

PRACTICAL ADVICE

Building a Socially Accountable Health Professions School: Towards Unity For Health

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ABSTRACT *In many countries, health systems suffer from fragmentation as different health activities conducted by different stakeholders are poorly coordinated, resulting in a mitigated performance to improve quality, equity, relevance and cost-effectiveness in health care.*

The impact on health would be enhanced if main stakeholders such as health professional schools, service organizations, professional associations, health policy bodies and the general public shared a common vision on how to best meet people's priority health needs.

An approach initiated by WHO in 1999 and developed by The Network: Towards Unity for Health endeavours to create a unity of purpose and action among these stakeholders. This article comments on challenges and opportunities in implementing this approach whose pillars are integration and partnerships. The conditions for each stakeholder to become more socially accountable and the role of a teacher, researcher, manager or community representative in contributing to this process are discussed.

KEYWORDS *Health system, social accountability, unity in health, integration, partnerships.*

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What is Social Accountability?

Recently, the Dean of a medical school in a developing country mentioned that his school prepared the best doctors in the whole region. The argument he gave was that his graduates were having the highest scores on the US medical licencing

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examination test. And he proudly added that half of his graduates could now be found practising in the US and in Canada. His school is indeed well known for its excellence in medical education, implementing a community-oriented and problem-based curriculum and various innovative didactic techniques. But this is not sufficient to be graded a socially accountable medical school.

What are the striking issues in this case? The medical school is located in a country where people have poor access to essential health services, particularly in rural areas which count for 75% of the nation. The graduates are well-trained according to the standards of medical schools in other countries. They are in medical training for seven long years at a high cost to this poor country only to have the graduates go to richer countries. This, then, worsens the poor country's shortage and maldistribution problems.

Questioning the Basic Assumption

This very good medical school works on an assumption: that the good education of health professionals ultimately provides good health to the nation (Table 1).

However, this assumption is usually wrong. A good education for the health professions does not necessarily provide the nation with good health. There are other factors involved, such as the career choices of graduates, attractiveness of the most needed health careers, incentives and rewards for primary health care, fair geographical distribution of the health workforce, engagement of health professionals in community/public health programmes, working in multi-professional teams, creating models of health services that integrate personal care and public health, designing strategies to ensure quality in health care services, and formulating health policies that influence the health care system.

Educational institutions that are socially accountable adopt the position that these issues are too important to be left to others alone for resolution. The school feels accountable to its society and considers its mandate to include such things as following-up graduates and assisting them in preparing their future working environment (Gary *et al.*, 1999; Boelen, 2002). Thus, socially accountable schools dare to look beyond their immediate educational interventions and therefore, find themselves exploring alternative ways to adapt health systems for a better use of their graduates (Hallock, 2001; Health Canada, 2001). Bringing coherence among different stakeholders or partners—educational institutions, health service organizations, professional associations, policy-makers and the public—is quite a challenge as each has specific features,

Table 1. Questionable assumption

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1. Good education
 2. Good doctors
 3. Good practice
 4. Good health
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references, traditions, expectations and privileges. This leads inevitably to competition and conflicts of interest.

In many instances worldwide, efficient partnerships do not exist while fragmentation and overlapping within national or local health systems prevail, causing poor performance in achieving quality, equity, relevance and cost-effectiveness in health care. The so-called health reforms, which have been tried out in the last two decades and are mainly characterized by various administrative and financial arrangements, have brought little convincing evidence of their capacities to make significant improvements in health systems and people's health. Indeed, harmony between personal care and public health remains a distant target for both poor and rich countries.

Lessons learnt point out that health system reforms will only be productive and sustainable if the main stakeholders or partners share a common perception of how people's priority health can best be met. These stakeholders include: health managers, policy makers, practitioners, communities, and academic institutions (see Figure 1).

They must sit around a common table with a common agenda that provides " ... health services based on people's needs." (WHO, 2000). Each partner must have a commitment to the following three items:

- willingness to revisit their mandate and make institutional changes for a better use of their resources in consonance with a common set of values, i.e. quality, equity, relevance and cost-effectiveness;
- contribution to designing and implementing innovative models of health services whereby personal care and public health for a target population are integrated;
- engagement in long term partnerships using complementary strengths in a coordinated and mutually beneficial fashion.

Each partner must realize that their own objectives will not be met without the contribution of the others. The prime mover for a change in the health system may be any of the above health partners, but coalitions with others must be built progressively and steadily. For instance, a tobacco cessation programme may be initiated by a national association of general practitioners, but to be successful a coalition with other partners is indispensable. For example, health authorities would declare it a priority and provide adequate legislative support for disincentives for smoking; clinics for heavy smokers would be subsidized by health service organizations; educational institutions would prepare graduates with skills in health and patient education; communities would support prevention programmes in schools and factories.

The tree and the forest

Unity in action is a synonym for a systems approach. Every organization or institution represents an element of the system, or a piece of the puzzle, or a

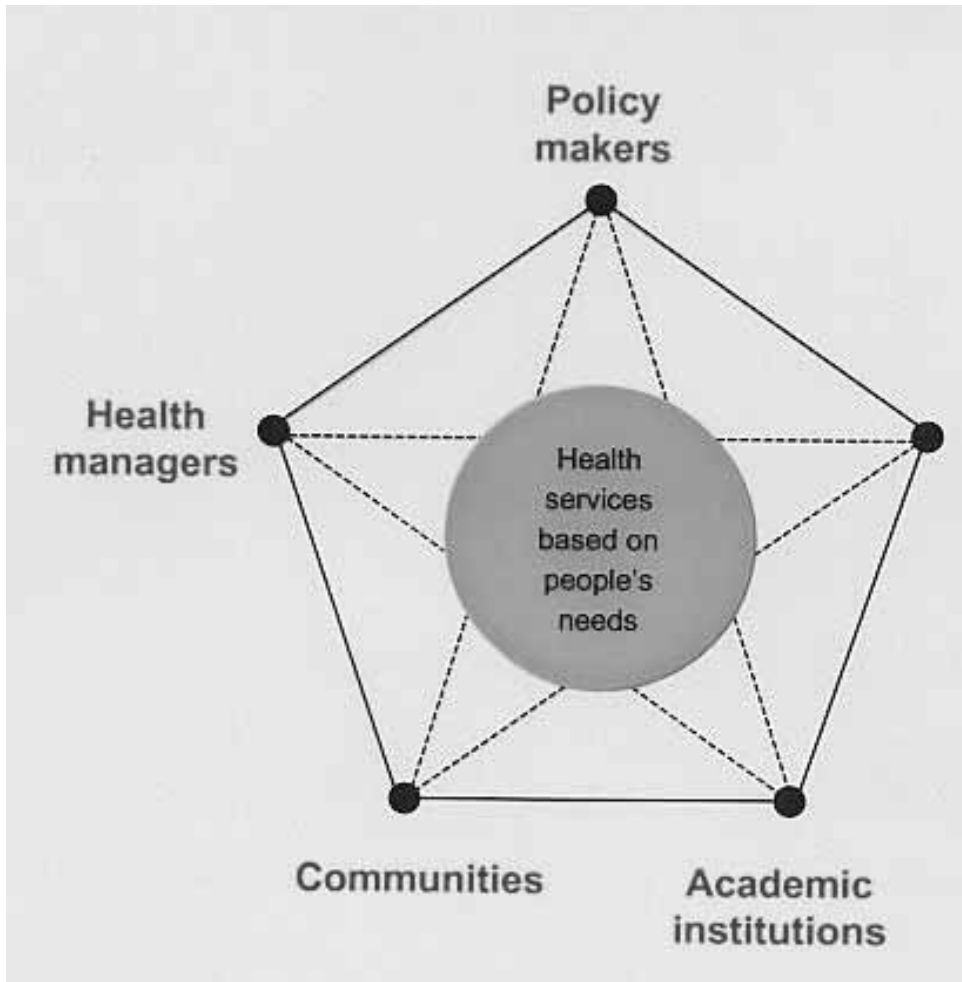


Figure 1. Pentagram of unity for health

tree in the forest. Our assumption is that a better perception of how the different pieces of the puzzle fit together, or how the different trees make up a forest, or how different organizations or institutions interact within the health system gives a definite advantage. This does not go without challenges as well as expectations.

Putting the common interest ahead of a particular interest and contributing to unity in the health system represents a cultural shift for many organizations and institutions and inevitably requires important adjustments.

For instance, integration of health services, i.e. centralizing a set of health activities otherwise managed by separate entities, may be perceived as a loss of control and authority. Similarly, partnership, i.e. contracting with other agencies, may mean a loss of autonomy and privileges. In addition, there are

few rewards for venturing in this new area of work as funding is biased toward vertical activities conducted by one partner over horizontal activities conducted by a consortium of partners. Finally, models documenting how unity can best be built and evaluated are not yet available, which adds to the adventurous character of the undertaking.

Why progress is being made

In spite of the great enthusiasm and expectations of the Alma Ata Declaration, a quarter of a century has passed and the goals have yet to be achieved (WHO, 1978). That is partly because the Declaration did not include an efficient strategy to mobilize main stakeholders and create a momentum towards unity of action around the common cause.

However, in recent times, encouraging initiatives have been taken at global and national levels. For example, in 1995, the World Health Assembly passed a resolution for the reorientation of medical education and medical practice for Health For All (WHO, 1995). Also, in 1999, WHO launched the approach “Towards Unity for Health” and supported 12 field projects worldwide that experimented with the approach (WHO, 2000, Boelen & Neufeld, 2001).

In 2002, an international non-governmental organization in official relations with WHO “The Network: Community Partnerships for Health through Innovative Education, Service, and Research” founded in 1975, amalgamated with WHO’s initiative “Towards Unity for Health”. This resulted in the expanded: “The Network: Towards Unity for Health”, which welcomed the membership of other health partners (The Network, 2002).

Also in 2002, WONCA, the world organization of family doctors, with the perspective of reviving primary health care policies, expressed interest in issues beyond the practice of family medicine and published the guidebook “Improving health systems: the contribution of family medicine” (WONCA, 2002).

In 2004, in the wake of a reform of the national security system in France, the union of general practitioners will hold a national congress to study the feasibility of their becoming coordinators of health services at the community level.

Interestingly, an analysis of the wider health context is being made from different angles by different stakeholders worldwide, all with the intention of moving forward on the notions of social accountability and partnership.

What should I do?

There is indeed room for anyone, be it a teacher, a practitioner, a researcher, a health manager or a social activist to participate in the process of building unity for health (Table 2). One should not be intimidated by the complexity of the task and always remember that innovative projects have often started with the commitment of one person. For each step that is listed below, a text in italics gives some examples of how one could practically be involved.

Table 2. What can I do?

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- Principles
 - Population
 - Partnership
 - Integration
 - Information
 - Impact
 - Institutionalization
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- **Principles.** Each stakeholder/partner should adhere to the basic principles or values on which the process of unity for health is built, namely: quality, equity, relevance and cost-effectiveness. *You may promote these values and suggest explicit reference being made to them in the mission statement of your organization or institution. You may review your programme of work to determine its consistency with the above principles. For instance, as a teacher, you may adapt a curriculum; as a practitioner, you may extend your services to vulnerable groups in the community; as a researcher, you may direct your investigation to the highest priority issues of your health system; as a community leader, you may advocate these principles to voluntary groups.*

- **Population.** Each organization or institution should be convinced of the importance of targeting a defined population as the ultimate beneficiary of its actions. People's health concerns should be addressed by taking also into account the family, social and environmental context in which they live. There should be a recognition by each health partner of a willingness to assume a shared responsibility in maintaining good health in the population.

For instance, in a medical school you might convince the leadership and staff to delineate a geographical area in which education, research and service activities will be conducted; as the manager of a disease control programme you may identify sick people as well as people at risk and extend preventive as well as curative services to an entire population; as a general practitioner you may wish to extend the tobacco cessation programme beyond your smoking patients to a larger group of people at risk.

- **Partnership.** Alliances are essential for a sustainable impact on people's health. Therefore, collaboration should be sought with other organizations or institutions.

You may wish to start a collaborative arrangement with one partner of your choice. Later you can consolidate it in firmer terms and extend it to other partners. For instance, as a teacher you might be concerned about the condition of street children. In addition to your teaching activities on the

subject, you may invite charitable organizations already active in the community to meet with students in the school as well as in the field. Encouraged by the strength of this first partnership, you may now wish to extend it to local health and social authorities for a city-wide and district-wide programme and progressively involve health clinics both in the public and private sectors.

- **Integration.** Part of the unity building process is to bring the multiple health services available for an individual or a population into a coherent and comprehensive delivery system. Specialized individual care services should be closely interrelated, which, in turn, should be linked to public health programmes.

You may wish to create some of these important bridges. As a teacher you may promote multi-professional education. As a family doctor you may use a patient record to follow-up all care given to a patient and his/her family, and share it with members of a health team. As a researcher you may design innovative models of health settings integrating clinical care and population-wide health programmes. As a policy-maker or a health manager you may provide incentives to support such experiments.

- **Information.** Unity in health can be enhanced if health information is widely shared. Making available to all the same sets of data on health risks, activities, expenditures and status for a given population indeed has the merit of associating health partners in the identification of priority health issues and need for better coordination. In many instances, the circulation of health information is restricted, i.e. patients' records, annual reports of health institutions, consumption of drugs and technologies, social and health statistics, environmental risks. What can be done to disseminate this information to all those who can make good use of it? How can a common pool of essential health data on a target population be at the disposal of all partners?

You may seek to obtain health information on the community in which you work, i.e. refer to epidemiological data. You may explore the willingness of other health partners to share their data periodically while confidentiality is protected. You may invite media to inquire on health expenditures and people's health expectations. You may convince local health authorities to design a system to collect, analyse and dispatch routine health information.

- **Impact.** Unity is strengthened if health partners use a similar framework to assess their impact on health. Reference should be made to quality, equity, relevance and cost-effectiveness, which are the basic principles and values advocated for incorporation in the mission statement. Each partner should be committed to gauge their performance not only in terms of intermediate products, i.e. number of trained graduates, articles published in scientific journals, health centres built, hospital beds, performed medical acts, volume of health expenditure, but also in terms

of improved health care and health status of the population it has a mandate to serve. As a mark of social accountability, reports should be made public.

You may question the extent to which the activities of your department or area of work have contributed to the quality, equity, relevance and cost-effectiveness in health. You may organize or participate in a forum to raise an awareness on similar issues. You may seek recognition from health authorities and obtain funding from donor agencies by bringing evidence that your organization or institution made an impact on health.

- **Institutionalization.** Creating unity is not a time-limited project, but an important measure in health system development. Each partner carries a responsibility for making necessary institutional adjustments. The mission statement of the institution should be reviewed. New activities related to integration and partnership should be initiated and properly funded. Standards used in accreditation should illustrate input, process, outcome and impact events. Political leadership should support organizations and institutions in their initiatives through appropriate legislative and financial measures.

You may wish to publish and disseminate your work for the advancement of unity for health. You may participate in national or international networks linking individuals and groups with similar objectives. You may lobby for an official statement or formulation of a national policy recognizing the value of creating unity in health. You may advocate the incorporation of elements of social accountability in current accreditation mechanisms.

In conclusion, it seems that for any initiative to have a sustainable impact on people's health, the creation of a momentum towards unity is not just an option but an essential prerequisite. As with any pioneering journey, the road is not without challenges and the rewards do not come soon. But the determination is great with the awareness of new opportunities for exciting research and development in advancement of health.

References

- BOELEN, C. & NEUFELD, V. (2001). *Towards Unity for Health*. Case studies, World Health Organization. Document WHO/EIP/OSD/2001.1, Geneva.
- BOELEN, C. (2002). A new paradigm for medical schools a century after Flexner's report. *Bulletin of the World Health Organization*, 2002, 80(7), 592–593.

- GARY, N., BOELEN, C., GASTEL, B. & AYERS, W. (1999). *Improving the social responsiveness of medical schools: proceedings of the 1988 Educational commission for foreign medical graduates/World Health Organization invitational conference. Academic Medicine*, 74(8) (suppl.)
- HALLOCK, J. (2001). Medical schools and health care. Towards Unity for Health newsletter, No. 4 , 1–3, Geneva: World Health Organization.
- HEALTH CANADA (2001). *Social accountability. A vision for Canadian medical schools.* Ottawa, Canada: Ministry of Public Works and Government Services.
- THE NETWORK: COMMUNITY PARTNERSHIPS FOR HEALTH THROUGH INNOVATIVE EDUCATION, SERVICE, AND RESEARCH (2002). *Report of a meeting of Network Executive committee and TUFH advisory committee*, Caltanissetta, Sicily, 2002.
- WORLD HEALTH ORGANIZATION (1978). *Alma-Ata 1978: Primary health care. Report of the international conference on primary health care.* Alma Ata, USSR, 6–12 September 1978. Health For All series No 1.
- WORLD HEALTH ORGANIZATION (1995). *Resolution of the World Health Assembly: Reorientating medical education and medical practice for Health For All*, WHO 48.8.
- WORLD HEALTH ORGANIZATION (2000). *Towards Unity for Health. Challenges and opportunities for partnership in health development.* Document WHO/EIP/OSD/2000.9, Geneva.
- WONCA: WORLD ORGANIZATION OF FAMILY DOCTORS (2002). *Improving health systems: the contribution of the family medicine.* Singapore: Bestprint Printing Company.