CONFERENCE SESSIONS

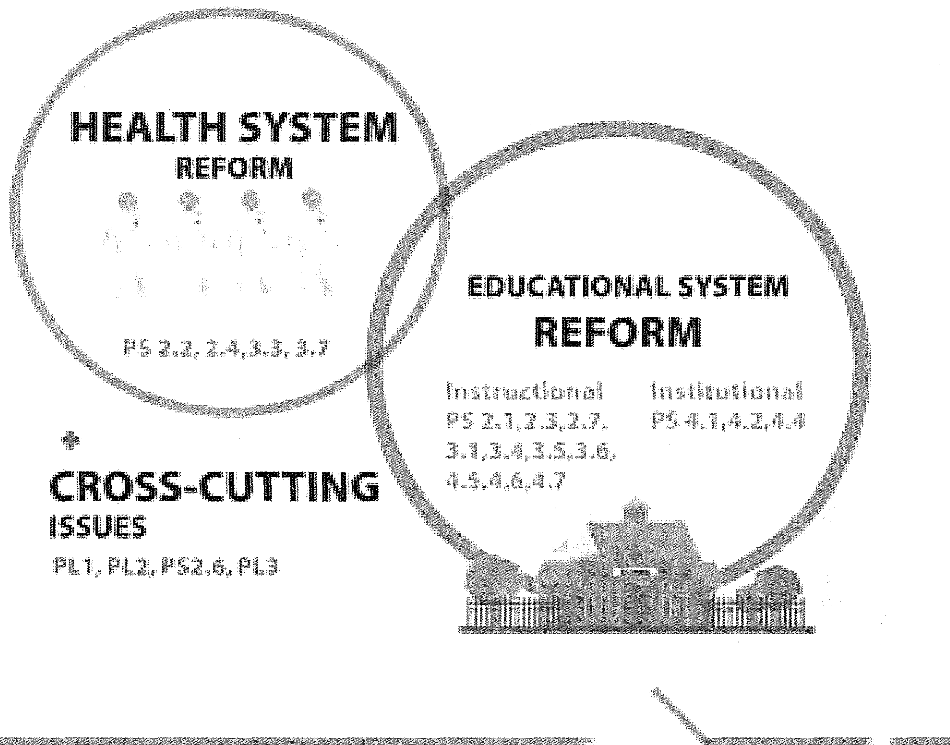


FIGURE 1

EMERGING CONFERENCE THEMES

The conference was organized into five plenary sessions and three sub-themes followed each plenary with 21 parallel sessions. All these conference sessions result in four emerging conference themes (see Figure 1). To achieve health equity, two major reforms are required: health systems reform in favour of improved access and financial risk protection; and health professional education systems reform for which two main elements, instructional and institutional reform are required. In such reforms there are a few cross cutting issues as well as other contextual environments such as demographics, economic change, globalization and health workforce life cycles that should be addressed in synergy. The ID number of Plenary Sessions (PL) and Parallel Sessions (PS) which contributed to each of the four sub-themes are depicted below each sub-theme.

MOVING FROM HRH TO LEARNING

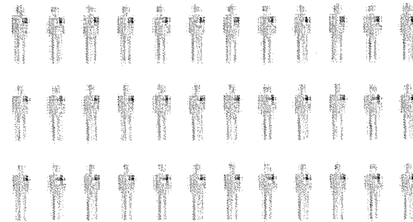
FIGURE 2

MAIN HISTORICAL EVENTS ON HEALTH WORKFORCE 2004-2014

Figure 2 depicts several key historical milestones which contributed to the global health workforce agenda movement. The 2004 Joint Learning Initiatives, set the scene and called for global attention on the health workforce. The 2006 WHO World Health Report offered the problems stream, introducing 2.28 health workforce (including doctors, nurses and midwives) per 1000 population as an indicative benchmark for minimum threshold of health workforce density contributing to high level of ANC and Skilled Birth Attendance. The 2006 advent of the Global Health Workforce Alliance at global level and the 2006 Asia Pacific Action Alliance on HRH at the Asia Pacific Regional level, contributed to national movements and several notable achievements.

After the 2006 GHWA inception, three consecutive global forums on HRH were convened: first in 2008 in Kampala, Uganda; second in 2011 during the Prince Mahidol Award Conference in Bangkok; and the most recent third forum in 2013 in Recife, Brazil. All forums contributed to sustaining global momentum on HRH. The WHO also contributed significantly, such as in the 2010 WHO Global Policy Recommendation on rural retention, the WHA resolution in 2013 on Transformative Health Workforce, the WHO SEA Regional Committee Resolution on Health Professional Education Reforms, and the 2013 WHO Recommendation on Scaling and Transforming Health Professional Education. These historical milestones have paved the way to convening the Prince Mahidol Award Conference in 2014.

CHANGING CONTEXT



As countries' health systems respond to significant demographic, epidemiologic and economic transitions, one of the most important responses will be that of health workforce policy, planning, and management. Understanding the labor market dynamics in each country, increasing proportion of ageing population, and changes of disease burden from communicable to chronic non-communicable diseases,- is therefore essential to coming up with the right solution. Supply problems in many countries have been exacerbated by out-migration and skills imbalances and quality of education (know-do gap), and HRH policies and regulations have failed to capture broader labor market dynamics (nationally and internationally), with too little attention on the growth of private sector and impact on health labor markets.

Health workforce challenges facing the majority of counties are numerous. Evidence shows that increased demand for health service, better pay and work environment are contributing factors to domestic and international migration. Along with increased demands for health and social care, demographic and epidemiologic transitions in high and low and middle income countries are occurring, requiring more effective health workforce policy, planning and management at the global level. These concerns led to the advent of the WHO Global Code on International Recruitment of Health Personnel in 2010. The growth of domestic private health markets and internal migration are key issues in these countries.

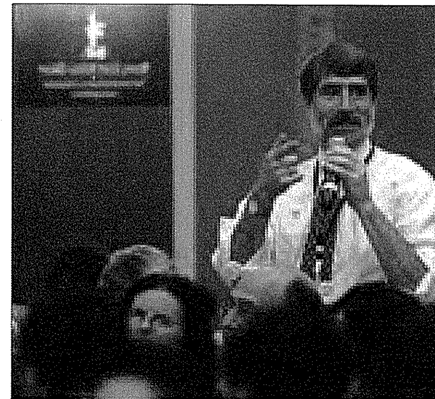
With improved socio-economic development, an increased proportion of middle classes, and the increased expectation of populations, international

labor market dynamics are driving demand for health workforce in rich countries, resulting in large scale international migration and recruitment from low and middle income countries. The WHO Global Code would redress the international migration issues, though it is the right of citizens to migrant and seek job opportunities. Added to this, student expectations for returns on medical education, private practices and specialization for higher compensation, social prestige and leisure time is resulting in over-specialization and lack of generalists and family medicine practitioners.

The structural health inequity, inadequate access to health services by the poor in rural and hard to reach areas occurring in many countries can be traced to a general lack of social accountability, both by health professional training schools, and by students and graduates themselves. The schools have yet

to adequately equip students with social commitment and inspirations to work for the poor in rural areas. Concepts of health equity and social justice are generally not in the curriculum, and this results in the "white (coats) following the green ($$$)" (student debits and career choices).

Concepts of social accountability need to be firmly embedded into medical curriculum and instructional methods of medical schools and all other associated health care professional education. Better understanding of the role professional bodies (medical association, unions and other regulators such as legally mandated health professional councils) in influencing labor markets outcomes



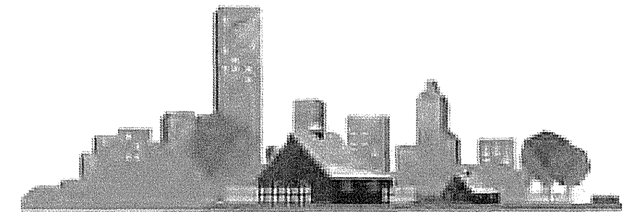
will allow intervention in the markets to make social returns as valuable as private returns – through regulation, training, and setting social values.

Health equity embedded in UHC is high on the global/regional/national agenda, and yet health delivery systems, especially primary health care usually is not equipped to provide adequate quality services. Human resources for health are still a key bottlenecks in most settings, both in number, skill mix

and responsiveness. Investment needs to be made in both number, competency and skill-mix to deliver UHC and services that are socially necessary and address skills portability (though not creating two-tier career systems). Added to this, inadequate financing and government spending on health poses a major challenge.

CROSS CUTTING ISSUES AND HEALTH SYSTEMS

> "...if I can influence
> their heart,
> I can influence
> their mind, then hands
> and feet follow."



There was a general consensus among the conference delegates that health equity, social justice, human rights, and social accountability are not explicitly embedded in the curricula and learning platforms in schools, right from primary level through to higher education. Embedding curricula with social values and concepts in addition to evidence based medicine, competencies, etc. is the way forward to create the next generation of socially responsible and responsive health care workers. Equally, educators with a 'good heart', as inspirational role models and with good leadership are essential for this to succeed. As one delegate stated,

".... if I can influence their heart, I can influence their mind, then hands and feet follow".

However it was equally recognized that there is no easy, single solution or "silver bullet"; a combination of engagement and empowerment of the community, long term vision to guide reform directions, and reforms to encompass 'broader pool of stakeholders' are all needed.

A concept that was raised many times was to apply "best practice", "best buys options" i.e. use what is known to work and what provides the best value for money. Both of these require a robust evidence base for policy making support, and a meta-analysis approach was suggested to underpin this approach.

The regular "tracking of graduates" to provide important inputs for improved school performance does not seem to happen with any prevalence or continuity. It would seem clear that it is in the best interest of all educators to collect this data and use it to push the necessary reforms i.e. respond to the marketplace and provide the right sort and numbers of graduates, with the right knowledge, skills and experiences. Data collection can be done through multiple cross sectional survey or establishment of professional cohorts.

Any reforms require stable investment in health workforce underpinned by long term political and financial commitment. A systems approach to long term solutions for improved health equity, inclusive of different cadres: mid level professionals, community healthcare workers, social workers, managers, regulators etc. is proposed. Better tools to measure and evaluate process and outcome of transformative education and health workforce performance are now becoming available e.g. the 3 Gaps model, that was widely discussed.

Several parallel sessions discussed the role of health system reform, looking at how transformative learning can improve the performance of health workers, responding to the health needs of populations by striking a balance between generalists and specialists, achieving a more integrated approach to health profession education through integrating policies, training strategies and institutional collaboration, and the importance of social accountability.

Several approaches to measuring health workforce performance / competencies were presented including vignettes, direct clinical observation, standardized patients, and the three-gaps framework. It was recognized that measuring performance helps inform HRH policy decision-

making, and that health workforce performance is linked to reforms in health professional education. Problem solving skills and a move from "know all" to "know how" requires promoting, but is being hampered by

- A dearth of evidence in the area of education investment
- Sustainability of the funding (external funding)
- Competition for good instructors across education institutes
- The need to transform routine information system to collect evidence of performance

There is a consensus that generalists add important value in health care systems and play important and effective roles to resolve population health needs and health equity. Generalists relate to many concepts and perspectives, including patient-centered care, person-centered care, people-centered care, community based care, rural doctor perspectives, and holistic approaches. However, the number of generalists versus specialists in each country is very different; in most cases, specialists significantly outnumber generalists.

To strike a balance between generalists and specialists, outcome measurements and evidence are needed to support health policy reorientation. However, all involved parties, including policy makers, health care professional, and people need to collaborate to resolve this issue for ensuring that resolution will serve the needs of the population.

Factors that influence and drive medical students or physicians to specialise were discussed. Hospital based learning for medical students is an important issue. In general, medical students are trained in and customarily exposed to tertiary care facilities rather than in primary care facilities and communities per se; therefore, tertiary care systems are the powerful magnet to increase specialists. This factor is found in countries that have a number of specialists higher than generalists, such as Thailand. However, it is not only formal medical curricula, but also other related factors that influence perceptions and attitudes of medical students toward generalism and specialism. Dr. Nick Busing raised an interesting issue

related to "hidden curriculum" that is identified as "a set of influences that function at the level of organizational structure and culture," affecting the nature of learning, professional interactions, and clinical practice of medical students.

Incentives for and retention of generalists, especially in rural areas were also discussed. Many countries reported that generalists are paid less than specialists, except in United Kingdom. Although it is a consensus that financial or salary is an important incentive for generalists, other incentives were also discussed. Dr. Steve Reid shared his opinion and experiences as a rural doctor that money plays a small part in this equation; other social recognition factors also play important roles. Job satisfaction and

self actualization are very important for retaining generalists in the health system or rural area. However, social status may influence medical students and physicians toward specialists, as found in Indonesia.

Definitions of terms "generalists" and "specialists" as well as their scopes of practices, roles, and professional identity also needed to be clarified for better understanding of these terms at the global level because balance between generalists and specialists is an important issue of health workforce and human development worldwide.

To balance generalists and specialists in health care systems, political support to strengthen capacity of primary health care is highly needed. Universal health coverage is also an indirect force toward necessity of generalists in health care systems. As a fact, most of the diseases or illness that the impact health of people can be cured or treated by generalists rather than specialists. However, there is no ideal of the exact ratio between generalists and specialists. It depends on needs of populations, capacity of primary health care, and the context of each country. Working environment, team work, and job satisfaction are also important aspects rather than absolute number of generalists and specialists in health care systems.

To strike a balance between generalists and specialists, interconnected reforms for medical education that need to transform and change focus toward community based and holistic perspectives, health system to support generalists, and economic related to payments and incentives are required. Although compulsory or mandatory service after graduation may be an effective way to retain generalists in rural areas, in the long term however, retention strategies also need to be developed.

Based on the discussion, it is clear that each country puts a lot of their endeavors to find balance between generalists and specialists in their countries to reach optimal health outcomes and health equity of their population. Many continuous studies have been conducted at both national and international levels. However, the resolution of each country will vary depending on culture, health system, and contexts. Because this issue is complex, it needs complex systematic thinking, and evidence from research to

support and resolve this important challenge.

The issue of social accountability was widely discussed. There is a need to train health professions to understand and respond to people's health. Transformative education should focus on and emphasize social accountability in regard to contributing to the constructive relationship between health professions and patients. This transformation in education can be achieved by changing the information landscape, which can be improved by making it more global, more accessible, and more instrumental.

Social accountability in transformative education should focus on values of quality, equity, relevance and cost-effectiveness in health care. Social accountability is needed as changes in information technology and increased electronic access to information has created

more expectation from patients. The core value of social accountability has a huge impact on society and responding to society's priority health challenge.

Health rights are for the patient, and have changed the accountability to society in general. There should been a clear change from what has been seen as a human right, to have more focus on community, because community orientation is also an important foundation in transformative learning. On the other side, health professional education curricula should address social determinants and social accountability and how to apply these skills and knowledge in their practice. The transformation implies not just improving the content of

education but assuming responsibility for outcomes and eventual impact of the educational institution on the overall performance of the health system.

There are challenges to address to integrate social accountability into the curriculum. Health professional associations and education institutions can play an active role in supporting transformative education that will facilitate social accountability. The social accountability movement that emerges in educational institutions should also affect other key stakeholders in the health system, such as health professions, health care organizations, and the pharmaceutical industy, as current and prospective needs and challenges will only be effectively addressed if a strong partnership is established and supported to improve quality, equity, relevance and cost-effectiveness in health care.

Another problem is the communication between doctor and patient which is often poor and professional ethics and conduct consequently suffer. This needs to be changed as the implementation of medical ethics is often poor and the teaching of ethics is not successful in many education institutions. We should also look at the public and private sectors which are very competitive, making access to healthcare distinct in a negative way. The inequality of healthcare providers in terms of telling people their rights in a clear, understandable way, particularly in private hospitals, must be tackled with more transparency.

Education leaders should include ways to address the social accountability issues in education, health professional councils and other groups of people in society. The address here is to focus on the key principle of social accountability and fairness in delivery of health services. Inter profession teamwork is a very important approach to provide health services and