 partnerships in 41 countries and trained almost 40,000 healthcare professionals (European ESTHER Alliance, 2013; ESTHER, 2011). Click here to learn more about this program.

High Resource Commitment

- Partners HealthCare International (PHI) in the United States (established 1997) is a sector of Partners HealthCare System working to spread the capabilities of healthcare systems worldwide by establishing various IHPs (Mudge, 2012). Click here to learn more about this organization.

- ESTHER in France (established 2001) was developed by the French Ministry of Health (Loutan, 2010). ESTHER's "main objective is to ensure access to treatment and care for people living with HIV and AIDS" by facilitating numerous IHPs (ESTHER, 2011). Click here to learn more about this initiative.
- Human Resources for Health Program in Rwanda (established 2012) is an arrangement with 16 "academic medical centers to increase the quality and skill level of Rwanda's physicians, nurses, midwives, and health managers, while diversifying the health workforce's skill mix over seven years" (Binagwho et al., 2013). Click here to learn more about this program.
- Tropical Health & Education Trust (THET) in England (established 1988) is an organization that educates, trains, and supports healthcare providers through partnerships, strengthening health systems and increasing accessibility of necessary healthcare in LICs (Loutan, 2010). THET is a thought leader in this industry and provides valuable funding and tool kits for organizations working to establish IHPs. Click here to learn more about this organization.

Potential for Collaboration - A Starting Point for Discussion

As seen in the findings from the European ESTHER Alliance (2013) Evaluation Report, a commonly held belief is that IHP model needs to "move from faith to science." The next step is to "understand why interventions work and underpin this with a robust evidence base" (European ESTHER Alliance, 2013). We encourage healthcare organizations in high-income countries to determine how they can be part of this global collaboration and learn from organizations and people practicing in low-income countries. They should work to understand what this type of partnership can bring to each organization.

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