REPORT OF THE WORKSHOP

RELATIONSHIPS OF MEDICAL SCHOOLS AND MINISTRIES OF HEALTH

Professor Panabokke (Sri Lanka), in his discussion of the relationship between medical schools and ministries of health (see text of his keynote speech, on preceding pages), identified five areas which needed particular attention, namely:

(a) the collection of basic information on health conditions in the community;

(b) the identification of problems, based on the data so obtained;

(c) the formulation of objectives for the solution of these problems;

(d) the establishment of operational mechanisms for their solution, and for the evaluation of the results applying these mechanisms;

(e) the allocation and distribution of resources.

2. Dr Jagjit Singh (Malaysia), considering the relationship from a ministry of health point of view, suggested that the present organisational structures of ministries of health and medical schools did not allow sufficient co-ordination. He thought that closer co-ordination should be achieved in four areas:

(a) administration;

(b) training;

(c) consultant/advisory functions;

(d) research.

He illustrated these suggestions by describing the situation in Malaysia.

3. Professor Casselman (Canada) gave two Canadian examples of the type of relationship that could be established between medical schools and ministries of health:

(a) the Outreach Program of the Health Sciences Faculty of the University of Western Ontario, designed to reach the remote areas of the Province of Ontario;

(b) the development of teaching health units, analogous to teaching hospitals.

4. In the general discussion a number of participants described, and commented on, the relationships between medical schools and ministries of health in their respective countries. It was evident that a communication gap existed and it was felt necessary that this gap should be bridged.

5. A mechanism suggested as useful for bridging the gap was a national health development council or committee, with the required political commitment and with appropriate representation from the ministry of health, the ministry of education and the medical schools. It was further recommended that this council or committee should establish sub-committees with responsibility for particular areas, such as education, manpower planning, manpower production and research.

6. Some of the attempts at bridging the gap which had been made so far depended on informal, personal working relationships; but there was a need to reinforce these by making more formal arrangements.

7. Difficulties in obtaining adequate political support were recognised. So also were difficulties that arose as a result of decisions made on purely political grounds.

8. Concern was expressed at the insufficient co-ordination and co-operation between ministries of health and medical schools in their respective functions. This led to conflicts between political decisions as implemented by the ministries, on the one hand, and the academic autonomy of the medical schools on the other.

9. Another area of concern was the adminsitration of ministry of health hospitals which were used by medical schools as teaching hospitals. It was considered that problems which arose might be solved if such teaching hospitals were managed by boards of management on which ministries of health, medical schools and the community were represented.

10. The types of doctors trained in medical schools for community health care delivery were also scrutinised by the workshop. It was agreed that for this purpose the "super-generalist" (i.e. general medical specialist) would fulfil a more useful function than the "super-specialist". But while the requirements of the community and ministries of health favoured the production of general medical specialists, the medical schools were oriented to the training of the "super-specialist".

11. It was suggested that co-ordination between ministries of health and medical schools should be promoted through joint representation at international meetings where matters concerning health care delivery were discussed. This would encourage joint decision-making, the desirability of which was repeatedly endorsed during the discussion. It would also constitute a recognition of the need for, and would make possible, the best use of scarce resources, which were a constraint common to the majority of Commonwealth countries.

Recommendations

12. The workshop made the following recommendations:

(a) Commonwealth ministers of health, deans of medical schools and representatives of the health professions should jointly establish effective means for discussions on, and the preparation of, agreed joint plans of action for national health development.

(b) Ministries of health, ministries of education and deans of medical schools should jointly strive to establish formal national health councils, or similar advisory organisations, which might incorporate the concept of the national health development network put forward by the World Health Organisation.

(c) The national health councils should include in these areas of concern national health policy formulation and implementation; multi-sectoral health planning, monitoring and evaluation; health manpower and development; and the development of health services. The councils should provide opportunities for the exchange of views on health matters of mutual concern, and should advance better mutual understanding, between the ministries and the medical schools/universities on specific issues and on their respective roles and objectives.

(d) The national health councils should establish medical and health education sub-committees with representation by appropriate personnel from medical schools, ministries of health, ministries of education and health professional associations.

(e) The medical and health education sub-committees should advise on the formulation, implementation and monitoring of national medical and health education policies appropriate to the needs of their countries and consistent with the general national health policies. The medical and health education policies

should be drawn up for each category of health professional, including medical undergraduates and postgraduates and all other categories of health workers.

(f) National health councils should likewise establish other sub-committees for such important areas as health manpower planning, health services research and medical research.

MEDICAL SCHOOLS AND COMMUNITY HEALTH EDUCATION

13. Professor Sir Kenneth Standard (University of the West Indies) described as background to this item into the development of community medicine in the medical faculty of his university (see also his paper, included in the documents section of this report). Under this programme medical students had received some of their training while living and working in the community itself. They also gained experience in basic epidemiology through project work which exposed them to some of the socio-cultural determinants of health and disease. The medical faculty had also assisted with the training of health workers other than medical students, some of them in joint courses with medical students.

14. Experience with the community medicine programme had indicated that community participation might be improved as a result of including health education as an integral part of the training courses.

15. Professor Standard concluded his presentation by suggesting some guidelines for further action and certain proposals and recommendations for consideration by the workshop.

16. Dr Pathik (Fiji) presented a paper (included in the documents section) reflecting the views of his ministry of health on modifications of the medical curricula to make the training of medical students more appropriate for the purpose of meeting community needs, an approach much appreciated by ministries of health. He pointed out that medical schools could be considered a pivot for community health education. For community health education to be effective, however, close liaison between ministries of health, ministries of education and medical schools was essential. Voluntary organisations active in the community and professional associations should also be involved.

17. The workshop agreed that medical schools had an important responsibility in connection with community health education, and that health education was a vital component of community health development strategy. The problem, however, concerned the responsibility for transferring knowledge and imparting health education to the community. It was suggested that doctors themselves, besides other health personnel, should perform this role.

18. The workshop considered some of the constraints preventing the orientation of medical education and medical practice towards the development of community health. It was felt that the concept of a "doctor" should not be restricted to the technical aspects of medical practice, but should include the role of the doctor in health education and community health development. The orientation of their training was an important determinant of the attitudes of medical trainees. Indeed, the success of some recent community medicine programmes appeared to be the result of greater awareness of community needs.

19. It was agreed that, in order to encourage the participation of doctors and specialists in community health work, appropriate basic facilities, equipment and incentives should be provided.

20. The workshop urged greater participation in community health training and education activities by all departments of medical faculties, so that medical students

should be brought to appreciate the joint role of all in community health development.

21. Correspondingly, joint training of medical undergraduates, nurses, health inspectors, midwives and other paramedical personnel was urged. It was felt that the joint learning experience would serve as a basis for team work, since promotion of interdisciplinary collaboration was an essential foundation for successful community health development.

22. The need for collaboration between medical schools, ministries of education, ministries of health and international agencies was also endorsed, as close links between them would promote the necessary team approach.

23. The importance of community participation was emphasised, not only for imparting knowledge but also for awakening people's sense of responsibility for the maintenance of their own health and that of their families and community.

24. The desirability of expanding the role of medical schools to include participation in the training of other health personnel besides doctors, such as nurses and paramedical staff, was also stressed.

25. to achieve these objectives, the workshop considered that training in the techniques of mass communication, information transfer, and management skills should be an essential component in the training of health personnel. Medical schools should be resource centres, providing guidelines on health education for schoolteachers, including teachers of pre-school children, and for children themselves. They should also provide facilties for the continuing education of health workers at post-basic and postgraduate level.

26. Learning experience in practical situations in the field was as effective as formal training sessions, if not more so, since "involvement" was seen to be the crux of the desired change of attitudes towards more effective delivery of community health care.

27. An example of how better community health could be promoted was the establishment of "doctor in the clinic" or similar radio or television programmes, linking medical personnel with the community.

28. The workshop recommended that specialists in health education should be trained, in local settings, and made available to give direction and advice in health education services.

29. It was recommended that there should be a **clear policy statement** from the highest level regarding health education, including school health education, not only to give guidance for action but also to indicate the priority given to this important area of community health development.

30. It was also recommended that there should be a well-organised health education unit strategically placed within the administration of each ministry of health in order for it to function effectively.

Recommendations

31. Having accepted that the training of a doctor should include, and place appropriate stress on, his or her role in health education and community health development, as well as the technical aspects of medical practice, the workshop made the following recommendations.

(a) Medical schools can and should play a role in community health education by developing interdisciplinary programmes for health education. One way to do this would be to hold seminars, workshops or short courses for health professionals and

for medical students, student nurses and other health trainees - in recognition of the distinct advantages of having these different categories together for such activities.

(b) There should be active encouragement of, and incentives for, health professionals to work in community health development.

(c) Medical schools, ministries of education, ministries of health and international agencies should collaborate to promote the team approach which is a vital component of community health development.

(d) The training of health personnel should include techniques of mass communication and information transfer to the community, and the imparting of management skills should be an essential component. Techniques used should emphasise field-based learning experience in practical stituations in addition to formal classroom training sessions, since "involvement" effects faster changes of attitude.

(e) Medical schools should be resource centres, providing guidelines on health education for the community, including teachers and also children.

(f) Medical schools should provide facilities for the continuing education of health workers at post-basic and postgraduate levels.

(g) In order to achieve the maximum impact in community health education programmes, appropriate use should be made by ministries of health and ministries of education, in conjunction with medical schools, of the public communication media: press, radio and television.

(h) Specialists in the field of health education should be trained and made available to give direction and advice in the health services of each country.

(i) Ministries of health and ministries of education should make a clear policy statement from the highest level regarding health education and school health education, where this has not already been done, not only to give guidance for action but also to indicate their commitment to total community health development.

(j) All local development staff should be utilised as much as possible, under the guidance of district medical staff and specialist health education workers, in the implementation of community health education programmes at grass-roots level.

MEDICAL SCHOOLS AND PRIMARY HEALTH CARE

32. Professor Fendall (formerly of the Liverpool School of Tropical Medicine, Britain) introduced his paper (included in the documents section of this report) with a brief historical summary of the development of health services, medical schools and health manpower in general. He viewed primary health care as part of the overall socio-economic development process, existing at various levels. Although all countries wished eventually to have professionally-manned health services, most had to settle for a mixture of professional and para-professonal personnel. The objective of primary health care was to bring health services into closer and more intimate contact with the family in its own setting, having regard at the same time to safe arrangements for referral.

33 In order to determine an appropriate delivery system and suitable educational courses within the resources of each country, Professor Fendall advised a systems analysis approach involving social, epidemiological and facility services, and task and job analysis. These aspects were portrayed in diagrams appended to his paper.

34. Development was a complex process; the role of the physician in this process had to be determined and the composition of the interdisciplinary health team defined.

Medical schools had a considerable role to play within primary health care in teaching, research and services. But the first requirement was that they should become informed about primary health care and that they should relate their activities to agreed national policy decisions.

35. The options open to medical schools ranged from no participation, a co-ordinating role in teaching and research, a consultant and advisory role, an active co-operative role assisting in teaching, research and evaluation, to a total activity in all aspects.

36. Expanding on these various options, he mentioned in particular the need for the design of specific curricula and lesson content, for the design of teacher training and management courses in primary health care, for the preparation of research protocols, and for evaluation studies. Special attention needed to be given to the curriculum of the medical student. Studies were required to determine circumstances in which referral was required, and to determine the input of various specialities into primary health care activities.

37. Professor Fendall considered that the medical school should be mindful of its role as an integral part of the university in ascertaining and affirming the aspirations of the society it served in respect of health care. He warned that primary health care was not a cheap option, providing simplified care, but was likely to result in an increasing demand for resources, facilities and manpower, and a considerable increase in the need for referral care. He saw virtue in medical schools expanding into faculties of health sciences, in order to give reality to the health team concept. He also referred to the potential of traditional practitioners for primary health care.

38. Dr J J Thuku (Kenya) introduced his paper (included in the documents section) by pointing out that, despite an internationally-agreed definition of the term "primary health care", the application of the concept varied in different parts of the world, to meet a variety of actual conditions and aspirations. Essentially, it implied a change in the pattern of resource allocation to give more attention to the needs of rural communities, at present disadvantaged. Its application was thus likely to arouse resistance from policy-makers who tended to be members of the more advantaged groups and reluctant to give up what they already had. It was consequently necessary to convince those at the highest political level, and also the professionals, of its desirability.

39. All countries were committed - at least, in theory - to provide health for all by the year 2000, based on the primary health care concept. Among the many things to be done an important one was to get medical schools to influence medical students, at both undergraduate and postgraduate levels, so that they would fully understand the concept and facilitate its implementation.

40. Medical schools could do this in a number of ways: for example, by modifying their criteria for the selection of medical students, by modifying curricula, and by bringing medical students into contact with other health workers at an early stage of their training. Kenya's faculty of medicine had been involving its students in rural realities since its inception. The periods during which they worked in rural settings might not be long enough, however. There were financial constraints and external assistance might be needed to overcome these.

41. In the workshop discussion of this item, basic issues which were considered included:

(a) the definition and scope of primary health care;

(b) the acceptance of primary health care by faculties of medicine and ministries of health as a vital part of the strategy for health for all by the year 2000;

(c) ways of increasing the involvement of medical faculties in primary health care delivery.

42. It was agreed that primary health care was vital in community health development, but doubts were expressed as to whether its acceptance as such by faculties of medicine and ministries of health was universal. It was also agreed that primary health care should not be the isolated concern of the department of community health, but that it should permeate the entire spectrum of activities in the faculty. This necessitated the identification of areas relevant to each department or discipline: for example, what constituted primary surgical care, primary medical care, and so on.

43. The identification of community needs was considered important for the planning of primary health care delivery systems, and it was felt that generalists rather than specialists were required for community work. Primary health care delivery involved political, social and cultural factors outside the scope of medical schools; attitudes towards community health were determined not only by medical school curricula but also by the needs and demands of society.

44. The need to evaluate primary health care activities, and techniques for doing this, were also discussed. Areas suitable for attention were seen to include the content of care, acceptability to the community, and success in reaching targets.

45. It was accepted that the promotion of primary health care must vary from country to country, depending on such factors as population structure, health priorities of the community and differing roles of health personnel.

46. As regards training for primary health care work, participants were agreed on the importance of non-formal exposure of medical students to field conditions and of learning experience through involvement in field situations for sufficiently long periods.

47. The importance of various categories of staff needed for primary health care work was discussed. The essential role of paramedical staff was emphasised, and their existing contribution was given due recognition. A key factor for the success of primary health care was seen to be the selection of medical trainees for primary health care work. Should they be drawn from rural areas, in the expectation that they would return after training to serve such areas? - It was recognised that this expectation was seldom realised. The causes of this were discussed, and it was felt that poor rural conditions and the absence of incentives were contributory factors.

48. As for the cost of primary health care programmes, it was recognised that expensive inputs were required and that the optimum use of existing resources and facilities would have to be made.

49. It was thought desirable that the various categories of personnel should be complementary in their functions, rather than constituting a hierarchy of separate classes of low-tier and high-tier staff. This should be borne in mind in relation to their training (and their emoluments). For all categories of trainees, the conventional curricula were seen to be deficient in motivation towards primary health care and in generating the required attitudes to it.

50. One of the topics raised by Professor Fendall which was discussed at length was the extent to which medical schools, in relation to primary health care, should be involved in both training and delivery, in training undergraduates and para-professional staff (including non-medical staff from relevant government departments) and in postgraduate training. Although several participants suggested that medical schools were already overburdened and doubted the desirability of them becoming involved in primary health care, most thought that they should be so involved. On the question of whether training in primary health care should be given separately within the medical faculty or whether programmes involving all departments of the faculty should be devised, the consensus was in favour of multidisciplinary involvement; this was considered more useful than isolating primary health care activities in a single department. Another approach suggested was an extended internship to include primary health care.

51. There was general agreement on the need for a permanent body composed of both medical faculty and health ministry representatives to co-ordinate planning, for an active role by the medical faculty in relation to primary health care delivery, and for every health facility in the field to be used for teaching purposes.

Recommendations

52. It was agreed that each participant in the workshop should bring to the attention of his/her minister of health/medical faculty the recommendations of the workshop, and in particular the following.

(a) Each minister of health should consider establishing within his/her ministry a special primary health care unit with additional funding to promote primary health care projects, if this has not already been established.

(b) Deans of medical faculties should initiate discussions with every department of medical schools to determine their potential role in primary health care.

(c) Deans of medical schools should, through appropriate channels, initiate and organise a series of meetings involving teachers in various health training institutions to discuss what they can do to promote primary health care.

(d) Deans of medical schools should, where necessary, request their curricula development committees to review the structure and content of curricula with a view to strengthening involvement - including work assignments - in primary health care.

(e) Ministries of health should initiate discussions at various levels - headquarters, provincial, district and sub-district - to define clearly the roles of individual personnel at each level in the implementation of primary health care.

(f) All departments in medical schools should be urged to promote research into the health services aspects of primary health care in their respective disciplines, with encouragement and support including funding from the ministry of health and other agencies.

COMMONWEALTH POSTGRADUATE AND HIGHER EDUCATION NEEDS

53. Dr A Christodoulou (Association of Commonwealth Universities) drew the attention of participants to the Commonwealth Foundation Medical Electives Bursaries Scheme, which was administered by the Association of Commonwealth Universities (ACU). He explained the arrangements for the consideration of proposals for electives and for the eventual selection of candidates. He pointed out that the choice of areas of work and placements was the responsibility of applicants. In general, priority in the awards was given to students from the most needy countries for work in areas of the greatest need. (A copy of the relevant ACU letter to deans of medical schools, with the conditions of award, is included in the documents section.)

54. Turning to the question of student mobility, Dr Christodoulou reviewed the obstacles to the movement of students, and also junior staff, between Commonwealth countries for postgraduate training. The most significant of these was high student fees in the receiving countries for overseas students, but they also included visa charges, charges for medical services, high costs of living, travel and extra clothing costs, and difficulties in getting work permits.

55. In Britain, for example, the policy of charging fees at the full economic cost, introduced from October 1980, had resulted in a considerable fall in the numbers of overseas students - numbers in the higher education system as a whole falling from

84,000 in 1979-80 to 62,000 in 1981-82. This overall decrease concealed even sharper falls in the numbers of students from the poorer developing countries. Influential lobbies, including the Overseas Students Trust which had recently published the study "A policy for overseas students: analysis, options, proposals", were endeavouring to bring about a more favourable fees policy, with additional scholarships and technical awards through such existing schemes as the Commonwealth Scholarship and Fellowship Plan, administered by ACU, and through aid programmes.

56. The problem should not be looked at simply from the standpoint of Britain, however. Barriers to student mobility in general were seen as a major constraint on the efforts of developing countries to obtain the higher education and training necessary to sustain their development plans. They also weakened the links between Commonwealth countries.

57. There had since 1979 been various moves to develop a Commonwealth strategy to improve the situation, in which a leading role had been played by the ACU and the Commonwealth Secretariat. The matter had been discussed at the 1980 conference of Commonwealth Education Ministers and at the 1981 ACU conference of heads of Commonwealth universities. The Commonwealth Secretary-General had appointed a consultative committee on student mobility whose recommendations had been endorsed by the October 1981 meeting of Commonwealth Heads of Government. As a result, a Standing Committee on Student Mobility, of which Dr Christodoulou was himself a member, had recently been appointed by the Commonwealth Secretary-General to advise Commonwealth governments on all aspects of student mobility, including measures to assist the movement of students between member countries.

58. The strategy was to achieve a lowering of barriers to mobility by such means as:

(a) charging fees on a marginal cost/no subsidy basis;

(b) strengthening existing scholarship and bursary schemes;

(c) providing special awards for students of high academic merit;

(d) special consideration for countries with inadequate or no university facilities of their own;

(e) special bilateral arrangements between developed countries and the poorest developing countries;

(f) encouraging a more diverse flow between member countries of the Commonwealth.

The possibility of a coherent Commonwealth Higher Education Programme was also being considered.

59. These ideas were coupled with an explicit awareness that universities in Commonwealth developing countries were less dependent than formerly on those of the developed world. They were achieving their own maturity and were able to make a significant contribution to the development efforts of their own countries and regions. To do this more effectively, however, they needed help to develop further their strengths in postgraduate study and research - both to retain more of their own high-quality first-degree students (and give them expepience closely relevant to their own socio-economic environment) and to offer opportunities to other students from countries in their geographical regions. This pointed to an important role for the Commonwealth Secretariat (including the Commonwealth Fund for Technical Co-operation), the Commonwealth Foundation, the Association of Commonwealth Universities and other agencies and associations.

60. The Standing Committee would be promoting the collection and analysis of information about the present pattern of student flow, and the identification of higher

education institutions with advanced study and research strengths which might be assisted to develop into regional resource centres. Although the emerging strategies were ambitious, the needs were real and the time was ripe for a major new phase of Commonwealth collaboration.

61. Sir Kenneth Stuart (Commonwealth Secretariat) considered the factors that would influence the setting-up of centres of higher medical education in Commonwealth regions. He stressed that Britain should no longer be regarded as the sole focus for higher medical education. He saw the need for more information about student flow and about the strengths of existing medical teaching institutions in the regions, and for political backing if regional centres were to be suitably developed. Existing institutions would have to be up-graded and new ones designed, current teaching and research programmes would have to be modified according to prevailing needs, and additional staff and facilities would have to be provided. Standards would need to be monitored by review boards. An international group of experts might be useful to advise on the implementation of these proposals.

62. Participants in the workshop agreed that these developments were desirable. The problem of the failure of students to return to their home countries after overseas training was referred to, and it was pointed out that the strengthening of centres in the less developed countries of the Commonwealth might reduce the attraction of the developed countries as sources of medical training. They might promote greater relevance of studies to local problems, and make possible more appropriate field work in the course of training. They might also help in the development of the "super-generalist" as an important agent for appropriate health care delivery in the less developed countries.

63. It was suggested that, in strengthening particular areas of training, some of the new programmes should be oriented towards middle-level rather than high-level courses - leading, for example, to diplomas rather than fellowships. This might also make it easier to overcome possible financial constraints.

64. The importance of flexibility in the content of training programmes in the projected centres was emphasised. Programmes might have to be re-designed from time to time to meet the needs of user countries.

65. The workshop agreed on the desirability of strengthening existing institutions rather than attempting to build new ones. Appropriate programmes of such institutions could be up-graded to meet agreed needs. Their standards and qualifying examinations could be certified by Commonwealth review groups, and appropriate safeguards could be introduced for sustaining them at the desired levels.

Recommendations

66. The workshop recommended that detailed guidance for initial measures to be adopted at national, regional and Commonwealth levels for the development of higher medical education centres might be given by recommendations of an **international advisory group of experts**. This group might consider such matters as:

(a) the centres and disciplines to be strengthened;

(b) their curricular, staffing and financial requirements;

(c) their research and other targets and how these might be met;

(d) their relationship with member governments at national, regional and Commonwealth levels;

(e) the regulatory and administrative arrangements for ensuring the achievement and maintenance of the highest standards of excellence and relevance.

67. In addition, the advisory group of experts might examine the programmes of existing national and regional higher medical education institutions, including those of the British Postgraduate Medical Federation, the British Schools of Tropical Medicine, the World Health Organisation and the Wellcome Trust, so that the most appropriate Commonwealth sites and programmes could be arrived at. Representatives of such institutions might be included in the advisory group.