A GUIDE THROUGH THE PATH OF SOCIAL ACCOUNTABILITY

I-SAT (Indicators for Social Accountability Tool)

The I-SAT Working Group*
“Education is the most powerful tool that can be used to change the world”

Nelson Mandela
Social mission is about making health not only better but fairer—more just, reliable, and universal.

Fitz Mullan @ JAMA 2017
It doesn't matter how many resources you have.

If you don't know how to use them, it will never be enough.
MILESTONES IN HUMAN RESOURCES FOR UNIVERSAL HEALTH

2007
REGIONAL GOALS
Regional Goals for Human Resources for Health 2007-2015

2010
Strategy for Health Personnel Competency Development in Primary Health Care-based Health Systems

2013
RECIFE POLITICAL DECLARATION
Third Global Forum on Human Resources for Health

2015
2030 AGENDA FOR SUSTAINABLE DEVELOPMENT
SUSTAINABLE DEVELOPMENT GOALS

2016
High-level Commission on Health Employment and Economic Growth-United Nations

2005
TORONTO
Toronto Call to Action: Towards a Decade of Human Resources for Health in the Americas

2008
KAMPALA DECLARATION
First Global Forum on Human Resources for Health

2013
Human Resources for Health: Increasing Access to Qualified Health Workers in Primary Health Care-based Health Systems

2014
Strategy for Universal Access to Health and Universal Health Coverage

2016
Global Strategy on Human Resources for Health: Workforce 2030

2017
Strategy on Human Resources for Universal Access to Health and Universal Health Coverage
Offline: A prescription for prosperity

Health is bad for you. That's what many economists believe. A man called William Baumol may largely blame. In the 1950s, he invented the notion of a “cost disease” in modern societies. It was a powerful metaphor one that shaped the perceptions of many a generation of financial analysts. His central idea sounds convincing. Some industries are good at increasing their productivity. As a result, they earn more money to invest in the wages of their employees. These sectors of the economy deserve our praise. There are others where increasing productivity is harder. An orchestra, for example, earning lower pay, trying to keep up. Or baked (suggesting hastily made goods), or even health professionals. In areas that depend on human beings interacting with one another, as medicine does, productivity gains are hard to achieve. But the salaries of those working in these productivity-poor sectors, the jury is out. Why? Because, thanks to increases in salaries in productivity-enriching sectors, salaries also increase in productivity-poor sectors to keep pace with the rising expectations of employees. If wages stay low in productivity-poor sectors, medical workers, and workers in this sector will seek lower salaries and become trade in Goldman Sachs. The result of the Baumol effect is a disaster in society. The costs of a concert, medical treatment, or health service increase even though productivity stays stubbornly the same. What else could this be, but a malignant “cost disease” on our collective welfare?

But what if Professor Baumol got his reasoning wrong? In an eye-opening article in the Financial Times, Professor Jean-Yves Fréchette found that medical professions are experiencing a productivity increase. This is the case in sectors that are not productivity-poor, such as healthcare. Investing in health and medical care is not only good for health but also for the economy. In a more global view, Baumol, who studied only nations in the Organisation for Economic Cooperation and Development, including low-income and middle-income countries, found that productivity growth in healthcare sectors is not a “cost disease” at all. On the contrary, investing in health workers improves the growth rates of economies. The effects of higher health employment are significantly greater than even the financial sector can achieve. This result is discovered by the OECD proportions.

What is the point of all this discussion into the minutiae of economic theory? Last week, President François Hollande and Jacob Zuma launched the final report of their High-Level Commission on Health Employment and Economic Growth at the UN General Assembly in New York. The purpose of the Commission was to examine the economic case for investing in the health workforce. The result was an affirmation of the value of the health sector to wider society, providing the number of health workers, and transforming their education at the same time, has the potential to accelerate health equity and include economic growth. Employing these additional health workers in national programmes to deliver universal health coverage can be a trigger for economic reform. It sounds easy, but of course it is not. Many countries are facing, in whole or in part, economic challenges. Conflict, post-conflict, or natural disaster. In these settings, the economy is likely to be destabilized. Investing in more doctors, nurses, midwives, or community-based health workers will be no magic solution. Added to that, health workers don't stay still. They often migrate. How does one encourage a doctor to stay and work in a difficult setting when moving country might be a far more attractive prospect?"
Strategy on Human Resources for Universal Access to Health and Universal Health Coverage
Human resources for health, for all people, in all places

**Intersectoral Policies**
Intersectoral policies are required to ensure the availability, accessibility, acceptability, and competence of human resources for universal health.

**Investment**
Increasing public investment in human resources for health promotes employment and improves people’s health, thereby contributing to national economic development.

**Strategic Planning**
Strengthening strategic planning and establishing information systems on human resources for health are vital for long-term planning.

**Interprofessional Teams**
Trained, motivated, and interprofessional teams are essential for addressing people’s health needs, wherever they live.

**Jobs**
Providing stable and decent jobs for health workers helps strengthen the health system and promotes national economic and social development.

**Training Health Professionals According to What Communities Need**
The education of health teams requires changes, including training and working actively with the community.

**Intersectoral Agreements**
High-level agreements between the education and health sectors facilitate the attainment of quality standards in training health workers to meet the needs of communities.

**Health Professionals**
The education of health professionals should be planned with a view to the present and future needs of health systems.

**Remote Areas**
Implementing strategies that motivate health teams – through economic incentives, professional development, and quality of life – encourages retention and continued presence in remote and underserved areas.

**Gender**
Incorporate a gender perspective in future models for organizing and contracting health services.

**Human Resources for Universal Health**

PAHO-2017
Social Accountability / Social Mission in health professions education

A growing option
Mr Flexner - Himself
PARADIGM SHIFTS
Three generations of reforms

1900

Scientific curriculum
University based

Problem based learning
Academic centers

Competency driven: local-global
Health education systems

Science based
Problem based
Systems based

2000+
Social Accountability of Medical Education

Obligation for medical schools to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve.

WHO, 1995
Social Accountability @ PAHO/WHO

2011

2012

2014
THE CONSORTIUM  (to be born)

PAHO / WHO Collaborating Centers on Medical Education
Medical Schools Advancing Social Mission in Latin America & the Caribbean

Sherbrooke (Canada)
New Mexico (USA)
Rockford (USA)

+/- NOSM (Canada)
+/- Morehouse (USA)

Leon (Nicaragua)
UDELAR (Uruguay)
Cusco (Perú)
FAFEMP (Argentina)

+/- 38 Mais Medicos (Brazil)
+/- UWI (Caribbean)
THE LAUNCHING OF A CONSORTIUM FOR THE ADVANCEMENT OF SOCIAL ACCOUNTABILITY IN HEALTH PROFESSIONAL EDUCATION IN THE REGION OF THE AMERICAS

Martine Morin1, Larisa Carrera2, Mercedes Cáceres2, Tomlin J Paul3, Jose Francisco García Gutierrez2, Michael Glasser1, Arthur Kaufman1, Ruy Souza3, André-Jacques N euisy1

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GENERAL CONTEXT

- Health systems worldwide are confronted with an increased demand for quality health services, an aging population, a variety of health risks, and limited resources.
- Health educators have to prepare graduates for this new context by training them in multi-professional healthcare settings at the community level, if they are to fulfill their social mission to achieve Universal Health.
- Social accountability (SA) is a concept that encourages academic centers and health services to produce not just highly competent professionals, but professionals who are equipped to respond to the changing challenges of healthcare through re-orientation of their education, research and service.
- Moving towards social accountability in health professions education means changing academic institutions into health systems change agents.

LATIN AMERICA AND CARIBBEAN CONTEXT

- Numerous health inequalities persist.
- Evidence shows a systemic mismatch across countries between professional competencies and health needs.
- Pan American Health Organization/World Health Organization (PAHO/WHO) promotes Primary Health Care and SA as a strategy to reduce these inequalities.
- Since 2011, PAHO facilitate a SA project that grew out and brought together:
  - Innovative Medical and Health Sciences Schools of South America, Central America and the Caribbean.
  - The 3 PAHO’s Collaborative Centers (PAHO CC) on human resources education.
  - 2 leading organizations on SA: Training for Health Equity Network (THEnet) and Beyond Planner Alliance

MEETINGS

- Cartagena de Indias, Colombia
  - June 2017
- Manaus, Brazil
  - September 2014
- Buenos Aires, Argentina
  - December 2016
- New Mexico, USA
  - April 2016
- Washington, USA
  - December 2016
- Lima, Peru
  - November 2015

CONSORTIUM MEMBERS (2017)

- Universidad de Sherbrooke (UdeS) / PAHO CC
- College of Medicine at Rochester, University of Illinois (CMRU-UIC) / PAHO CC
- New Mexico University (NMU) / PAHO CC
- University of the West Indies (UWI)
- Universidad Nacional Autónoma de Nicaragua, León (UNAN-León)
- Universidade Federal de Pernambuco (UFPE)
- Universidade Federal de Santa Catarina (UFSC)
- Universidade Federal de Minas Gerais (UFMG)
- Universidad Nacional Autónoma de Honduras (UNAH)
- Universidad de la República (Gral. José Batlle y Ordóñez)
- Universidad Nacional del Sur (UNS)
- Universidad de Buenos Aires (UBA)
- Universidad Nacional de La Plata (UNLP)

MISSION

- To promote, disseminate and support the implementation of SA principles:
  - among medical and health sciences schools in the Region of the Americas (specially in Latin America and the Caribbean)
  - taking into consideration their context, diversity and resources

2017-2020 ACTION PLAN

Advocacy & Networking
- Promote better understanding of SA movement at global, regional and national levels
- Foster combined participation of health and education sectors
- Facilitate exchanges and sharing of best practices among schools

Mentoring & collaboration
- For medical schools interested (or in the process) of transforming their programs according to the principles of SA in the Region of the Americas

Research & Partnership
- With other global networks focused on SA
In conjunction with the Annual Meeting of The Network: Towards Unity for Health (TUFH)

Improving the Impact of Educational Institutions on People’s Health

WORLD SUMMIT ON
SOCIAL ACCOUNTABILITY

8-12 April 2017 • Hammamet • Tunisia
Accountability for Social Accountability
The Social Mission of Medical Education: Ranking the Schools

Fitzhugh Mullan, MD; Candice Chen, MD, MPH; Stephen Petterson, PhD; Gretchen Kolsky, MPH, CHES; and Michael Spagnola, BA

Background: The basic purpose of medical schools is to educate physicians to care for the national population. Fulfilling this goal requires an adequate number of primary care physicians, adequate distribution of physicians to underserved areas, and a sufficient number of minority physicians in the workforce.

Objective: To develop a metric called the social mission score to evaluate medical school output in these 3 dimensions.

Based medical schools had higher social mission scores than private and non–community-based schools. National Institutes of Health funding was inversely associated with social mission scores. Medical schools in the northeastern United States and in more urban areas were less likely to produce primary care physicians and physicians who practice in underserved areas.

Limitations: The AMA Physician Masterfile has limitations, including specialty self-designation by physicians, inconsistencies in re-
Special Communication

The Social Accountability of Medical Schools and its Indicators

Charles Boelen¹, Shafik Dharamsi², Trevor Gibbs³

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²Faculty of Medicine at the University of British Columbia and Co-Lead Faculty of the Social Accountability and Community Engagement Initiative, Canada,
³Development Officer, Association for Medical Education in Europe, Independent Consultant in Medical Education and Primary Care, United Kingdom
THEnet: Network & Framework

THEnet: Training for Health Equity Network
Social Accountability in Action
Education alongside research as the mission of a medical, dental and veterinary school

ASPIRE RECOGNITION OF EXCELLENCE IN SOCIAL ACCOUNTABILITY OF A MEDICAL, DENTAL, VETERINARY SCHOOL

CRITERIA

Beyond Flexner is a national movement, focused on health equity and training health professionals as agents of more equitable health care. This movement takes us beyond centuries-old conventions in medical education to train providers prepared to build a system that is not only better, but fairer.

The broad themes of social mission include social determinants of health, community engagement, disparity reduction, diversity promotion and value-based health care. Interprofessional education and practice are essential components of a transformed health system. This website serves as a repository of information about Beyond Flexner gatherings as well as a wide array of resources for learning more about the movement and how to integrate social mission into health professions education and practice.
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I-SAT (Indicators of Social Accountability Tool)

The I-SAT Working Group*
The I-SAT Working Group

Dr. Louise O'Meara (Institute for Social Change)/Facilitator

Ms. Björg Pálsdóttir (THEnet), Dr. André-Jacques Neusy (THEnet), Dr. James Rourke (ASPIRE), Dr. Sonal Batra (Beyond Flexner), Dr. Sarita Verma (AFMC), Ms. Katie Qutub (USAID),

Dr. Ruy Silveira de Souza (Brazil), Dr. Mourad Belaciano (Brazil), Dr. Larisa Carrera (Argentina), Dr. Marcela Groppo (Argentina), Dr. Tomlin Paul (University of West Indies),

Dr. Fernando Menezes (PAHO/WHO), Dr. Jose Francisco Garcia (PAHO/WHO), Dr. Erica Wheeler (PAHO/WHO), Ms. Karen Gladbach (PAHO/WHO), Dr. Noora Alhajri (GWU)

PAHO/WHO HQ @ WDC June 2017
Sponsors

Pan American Health Organization

World Health Organization

United States Agency for International Development
Experts & Tools

EXCELLENCE IN SOCIAL ACCOUNTABILITY

- THEnet
- ASPIRE
- beyond FLEXNER
Accreditation Innovators
Argentina
Brazil
Jamaica

Academic Insitutions & Accreditation Agencies from Latin American & Caribbean Countries
Social accountability (SA) for health professionals is about directing their education, research and service activities toward addressing the priority health concerns of the population, and especially underserved communities.

In June 2017 PAHO/WHO brought together a group of international experts to produce a new guide that medical schools in the Region of the Americas (and globally) could use to monitor their social mission.
Stages of change of Indicators of Social Accountability of Medical Education (I-SAT)

I-SAT’s philosophy of Socially Accountable Medical Education

The School’s mission, values, standards, goals, and governance are needs-based and centered on addressing health issues and community needs among target population, strengthening local health system and reducing health disparities.

The school has a participatory approach where decisions, governance and strategies are based on valuable inputs from stakeholders within the community, local public health organizations and policy makers, with a priority focus on social determinants of health within the community they serve.

I-SAT Activities

Student
Successful outreach/orientation pipeline programs for schools in underserved communities that include learners from those communities and track participant’s outcomes.

Faculty
Proportion of faculty members who engage in teaching and research activities related to community health needs. Training, use and recognition of community practitioners and members of the healthcare team in underserved communities and across the region.

Curriculum
School identifies graduate competencies that are based on the priority health, cultural and social needs of the geographical area the school serves and the health system and services in collaboration with community stakeholders.

Research
Proportion of community-based research projects that involve community members and other stakeholders. Demonstrated impact of research on health services, health outcomes, policy and practice.

Governance
Evidence that external stakeholders from the community are actively involved in the design, implementation and evaluation of education, research and service.

School’s Outcome
There is a system in place to continuously track the school’s graduates and the relevance of the training they received to their practice.

I-SAT Outcomes

Students
The student body reflects the socio-demographic and other characteristics of the communities and regions the school serves including underserved populations and those deemed most likely to be willing to serve those populations and regions.

Faculty
The school employs and promotes faculty who possess competencies needed to address health system and community needs and those reflecting the diversity of the communities it serves and incorporates the principles of social accountability in their teaching.

Curriculum
The curriculum design, content, delivery, assessment and evaluation reflects the expected competencies of graduates. Professional orientation is identified through needs assessment of the geographical area the school serves.

Research
The school has an integrated research program based on the determinants of social accountability, with participation of students, faculty, health workers and community members.

Governance
A socially accountable mandate in the school’s vision, mission and values that is fully defined, with metrics and benchmarks, and is being implemented.

School’s Outcome
The school’s graduates practice according to where they are needed in the geographical region the graduates serve. The school’s education, research, its graduates, health service and partnerships have a positive impact on the health care, the health and health equity of the communities/regions that the school and its graduates serve.

Regional Impact

Quality and equity of health care access. Little or no geographic areas with shortage of health professionals. Responsiveness in addressing health inequities in target population. Culturally competent health service delivery that is cognizant of social determinants of health.

Long-term goals

The school’s graduates practice according to where they are needed in the geographical region the graduates serve. Health equity and improved health care access.
THE PDF TABLES
CONCLUSIONS

The I-SAT instrument will be useful to:

(1) Promote the orientation of education, research and service delivery to meet population health needs linked with health system priorities.

(2) Recruit students and faculty bodies that reflect the ethnic, geographic, and socioeconomic diversity of the population served.

(3) Support advocacy at the political leadership level for the adoption of health and academic policies consistent with the values and principles of social accountability.
Accreditation & Social Accountability
“… the inclusion of the concept of social accountability in the accreditation process of medical schools and other health institutions.”
Reflections

1. Change takes time

WHO 1995

Health Canada report 2001

Future of medical Education in Canada 2010

MOU signature 2013

CACMS Accreditation element 2014
Reflections

2. Change is doable

‘We can’t change because of link with LCME.’

‘We’ll lose reciprocity with the U.S.’

‘LCME sponsors will not approve.’
3. Change requires leadership and partnership

At a national level, to develop the vision

- Health Canada
- Deans of medical schools
- Association of Faculties of Medicine of Canada
- Student and resident organizations
- LCME and CACMS sponsors
- CACMS and LCME members and secretariats
Conclusions

• Accreditation is a driver for social accountability

• Flexible more than prescriptive

• Emergence of a culture of social accountability

• Anticipation of accreditation element on social accountability
Thanks for your attention
Max Ernst
Juego de Ajedrez
Game of Chess