Series Human Resources Development

17

Toward the Achievement of Equity and Quality of the Social Response in Health: Interventions in the Interface of the Medical Practice and Education

Proposal of Cooperation Among Countries

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TABLE OF CONTENTS

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INTRODUCTION

In the second half of the 1980s, the widening gap in the Region between the populations' problems, needs, and ideals in health and the corresponding organized social response was evident. Within this framework, the social significance of medical practice–which had dominated the field of health and health practices—deteriorated even further, as did its technical quality, especially in the public sector.

With the beginning of economic recovery in the countries in the 1990's, the prospects for curbing the deterioration in the health and living conditions of the people appear to be improving, although large gaps still remain in the distribution of health determinants, access to health care services, and the quality of such services. At the same time, as privatization has increased, medical practice has been influenced by a growing number of intermediary institutions. Sound reform of professional practice would be an important milestone on the path toward greater integration and equity in the health services delivery model.

Repeated attempts have been made to modify medical practice through medical education. Nevertheless, efforts to train physicians who meet the countries' needs or to educate physicians as agents of social change (or alternatively, social agents for change) have proven fruitless with respect to counteracting the enormous influence of practice on education. Furthermore, the problems in the curriculum that were to be modified as an intermediate target in the sought-after reform have persisted in most cases. However, certain academic centers in a number of countries have made progress in instructional methods through greater contact between the educational process and the immediate situation of the school, as well as the promotion of more active modes of learning.

This situation has set the stage for continued progress, building upon the contributions of the new methodological curriculum proposals for university education. In recent years, the WHO Member Governments, in a joint effort with other actors, such as associations of medical schools, have been reaching a kind of consensus that seeks to make medical practice and medical education contributors to the goal of Health for All and to the principles of equity and quality in health. Resolution WHA.48.8, adopted at the World Health Assembly in 1995, urges the Secretariat and the countries to work toward that end.

Within this new context, the design and implementation of methodologies for professional education is one of the factors that must be reformed. Recent consultations by PAHO have emphasized that medical education should be conceived as a continuum and that efforts in this direction should therefore be targeted not only to the initial training phases (for both generalists and specialists), but also to established professional practice.

In this vein, the present proposal seeks to promote lines of action geared toward developing closer links between medical practice and medical education. Emphasis on the initial decentralized and generalist professional practice and preprofessional practice will in all probability provide feedback for the development of other aspects of medical practice

and education. To that end, two areas—international and national—have been targeted to foster greater coordination among the various efforts under way or waiting to be implemented.

1. THE CONTEXT

1.1 GENERAL CONSIDERATIONS

In general, social, epidemiological and demographic trends in the Region are posing new and growing challenges, making increasing demands on health systems and services. This situation is exacerbated by the emergence of new diseases, such as AIDS, and the re-emergence of other maladies that were previously considered under control, such as cholera, malaria, and tuberculosis. The magnitude of these problems varies markedly between subregions and countries and even within a single country.

Medical care, like education, has changed more as a result of the supply of institutions and professionals, especially in the private sector, than of the real needs and demands of the population--including undiscovered needs. The stratification of society prevents more integrated and appropriate responses, which translates into inequities in living and working conditions, in access to services and the quality of such services, and in the downward social mobility that accompanies illness. The need—especially in institutions—to guarantee quality performance by physicians and greater user capacity to demand accountability for the services rendered, coupled with the respective social, economic, and legal implications, is leading to the establishment of mechanisms for the regulation and control of professional practice (*recertification*).

Many opportunities are available for the training and continuing education of the medical profession. However, the objectives are not necessarily geared toward the achievement of Health for All. A new look at both processes (ongoing education) must be taken to deal with the modern megatrends of rapid and far-reaching social change in a more appropriate fashion.

Social service, a practice adopted in most countries a number of years ago, is facing an uncertain future in the Region. An oversupply of physicians has distorted its original purpose by rendering insufficient the number of job openings available for this human resource—a situation aggravated by the lack of academic supervision and proper working conditions in the peripheral services. Once considered a low-paying position, with medicine an undervalued profession, the shortage of other opportunities has led to a situation where positions in this field are now considered job opportunities for graduating students or recent graduates and even as a potential gateway to government jobs (*civil service*). In some countries, the opening of jobs with the same functions as those of social service posts can be a significant source of tension in national systems. Another preprofessional practice, *internship*, must also be reviewed and systematized. Internships generally last one year and are increasingly including a rotation in rural areas. Some countries—such as a few of the countries of the Southern Cone—do not have internships.

In general, *professional training for physicians* has not been geared toward promoting equity when addressing the priority needs of the population. Training has been

compartmentalized, centered on biological issues, and overspecialized. It has taken place largely within hospital settings with an increasingly commercial orientation. The main critical areas include: the loss of the scientific method; the poor quality of the academics; and the obsolescence of the methodologies. The numerous attempts to upgrade medical education in recent decades, seeking to improve training and redefine the role of medical departments and schools of medicine as social actors, have largely been in vain. This explains the growing interest in the definition and application of categories, standards, variables, and indicators of quality to assess the real or potential performance of educational institutions (*accreditation*).

Nowadays, heterogeneous and complex processes are unfolding to introduce substantive reforms in the national health systems (*health sector reform*). There are certain similarities among the forces working to promote health system reforms in the various countries of the Region. These include:

- Limitations in the population's access to health services due to lack of coverage, inefficient organization of the services, poor geographical distribution of the medical work force, and deficient distribution of specialized medical work force, with too many specialists.
- Increases in the cost of care as a result of the technological explosion in biomedicine and the indiscriminate use of new diagnostic and therapeutic technologies, without firm evidence of their effectiveness; fragmentation and over- specialization of medical care; a reduccionist and biologist model of medical care; and strategies that are possibilistic rather than probabilistic.
- Skepticism over the quality of care, especially by purchasers of health services, given doubts that increases in costs have yielded commensurate increases in quality as measured by standard epidemiological indexes, measures of the functional state of health and the quality of life related to health, and user satisfaction.

For these reasons, reform of the health systems tries to increase access and equity in care, offer high-quality services for all members of society, and optimize the relationship between costs and quality of care.

The stated *objectives* of these processes include: 1) improving health and living conditions; 2) reducing inequities in health status; 3) improving access to quality services; 4) promoting shared responsibility by individuals, institutions, and communities; 5) modernization and decentralization of the structure and role of public service providers; and 6) oversight to ensure that the sector has the resources to guarantee the sustainability of its basic functions. The principal *characteristics* of these processes include mechanisms and actions targeted, first, to extending coverage, reformulating health care models, modifying the organization and management of sector institutions, and promoting decentralization and social participation; and second, to providing separate financing for the services, modifying

the public-private mix and seeking new forms of remuneration for service providers and new sectoral directions and investment strategies.

Understandably, the reforms currently underway in the majority of the countries of the Americas are harbingers of major changes in the models of medical care. In medical practice this necessarily implies changes in the models for developing human resources in health, particularly in medical education, in order to respond to the needs of the health care system. The major trends in medical practice throughout the Region are highlighted below, followed by trends in medical education that have arisen in response to the changes in medical practice.

1.2 TRENDS IN MEDICAL PRACTICE

1.2.1 Redefinition of the Model of Care

The major trends in the reform of health systems throughout the Americas include: the implementation of managed care systems; the implementation of integrated (and it is hoped more comprehensive) health care systems (with vertical and horizontal integration); improvement of primary level care (provided by general practitioners, family doctors, and physicians with basic or "generalist" specialties); and the decentralization of services, especially those of primary care.

1.2.2 The Technological Explosion

We live in an era of explosive technological growth and this has an enormous impact on medical practice. The effects of this phenomenon, which has an impact on biomedical technology and the general corpus of biomedical knowledge, are such that both fields quickly become obsolete. The new technologies promote ambulatory medical care (surgery, antibiotic and chemotherapy by intravenous treatment, etc.). The hospital of the future will increasingly look like the intensive care units of today. Information science is becoming the cornerstone of integrated health systems, and of medical practice, by enabling access to bibliographic and clinical databases, clinical data files (with increasing use of computerized medical files), and the use of expert diagnostic systems.

1.2.3 Importance of Psychosocial Aspects

The psychosocial aspects of medical care are increasingly important. Psychosocial problems are highly prevalent (more than 50% at the primary level care). Making patients follow their medical prescriptions poses an enormous challenge for medical practice, and a high percentage of the population resorts to alternative therapies and to allopathic medicine.

1.2.4 Disease Prevention and Health Promotion

Preventive medicine is increasingly important. The epidemiological transition from infectious diseases to chronic-degenerative diseases implies a different preventive strategy. This includes the identification of individual- and family-risk factors, changes in lifestyles and health habits, and a longitudinal physician-patient relationship structured as a process, in which every consultation provides an opportunity for prevention.

1.2.5 Evidence-based Medicine

It is increasingly important that diagnostic and therapeutic medical treatments should be based on rigorous scientific evidence. The objective is to optimize the cost/quality equation. To this end the standards and guidelines of medical care should be based on appropriate evidence.

1.2.6 Accreditation of Medical Practice and Educational Institutions, and for Certification and Recertification of Physicians

This trend seeks to raise the quality of medical care by means of structural improvements.

1.3 TRENDS IN MEDICAL EDUCATION

1.3.1 Early Clinical Experiences

Ideally, medical students will have acquired clinical experience at the primary level of community care from the very start of their medical studies, that is, during the years of basic sciences. This shows the student the systemic complexity of health problems, eschewing both reduccionists model of health-disease and biases in resorting to tertiary hospitals.

1.3.2 Decentralization of Clinical Experiences

Technological changes that promote outpatient instead of hospital care imply that the clinical training experiences should increasingly occur in the ambulatory and community area.

1.3.3 Problem-based Teaching/Learning

This requires emphasizing data searches and analysis for purposes of solving clinical problems, learning principles instead of encyclopaedic knowledge, and the effective utilization of medical information science.

1.3.4 Renewal of Thematic Emphasis

Principles of medicine based on evidence. Such principles can be drawn mainly from clinical epidemiology, clinical economy, decision-making theory, and analysis/evaluation of medical literature.

Biopsychosocial model. Teaching should be theoretical and practical, and should emphasize the physician-patient relationship.

Primary care oriented toward the community. Includes the evaluation of community health needs, planning of community interventions, and community linkages in order to achieve improvements in their health.

Clinical prevention. Should cover ways to stress prevention in the physician's daily office practice, to help patients change their habits and unhealthy lifestyles, and involve the community in disease prevention and health promotion.

Medical ethics. Principles and methods for facing and solving ethical problems in medical practice could be taught; attitudes and actions should also be modeled.

1.3.5 The New Model of Care and Demand for Generalist Physicians

Immediate changes in college and graduate-level curricula will have an effect on the educational product years later. The implication is that there is a mass of general practitioners at the primary care level who need "in-service" retraining and preparation in order to bring their knowledge and skills up-to-date. This will lead to professionals at a higher level of competence to pick up the new model of health care effectively and efficiently.

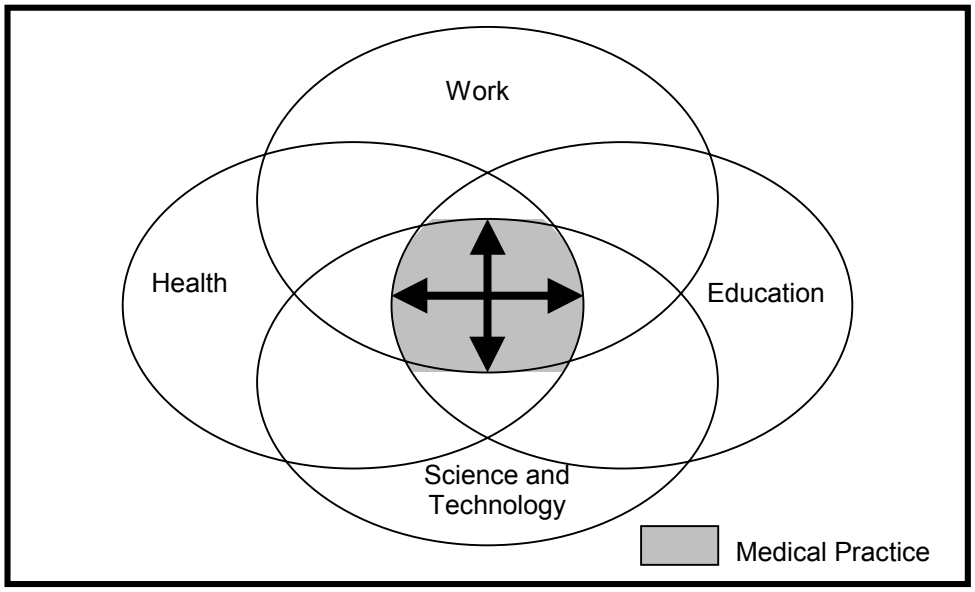
In short, within the framework of the renewal process of Health for All and of sectoral reform, the reorientation of medical education and practice should be a collective effort between the ministries of health, its services, and the universities which train health professionals, as well as with professional associations and other entities of civil society.

2. THE PROCESS OF PLANNING

2.1 RATIONALE

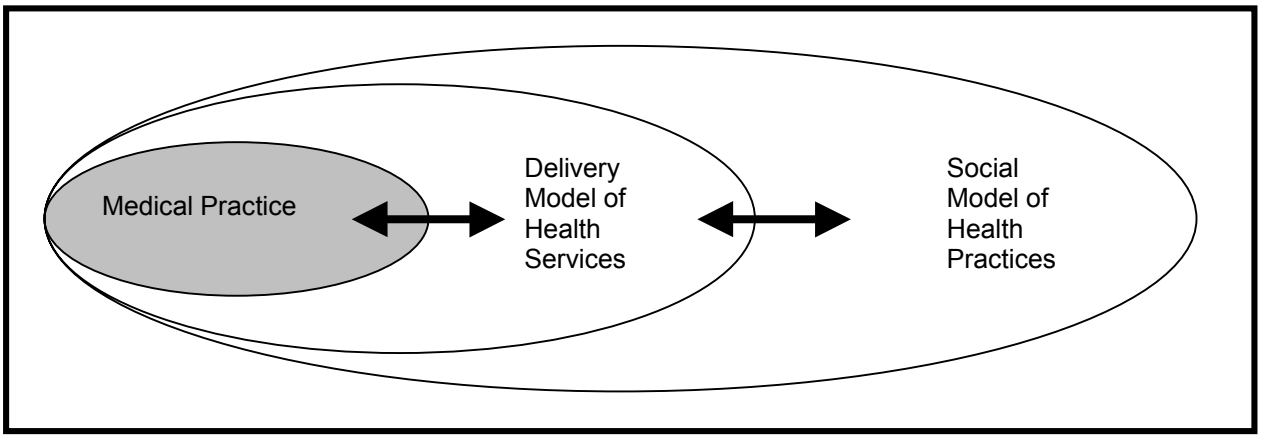
- Human resources in health, in general, and the physician work force, in particular, are developed through the interaction of health, education, science and technology, and labor. Acting at the intersection of these four areas, it is possible to influence medical practice from the inside out (that is, from its structural determinants, (Fig. 1).

Figure 1: Structural Determinants of Medical Practice



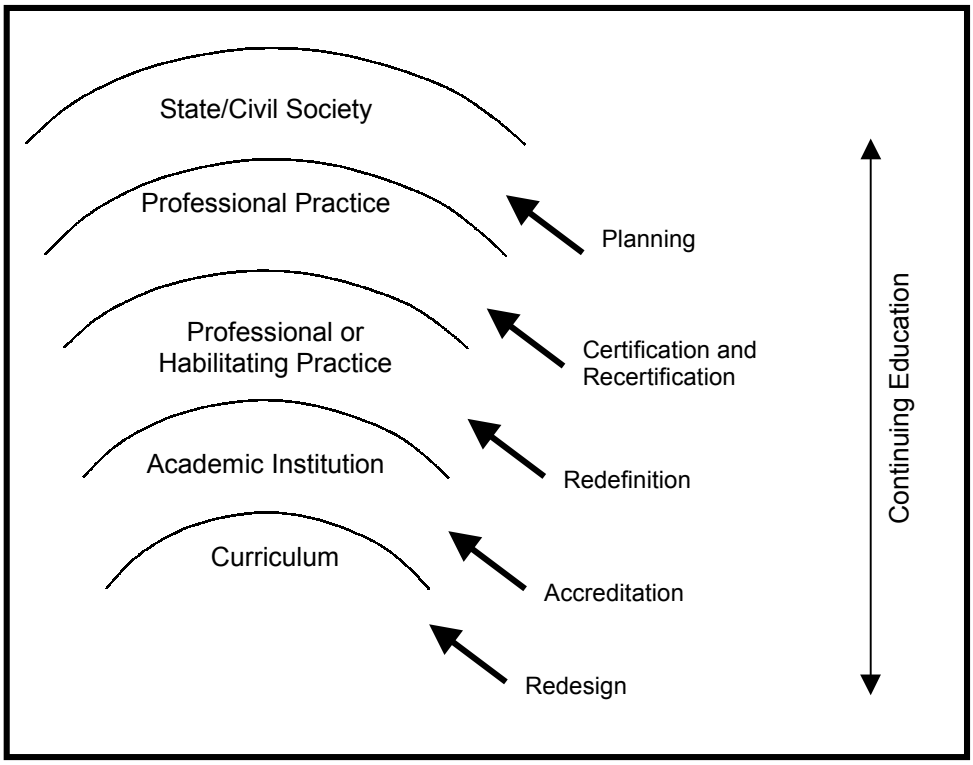
- Medical practice is part of the health service delivery model, which, in turn, is part of the social model of health practices. Acting at the level of the relations between such models, it is possible to influence medical practice from the outside in (that is, from its functional determinants, Fig. 2).

Figure 2: Functional Determinants of Medical Practice



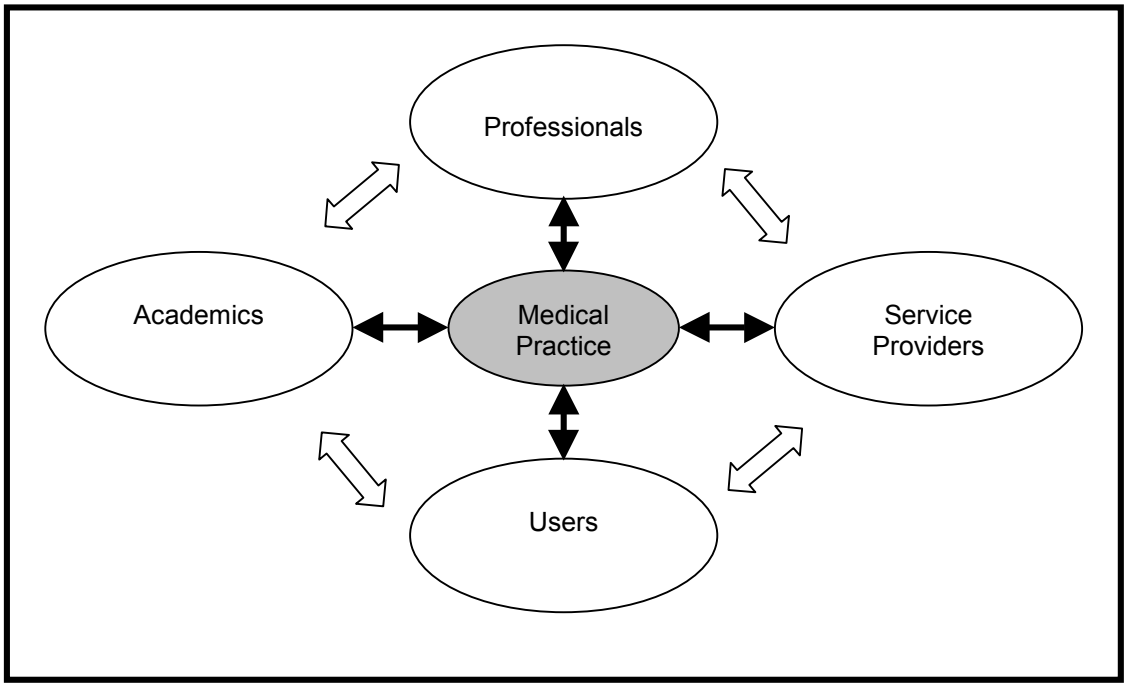
- At the different levels of linkage between medical practice and medical education (the State-civil society, professional practice, preprofessional or supervised practice, the training institution, and the curriculum), the potential for change or progress is either emerging or imminent (policy-making, recertification of professionals, changes in social service, institutional accreditation, and small group learning based on problem-solving). (Fig. 3). Acting on the socially relevant levels and processes in every situation can influence or provide feedback to other dimensions of practice or education.

Figure 3: Levels And Processes Relationship Of Medical Education And Practice



- The dominance of medical practice is the result of a number of factors: the autonomy of the actors, their conflicting interests, the nature of the services market, and the lack of clear national policies for the development of the respective human resources. Acting through partnerships, alliances, and coalitions increases the viability and feasibility of the proposed changes while developing, strengthening, and redefining the behavior of the individual actors. (Fig.4)

Figure 4: Synergistic Consensus-Building of Relevant Actors in Medical Practice



- In conclusion, the general rationale of this proposal is to attempt to reform medical practice in a positive direction by involving physicians in integrated human resource development strategies, wherein education plays a key role.

2.2 PURPOSE

- To contribute to the achievement of equity and quality in the social health response through the reform of medical practice in its crucial interfaces with medical education.

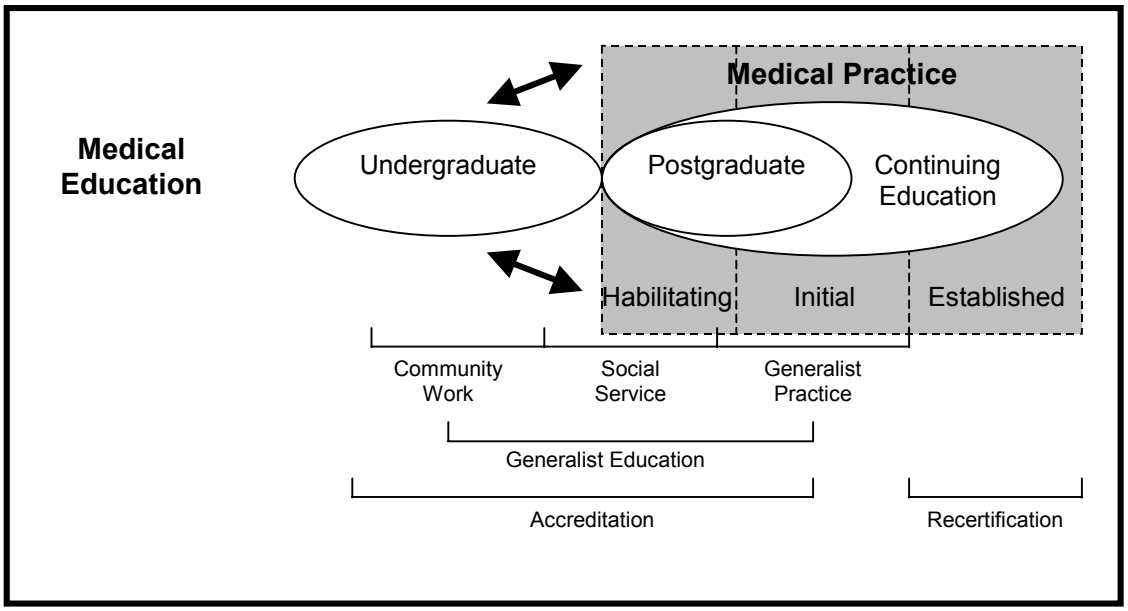
2.3 OBJECTIVES

Meeting the following objectives between 1997 and 2001 implies the development of proactive social behaviors by national actors (service providers, trainers, and professionals) that are relevant to the development of medical practice and medical education and increase their synergy and common direction or coordination.

- To coordinate activities among countries to reform medical practice in line with current needs.
- To provide international technical cooperation with the development of national activities geared toward the modification of medical practice.
- To update the theory and methodology of international technical cooperation for the development of medical practice and medical education, based on the national initiatives for the reform of medical practice.

The critical interfaces between medical practice and medical education are illustrated in Figure 5.

Figure 5: Critical Relationships between Medical Practice and Education



In this model, it is suggested that national actors consider primarily:

- Launching or strengthening national efforts to update or train physicians, in keeping with priority health needs.

- Strengthening and/or redefining social service and other forms of preprofessional medical practice (rural internships and their equivalents) in countries that have such services, with the direct involvement of the universities and health services as equal partners.

- Feedback to professional training with respect to its social relevance and technical quality.

Next, and as an extension of the three lines of action mentioned above:

- Implementing or consolidating the emerging accreditation and recertification efforts in the countries, based on a review of educational responses, performance evaluation, human resources management, and academic administration.

- Analysis of the bottom ranks of the civil service and the formulation of a proposal for their redefinition, based on an initial study.

- Strengthening and developing generalist medical specialties.

2.4 PRINCIPLES

Human resources development planning for health in general, and for physicians in particular, should remain under the supervision and control of national public agencies. These agencies should strike a suitable balance between identifying priorities and guaranteeing the provision of high-quality services by all groups and individuals in the health sector or related areas. This regulatory role of the State is the only one which can assure the necessary equity and quality. This responsibility should not be fragmented or transferred to local authorities. However, it is essential to acknowledge that individuals and groups in local communities must play a key role in the critical evaluation of health policies and must be taken into account when such policies are formulated.

Today it is essential to apply evidence-based medical principles in a more far-reaching manner to everyday health care--in terms of delivery, administration, and management. To avoid elitism and perpetuating courses of study that have no other goal than to respond to individual or commercial objectives, the health services (represented by the State) must play a vital role in curriculum planning and implementation.

Professional certification and recertification, which will enable professionals to keep their skills, social commitments and attitudes, knowledge, and other abilities up to date, should be furthered jointly by the three key parties to this process—namely, the health services, the universities, and professional associations. This will enable the health services to constantly maintain and improve their quality, with the support of continuing education programs that meet the needs of each individual—ensuring professional competence—and ongoing programs that guarantee the development of specific skills, knowledge, and attitudes to set up effective and efficient programs in public systems.

It is generally accepted that the physicians needed should have a global vision of the health care determinants and the processes that will permit their modification. Once the situation is better understood, it will be easier for physicians to provide efficient care of the highest quality with the human touch and, at the same time, with the greatest equity. To ensure this, the training of these professionals should reflect these objectives on concrete levels, with hands-on activities that permit them to acquire skills, attitudes, and knowledge that can be demonstrated in practice. Evaluation systems must possess characteristics that lead to such results.

The education of health professionals, either continuing education or undergraduate work, should be determined by the needs identified jointly by instructors, employers, and the professionals themselves. Medical education today usually focuses on specific pathologies, drugs, or diagnostic or therapeutic technologies. A relationship based on efficiency and quality should be established between the private and public sector, and service providers and the educational sector should build this new relationship with the private sector. Therefore, the policy-making and regulatory function of the State, which guarantees collective rights, should also oversee the private training of human resources in health. The current lack of regulation, which impacts on the health sector and its potential for improving or even maintaining equity, has led certain interest groups to attempt to regulate and train professional resources. Since these resources should be engaged in a more global task with clear social objectives, all agencies that train human resources in health, both private and public, should adhere to general standards set by society. Educational programs and training centers should be regulated efficiently.

The integrating factor or key element of the principles outlined thus far consists of the policies, essential public health functions, and priorities of the country.

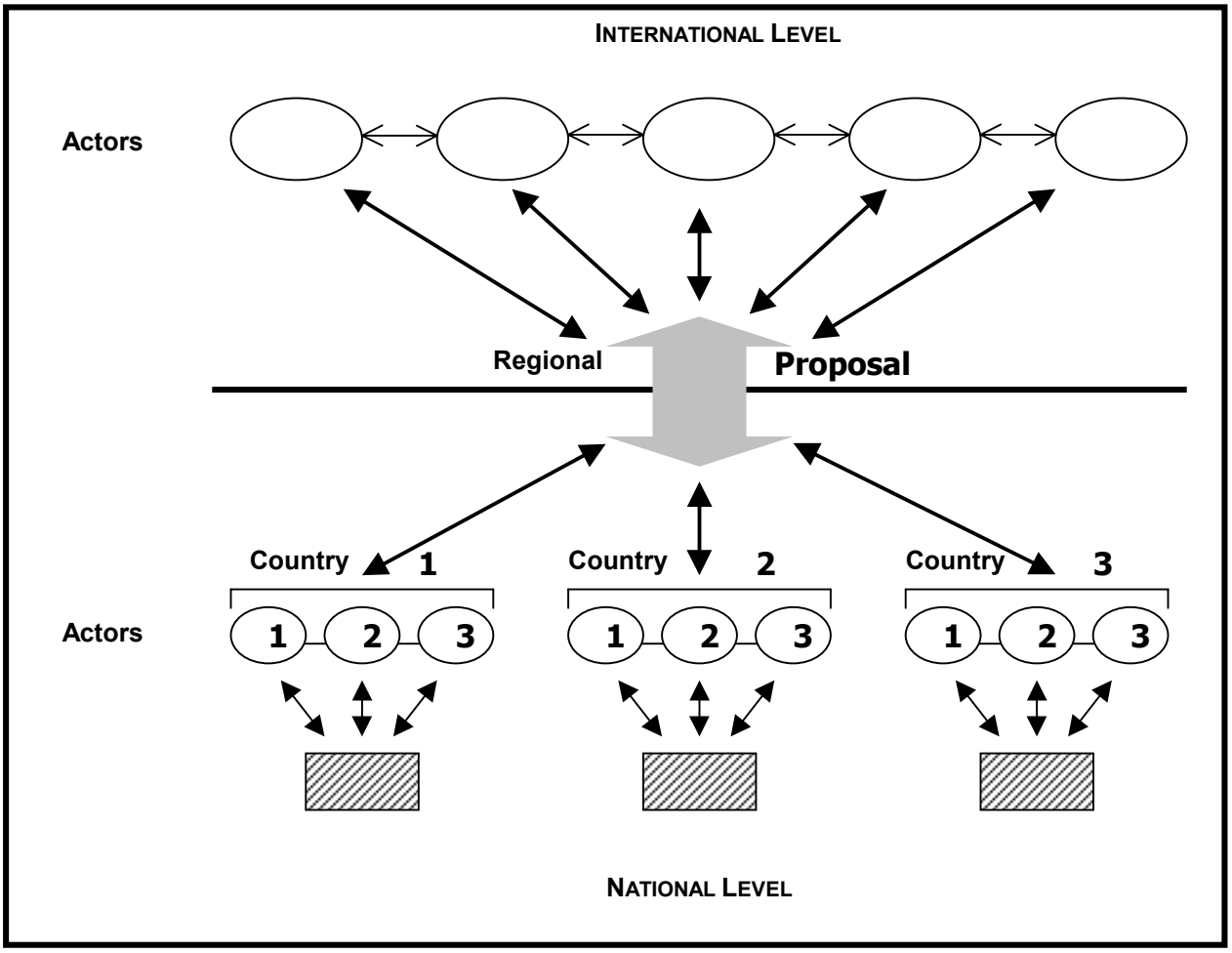
3. PRIORITY ACTIONS

This plan, which appears to enjoy widespread support from the actors who have traditionally collaborated in health and education, recognizes that efforts to improve education and practice in the health professions should be made within the framework of very concrete objectives.

In general, the proposal can be sequentially implemented at the international and national level, as illustrated in Figure 6.

The potential products, activities, indicators, verification methods, and assumptions, from both the regional proposal and from eventual national projects, are shown in Annexes A and B. A more detailed description of the options vis-à-vis the activities and tasks involved is given below.

Figure 6: Structure of the Proposal for the Development of Medical Practice and Education in Latin America and the Caribbean



3.1 INTERNATIONALLY

- Global coordination of the process. This would take place through a Management Committee, whose main responsibilities would include the mobilization of other actors, countries, and donors.

- Broad articulation of actors. This may include PAHO, UNESCO (CRESAL), private foundations and government agencies (CIDA, the Rockefeller Foundation, the W.K. Kellogg Foundation, AID, RWJ, GTZ, Macy, the Pew Charitable Trust, SIDA, and other European agencies such as DANIDA and AECI), CEU, IDB, World Bank, AAMC, and associations (FEPAFEM, ALAFEM, NETWORK).

- The definition of institutional actors and the potential participants among them (survey).

- Situation analysis of the dimensions of medical practice and medical education to be influenced on a priority basis (role of the work force at the primary care level, current status of social service and trends, current status of rural internships and trends, etc.).

- Initial promotion of the proposal nationally.

- Support in setting up national projects (meetings, consultancies, visits for scientific purposes, fellowships, etc).

- Ease of convening all national actors at the events where the analytical, regulatory, strategic, and tactical aspects of the proposal are being developed.

- Identification and systematization of demonstration experiences (study of development projects and their use as models).

- Organization of international courses on critical areas of professional practice at the levels targeted by this proposal.

- Creation of a multicenter program of research and action, coordinated regionally.

- Promotion of political support from the PAHO Member Governments.

3.2 NATIONALLY

- Contact with relevant actors: governments (ministry of health/services); universities; and health professionals (physicians, nurses, etc).

- Dissemination of the idea: creation of forums or use of existing ones (for example, annual national meetings of state or provincial secretariats of health and deans of the schools of medicine).

- Receipt of complementary proposals.
- Promotion of and support for the formulation of national projects to foster and strengthen the desired change.
- Support in characterizing the problem and determining needs.
- Training in critical areas of the work force.
- Analysis and development of general practice at the local level, social service, civil service, and rural internships.
- Support for institutional accreditation and professional recertification.
- Educational development (complemented with international seminars).
- Curriculum development, with emphasis on pedagogical development of the final professional training and generalist specialties.
- Development of instructional materials.
- The conducting of critical research.

The activities stemming from the preceding lines of action are more promotional at the international level and more operational at the national level.

4. ASPECTS OF IMPLEMENTATION

4.1 RESOURCES

This entire proposal is based on the maximization of every type of existing resource. In this vein, special importance will be given to WHO Collaborating Centers and to centers of excellence, such as those involved in the UNI projects (promoted and funded by the W.K. Kellogg foundation) as a result of their special links with academia, the health services, and the community. In countries or regions with such centers, processes actively promoted by professional associations can also be an important area of support. Such processes are aimed at accrediting schools and recertifying professionals or at promoting a restructuring of the civil service system. Of equal importance are the numerous training exercises for the work force promoted by the ministries of health as part of the reform process. Similarly, medical schools interested and involved in the reform of medical education in keeping with the principles here described are also key supporters.

4.2 PARTICIPING COUNTRIES

The importance, social relevance, viability, and feasibility of this proposal will initially be explored in countries of Latin America and the Caribbean in which there are favorable conditions for some of the critical interventions it encompasses.

4.3 BUDGET

At the regional level, the activities to be promoted initially in the selected countries will be financed chiefly with resources from PAHO.

At the national level, resource needs depend on the range of activities and the specific coverage that the respective national projects are intended to achieve. These needs should be satisfied through the best possible combination of domestic and foreign resources.

5. COORDINATION STRUCTURES AND ROLES OF THE AGENCIES

- Federations, associations or networks of colleges and medical schools: These will promote the proposal when its objectives are to be disseminated, and will incorporate the greatest possible number of educational institutions in order to make them participants in this way of thinking. They are the catalysts to carry out this idea at every association, college, or school, chiefly through national annual congresses. When timely, they will promote the idea at the level of ministries of health.

- W. K. KELLOGG Foundation: At the regional level, this foundation seeks to enrich the technical and operational content of the proposal by systematizing the far-reaching experience it has gained in recent years. At the national level, it seeks to enable UNI centers to become poles of development for the proposal in the countries where they exist.

- Collaborating Centers, the United States: These centers contribute by approaching the foundations. They are experienced in obtaining grants and have a great deal of experience in quality control, educational development, and evaluation. They will play an active role within the Committee of Management and will seek support and direct technical cooperation (technical resources, human and material, in order to accommodate recipients of scholarships, and provide support in the area of health economy and analysis of health policies).

- Collaborating Centers, Latin America: These centers are constructing a subregional subsystem of physicians and other professionals. Integration of academia and practice is geared toward continuing education.

- PAHO: Facilitating the management of the process, PAHO supports national meetings or workshops that promote the idea (for example, joint meetings with the deans of medical schools and state or provincial ministers or secretaries of health), as well as the integration of training with education, providing the necessary advisory services, groups of experts, contracts, etc. It contributes its methodological expertise in continuing education and seeks to orient the grants program in some countries. The Organization produces educational materials (PALTEX) and the interactive database on the status of the institutions. It expands the political and operational base for the project, linking it to those geared toward other professional resources, and streamlines the process for designating Collaborating Centers. It also promotes working by type of problem and not just by level of care (e.g., infant mortality and adolescent drug use).

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ANNEX A:
REGIONAL MANAGEMENT OF TECHNICAL COOPERATION FOR THE TRANSFORMATION OF MEDICAL PRACTICE AND EDUCATION

Development Objective	Indicators	Means of Verification	Major Assumptions
Contribute to achieving equity and quality in the social response of health, by promoting and supporting changes in medical practice in its critical interfaces with medical education.	Coordination of international technical cooperation actions oriented toward achieving greater equity and quality in the social response in health.		
Immediate Objectives			
1. Coordinate the implementation of activities between countries for the modification of medical practices as a function of current needs. 2. Provide international technical cooperation in the development of national activities aimed at transforming medical practice. 3. Update the theoretical-methodological basis of international technical cooperation for the development of medical education and practice, based on national approaches to the transformation of medical practice.	Regional groups and between countries periodically coordinating the development of actions to modify medical practice. Number of technical cooperation activities conducted at the national, subregional, and regional levels supporting the processes of transformation of medical practice. Principles, methods, and instruments of international cooperation for medical education and practice updated, based on the development of national experiences.	Meeting proceed-ings, progress reports, and joint documents. Reports on technical cooperation activities conducted. Regional documents on new approaches to medical practice and public health.	Conditions exist for a concerted effort at the national and international level.
Products			
1. National projects for transformation of medical practice being developed from a perspective of cooperation among countries. 2. National problems and responses in the transformation of medical practice prioritized and under way, supported by	Number of projects reviewed and reoriented with broad national participation and with technical support from international cooperation. Number of countries involved in the analysis and preparation of proposals for change. Up-to-date strategic and	Reports on workshops, meetings. Studies and plans of action. Regional document on new approaches to medical practice and education.	

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international cooperation. 3. Technical cooperation for the development of medical practice being carried out, consistent with the new challenges and approaches to public health	programmatic orientations and approaches to technical cooperation in medical practice and education.		
Activities			
1.1 Marketing of the proposal. 1.2 Inventory and articulation of actors. 1.3 Resource management and mobilization. 1.4 Diagnosis of the critical interfaces between practice and medical education. 2.1 Systematization of knowledge of development experiences in relevant areas of the proposal. 2.2 Definition and consensus-building of basic elements of the national protocols. 2.3 Systematization, at the regional level, of the categorization and prioritization of problems identified and responses adopted in medical practice at the national level. 3.1 Identification of theoretical, methodological, and operational guidelines and approaches, in order to approach the transformation of medical practice at the regional level. 3.2 Theoretical-methodological recovery based on national assessments of the impact the processes of transformation of medical practice.	Number of countries with promotional activities in the proposal and participating in the process. Number of agencies and institutions involved in resource mobilization and in the reorientation of cooperation actions. Number of national and regional protocols. Number of activities for sharing knowledge of experiences at the national, subregional and regional levels.	National progress reports. Reports of national and subregional meetings and workshops. Joint projects, with budgetary allocation. Research and studies on national and regional situations.	The political will and commitment of international institutional actors involved in the mobiliza-tion of the proposal. The capacity to mobilize and reassign national and international resources for implementation of the project.
Inputs			

ANNEX B:

NATIONAL PROPOSAL FOR THE DEVELOPMENT OF COMPREHENSIVE AND GENERALIST MEDICAL PRACTICE

Development Objective	Indicators	Means of Verification	Major Assumptions
Contribute to achievement of equity and quality of the social response in health through modification of the comprehen-sive and Preprofessional and Initial and Generalist Professional Medical Practice (PMPIG), of the critical interfaces between medical health services and education.	Coordinated action between academia, the services, and associations in the participating countries of the project for achievement of greater equity and quality of the social response in health.	Joint effort plans for universities and ministries of health	
Immediate Objectives			
1. Create opportunities for consensus-building between relevant actors in Preprofes-sional and Initial and Generalist Professional Medical Practice (PMPIG). 2. Analyze the contribution of the PMPIG to the essential functions of the public health. 3. Adapt initial and generalist medical practice to the needs and priorities of the health services	Groups or multi-institutional consortia that periodically evaluate the implementation of the project. Research on the relationship between PMPIG and essential functions of public health. Adaptation of the PMPIG to the needs and priorities of the services in the country.	Joint progress reports on the process. Meeting proceedings. Studies and position papers on the contribution of the PMPIG to the essential functions of public health. Documents and proposals for development of curricula. Joint plans of action for the modification of the PMPIG based on prioritized problems.	Concern exists over the inadequate fit of the PMPIG to national health needs.
Products			
1. National educational, professional, and services actors participating jointly in the analysis and implementation of processes for transformation of the medical practice. 2. The educational and services components of the PMPIG reviewed from the standpoint of	Groups and/or multi-institutional consortia that analyze and prioritize problems and define joint lines of action. Analysis and joint positions (MofH/Univ and others) on public	Plans of action under way. Progress reports Document on public health priorities.	

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essential requirements of public health. 3. The countries are orienting the PMPIG with an ethical focus, and with approaches of scientific and social relevance.	health priorities in the country.		
Activities			
1.1 Organization of groups and/or relevant actor consortia in the PMPIG 1.2 Preparation of multicenter research operations for analysis of the PMPIG 1.3 Prioritization of critical areas and lines of action for modification of the PMPIG 2.1 Establishment of forums for analysis of the contribution of the PMPIG to the essential functions of public health 2.2 Incorporation of comprehensive health advocacy into the PMPIG 3.1 Development of an intervention proposal 3.2 Evaluation of the intervention proposal in the PMPIG	Groups functioning periodically with the support of international technical cooperation. Analysis of strengths and weaknesses of the PMPIG as a function of essential needs for public health in the country. Analysis of subjects relevant to public health and medical practice, at the national level, with intra- and extra-sectoral participation. Analysis and consensus on lines of intra and extrasectoral intervention.	Files, meeting proceedings, and progress reports of the groups. Position papers on the characteristics, weaknesses, and strengths of the PMPIG. National documents on problems of public health and the social production of health. Plans of action in health with identification of sectoral tasks.	The various actors have the political will and commitment to change. Conditions for concerted efforts across the different actors. Possibility of mobilization of resources for project implementation
Inputs			

Tasks

Activity 1.1

- Marketing the proposal
- Identification of actors
- Discussion of regional proposal
- Adaptation of the proposal at the national level

Activity 1.2

- Characterization of the national situation of the PMPIG
- Research protocol preparation
- Application of research
- Data processing

- Systematization of information

Activity 1.3

- Analysis of the information
- Identification and characterization of the problems
- Prioritization of problems
- Identification of alternatives, and strategies for solutions

Activity 2.1

- Registry of participants
- Workshops on analysis and discussion of the essential functions of public health
- Identification of implications of the FESP for the medical practice

Activity 2.2

- Meetings and workshops for analysis of the contribution of the PMPIG with social managers from the national, regional, and local levels
- Individual and institutional development of the leadership of the PMPIG in the processes of social production of the health
- Development of social health advocacy processes based on intersectoral mobilization (instruction and empowerment of the population, signaling and surveillance of unfavorable situations)

Activity 3.1

- Prepare of Plan of Action
- Allocate responsibilities
- Define protocols that include the minimum components
- Resource mobilization
- Monitoring of the process

Activity 3.2

- Protocol preparation
- Operations research
- Analysis of results
- Sharing between countries of knowledge from experiences