Good afternoon, everyone. Thank you for your patience with our technical issues. My name is Beatrice Bernescut. I'm the communications person for the PHC team here at WHO. And I'd like to invite you all to join us for the webinar this afternoon. I'm going to turn it over to Dr. Marie-Charlotte Bouesseau to please say a few words and introduce our speaker this afternoon.

Thank you, Beatrice. And thanks to all of you. We know you are a big group around the world. So I would say good morning, or good afternoon or good evening, wherever you are. It's really a pleasure for us to be with you today. And despite these difficulties related to the technology, I do hope this is the first step to build what we would like to be a virtual community to talk about your experience, your daily work on primary healthcare, share information, share technical knowledge, and with the time be able to make progress in the way we deliver these kinds of services. This is, as you know, the first webinar of a series. And we decided to address what is probably the fundamental issue when we talk about primary health care - that is the people providing care. So we have the privilege to have with us today, our colleague, Jim Campbell, who is the Director of the department...
here who are working on health workforce, and he will discuss with you a number of priority issues related to this. For example, the shortage of health workers in most countries actually around the globe, the related question of training and educating health care workers - which is certainly an emergency to address the shortage of qualified human resources. We will also discuss with you how to build multidisciplinary teams in order to address the complex needs and expectation of people at primary health care level. There is other issues such as how can we have better data on health workforce available in countries, and you'll just leave this is a dialogue. So you will be able to suggest questions and the new areas to be discussed. has, you know, this webinar will be also available after this live session. So you can definitely encourage colleagues to look at it and react. So I now turn to Jim, and thank him again, we have actually a very good collaboration between our departments. And this is only one more expression of this collaboration. So thank you, Jim, for being with us for this webinar.

Dr Jim Campbell 04:01
Thank you very much. And similarly good afternoon, good evening, good morning, to all the colleagues that have joined from around the world, I was looking through the list of A to Z here, and a number of names that we have been working with and no or read publications from. So welcome everybody. Firstly, you'll be pleased to know that there is no PowerPoint presentation. We'd like to use this opportunity to have a conversation and exchange with yourselves using the chat facility. So please do - if you have particular questions - feel free to start typing those down. And we will try to work our way through either the themes or the many questions that come through come through that format. We are, as part of the series of this virtual collaborating network, trying to build a community of practice, of people that are engaging, and can contribute so that it's not only a one-way dialogue from Geneva to yourselves, but any engagement between primary health care from a workforce perspective. Just a few thoughts from myself, in relation to some of the points that Marie-Charlotte mentioned. We have less than four weeks ago completed the World Health Assembly, where primary health care and its renewal was part of every single conversation on every single day of the assembly. If we look at what governments, Member States, ministers, stakeholders, delegates, were saying in the events, is that the the work to follow up from the Astana Declaration to follow up on the Operational Framework that is necessary and to implement change is absolutely necessary, and needs to be a priority of WHO, but also of many, many partners. The evidence base that has helped us to get to this position, we saw lots of the technical papers that were prepared in advance of Astana. And each of those did ensure that we set out some of the the knowledge that we have, the priorities that are needed, and what can be done for countries at all income levels. So that evidence, the call to action from Astana is now gone through into major governance decisions at the assembly. The work
that we’ve been asking, as a result of this commitment to primary health care, as the foundation of universal health care bridges is fairly much a simple question. What are the workforce implications? If we want to reach all people at all ages, what workforce will we need? How will we have to pay them? What data etc. The consensus that we have is that the solution will lie in the role of a multidisciplinary team of health care professions, of associate professions, allied health workers, community workers, and a health-literate public and population that are actively involved in the concept of patient-centered, human-centered health care services and how we provide care responsive, yes to population needs and to epidemiology and demographic challenges, but also to the needs of people. And so it’s very encouraging that as the introduction here that Marie-Charlotte was saying exactly that - it’s the people that require health care, and it’s people that provide it. How do we therefore link these two things together? The my sort of perspective coming out of the assembly is exactly that. We’ve seen every put people center stage of our discussion. We’re not necessarily talking explicitly about disease or academic ideology, we’re talking about health and well being of people and the people that are going to connect the dots, the interaction between the healthcare system, the service, the equipment, and the needs of other people.

Dr Marie-Charlotte Bouesseau 09:29
Thank you, Jim. Maybe we already have some questions from the chat or

Beatrice Bernescut 09:39
no questions as of yet. But I wanted to ask you to elaborate a little bit more on how this fundamental sea change came about, because we’ve definitely shifted from a disease focus, fix the problem, to a people focus. Do you you have any sense of what were the factors that made that come together, that made that happen?

Dr Jim Campbell 10:06
I think there’s several - many. If you look at how does a global health issue become center stage, when does it become part of the political consensus as a priority? It’s a combination of the evidence, the technical knowledge. And I think fundamentally, in the last five to seven years, we’ve seen greater evidence around universal health coverage and primary health care. Astana was an uplifting moment - 40 years of time to reflect on it. We’ve also seen though the evidence in itself is not enough. You’ve got to make a contribution between the leadership agenda. And I think with the Director-General’s appointment, Dr. Tedros, who comes from a personal experience of delivering primary health care, of working in a district health facility, expanding through that knowledge in
his own promotion to come into a minister of health position, he drove health reform on the basis of primary health care, drove health reform on the basis of expanding access there, and using a multidisciplinary team. So I think his personal experience of how it can be achieved for political leaders has resonated to a universal health coverage dimension. So we've got evidence, we've got political leadership, and in a broader context of a moment in history, which is both the Sustainable Development Goals, but also the anniversary of Alma-Ata. And sometimes anniversaries and contacts just enable one another. I think the other reality, though, is striking is that we all recognize that health care systems in high-income countries also are absorbing more and more resources to respond to population needs, to respond to healthy aging, to respond to non-communicable diseases. And so the value of prevention promotion, the value of a strong primary health care system, no matter how much money they're spending. So these combinations of things have really helped us to put the primary health care at the center of the universal health coverage discussion. And, you know, socially, it makes sense. Population health wise, it makes sense; economically, it makes sense. And, you know, for health and well-being, whether that's national targets, regional titles, global events, it makes sense to invest in that type of functionality to be able to expand. So the combination is helping us drive that agenda. What I think we need to do is capitalize on this opportunity. And so we really need to say, well, how - irrespective of your income status - where does primary health care work? And for what reason had to add is the the voice of communities, the voice of patients and families inform health care systems to be responsive to their needs? Where do we see different models of service provision having improved effectiveness in terms of health outcomes? And those outcomes also, in terms of the patient experience, in terms of the trust in the health care system? And so how do we build that evidence base to have to say, well, it's all about context, moment and the opportunities here within the context, how can we make a difference in my environment in my country? What is the evidence of what could be tested?

Dr Marie-Charlotte Bouesseau  14:44
I have a question for you. Coming back to how people can be better prepared, because the reorganization of health system around primary health care focus is very important. But there is also a problem with the way people are trained in their initial training. And when I said people, whatever discipline, sector or beyond the health sector, to address, as you were saying diseases. So what does it mean, in terms of educational programs and continuous training?

Dr Jim Campbell  15:38
I think there's an opportunity, I think, we have some around the world. There are many,
many different approaches towards the education and training of the health care team to
the primary health care team. The opportunity here is to sort of assess and say, what are
the major health outcomes that we want to achieve? It was doing it and depending on our
context, whether that’s communicable disease, non-communicable disease, population,
youth, ageing, whatever it may be, what are the approaches that we’ve seen, with the
Global Burden of Disease study, we’ve seen, we’ve improved data and population, an
ageing issues, governments have got better data to actually say, well, we know what
priorities should be, and which will have the greatest impact on populations and services.
And from that, there is again, clear evidence, normative work, which says, in which case,
these are the most effective interventions to address condition x or condition y. And once
you know what the service and the system needs to provide, you can then provide the
skills and the competencies necessary to do that. And that doesn't necessarily approach
from what are we doing today in terms of education training, it says, where do we need to
be tomorrow to be fit for purpose? How do our medical professionals, specialists with
advanced education training, how do our bachelor-qualified clinical officers, nurses,
pharmacists, midwives, radiologists, how did they all get engaged in that delivering the
interventions to scale with high quality on every occasion, and the competence as a team
that then needs to deliver and then the education system becomes a conduit to achieve
that purpose. The education system has to be responsive to the labor need, and that’s the
same that we’re seeing in any sector. And if you want to be an active economic
development area, you need the skills of your workforce to be responsive to the needs of
the sector. And that’s what we need to shift and the work that was done by the likes of
Professor Julio Frank on this by The Lancet, and others that was on the transformative
education agenda, set out some of the thinking, the high-income countries, there's been a
number of pieces of work on this. We see similar the work of Afrihealth in Africa, looking at
these education and translation, and you’ve got to understand it to produce the
workforce to deliver the service you need. And that’s an opportunity. Really, it’s, not
something necessarily be concerned about, which it’s different than the traditional way of
thinking. It’s how do we make the people who provide care responsive to the people who
need it.

Beatrice Bernescut 19:12
If I may, one of our PHC Young Leaders is producing some research on this topic. For
example, she’s finding that, in Australia, nurses in graduate studies are not inclined to go
into primary health care, because they perceive it to be something you do later in your
career. And so she’s trying to outline the ways that the educational system in Australia can
change the curriculum to encourage more people to go into PHC nursing, as opposed to a
specialized area. So it’s not just low-income countries, it’s all over the world.
Dr Jim Campbell  19:48
Not indeed, and I think we recognize that. If we’re talking about primary health care as in many, many countries as a significant change or reform opportunity, because it’s often been seen as a foundation piece, but most of the investment goes into treating a disease rather than preventing it. But it goes beyond just curriculum, it goes beyond we have to change the concept of social accountability. We have to change how students are selected for clinical programs, medical programs, any of your professional degree programs that have to have a social accountability movement and the empirical data that’s available that says if you have different incentives in your selection, identification of students, you will have greater success in deploying your graduates into careers and practice in health care in some of the more rural and remote and less urban facilities. And we’re seeing that all over the world, in high-income, middle-income settings. So it’s not just the curricula. The skills that they need, then you’ve got to be honed and improved with inter-professional education practice, to have that impact that and quite rightly, the point you’re making and how do you also look at the role in that team. We will always need specialist clinical knowledge and education available in the team. But there’s lots of opportunity for advanced practice roles to be taken forward. Role substitution, role delegation, for tasks, which potentially can be at the end of a three-year or four-year degree program, where these tasks can be safely, competently achieved to quality on a repeat basis without necessary. So we get people to practice their scope of practice to the top of their profession, in an enabling environment to do that. We don’t always require somebody with more advanced education training to be working. So technically, some of these aspects are special but we’re seeing around the world these days demonstrate [portion of the recording unusable due to interference]

Beatrice Bernescut  23:31
I believe that one of the things that they found is that after a few years of initial deployment a renewal..

Dr Jim Campbell  23:40
....discussion and the adoption of a resolution of the role of community health workers in primary health care. It was an exercise to bring that guideline to the assembly which took two and a half years. We had experts from all over the world contribute to the development of peer review group at testing it with a group of implementers and governments, many from the African context but also from Americas, from from Asia, with different models of practice. And so a big thank you to everybody involved in the work. And the evidence quite clearly suggests that yes, you better remember that any people are not static. We all...commitment to lifelong learning health care behavior to our
practice as well and the evidence is that we should be looking at [unusable] There is an opportunity for appropriate terms and conditions in contract... [unusable] New Mexico, Ecuador, all of this .... Member States [unusable] The vast majority of the workforce. [unusable] If we don’t provide decent labor conditions for some of our health workers, at every level at the community - health worker level, physician and specialist, nurse and midwife and the many other professions. If we don’t guarantee some of those labor rights, social protection rights, we really are having very negative impact on SDG 5 on gender equality, on SDG 8 on women’s economic empowerment, engagement. Investing in health and investing in primary health care will create jobs for women in greater numbers than many other sectors. We’re also invest in some of the underlying principles around gender equality, and gender equity. So the guidelines is, you know, in decent work is absolutely critical to be part of that. We’ve seen in many, many countries, people across the health care system burnout, stress, and anxiety in our healthcare workforce, the mental health issues of the people providing mental health. Challenge as well as the mental health of the population. And we need to put these issues on the table, not only the occupational issues, but these people. So people issues.

Beatrice Bernescut 28:42
So what if I may, what I’m hearing from you is that it’s not only important to think about the jobs that health care professionals do, but to think of taking care of the health care professionals, which makes sense, after all, but I see we have had a number of questions come in. So if I may, I’d like to start by asking some of these questions. So first question we received is how can we achieve that our governments understand the importance of PHC and to prioritize it, to make it a focus of legislation?

Dr Jim Campbell 29:21
As I said at the start of the conversation, I think there’s a combination of evidence, political leadership and willingness to explore these issues that we haven’t had for many, many years. People may have caught the discussion by Christine Legarde, the head of the IMF, the International Monetary Fund, just last Saturday, where she said, investing in health, investing in education, investing in social protection, what should be described as social spending, is an absolute necessity. So when you know, these are not it is not only health professionals, saying that it’s time to invest in health care. It’s not only public health scientists and experts, but we’ve got people who are in charge of national economics, government financing, saying, investing in health is the right thing, morally, is the right thing to do against principles, but also it’s economically sane policy investment. And so all of us in the primary health care community, all of us interested in universal health coverage, we have to understand some of this economic literacy, and add it to our
advocacy to make sure that we get an investment in health decisions.

Beatrice Bernescut 30:51
In other words, we still need to prove the case. We have the proof, but we need to put that proof forward.

Dr Jim Campbell 31:01
I mean, the evidence is clearly there, the role of people-centered care, of integrated care, of primary health care, the evidence is there. But it does mean shifting health care systems in the right direction. And so it's constantly about providing evidence to justify/substantiate/build the all the investment case for change. I think that's always been part of a challenge for all health care professions.

Beatrice Bernescut 31:31
Going to our next question. So we have someone who welcomes the focus on community health workers, but points out that, of course, community health workers need good referral systems to family doctors and nurses. What are your thoughts on investing on this next level of workforce?

Dr Jim Campbell 31:51
Absolutely correct. We have seen both in the technical evidence documents that were prepared for the Astana conference. We’ve seen that in the language of the resolutions and decisions this year in the World Health Assembly, that to deliver primary health care needs a team. It’s a team of health professionals at all levels. We...the role of somebody with maybe six months’ or 12 months’ or 18 months’ education, with a supportive supervision from clinical supervisors and management supervisors can do prevention promotion referral, effectively. They can have an impact on non-communicable disease and impacts on communicable disease in terms of health behavior. But we will always need the referral mechanisms into the health facility discussion. When you identify a risk, when you identify a condition, we will always need that clinical knowledge and expertise to be engaged in it. Some of the best programs that see you in primary health care developing all of your patients at exactly the same time. So there’s an expansion of the community anchorage; there’s an expansion of the primary health care team in the facility. And there’s an expansion of the specialist team at the same time. That’s primary health care. It’s all occupations working together in a seamless fashion. So that you can enter a health care system and negotiate your way through it, depending on your
Dr Marie-Charlotte Bouesseau  33:35
On this specific aspect, I think we also need to be a little bit creative. And sometimes new technologies can be useful in the way to build the team. And the way to communicate just using cell phones and other kinds of easy and quite available technologies can help also to facilitate this discussion between the different levels and the different stakeholders, including perhaps first of all in very remote areas where sometimes complex, so I think we have to be also creative. Keeping the whole team together and facilitating this sort of behavior.

Dr Jim Campbell  34:28
Yes, I agree with you. I’m not, you know, the technology, we still have at the heart of the relationship is the people that require access to health care, and the people that provide it. And the people that manage the system overall. So this people triangle is at the heart, but using medical technology, using education, using different digital tools, communication technologies, to be able to facilitate those relationships, to facilitate learning, to fit to facilitate lifelong learning, to exchange pieces of information that will make your job as a referral specialist more efficient, is absolutely essential, I think. We’re seeing the growth in digital technologies and health technology. But at the same time, we’ve got to remember that we have to ensure that we don’t go too far. If you look at some of the high income countries, even where there’s huge investment in digital technologies and digital tools, they’re still nonetheless 70 to 80% of the cost of the health care system and the investment in the health care system is in their education, is in their learning. And the tools are there to enable that. There may come a time and there are there tools on the market where there can be automation in health care. Many, many examples, we still want to interact with our primary health care team.

Beatrice Bernescut  36:34
You actually jumped ahead and answered the next question on the list, which was what would be the role of enablers such as digital health and helping carers be more effective? Our next question is, in areas where there are shortages in human resources for health, will the problem be solved by adding more community health care workers? Where when we know that what is really happening is that doctors and nurses are being are emigrating to richer countries for higher salaries. And they go on to ask are low-income countries able to provide better employment terms for all carers? And to enhance better retention in PHC, rather than seeking cheaper options?
Dr Jim Campbell  37:23
The answer is yes. Okay. We have examples around the world of exactly that. We....the opposite. Again, the opportunity to invest in primary health care system doesn't mean it's necessarily a cheaper alternative. Doesn't mean it's a loss, less quality alternative. When primary health care functions well, it's excellent, excellent quality service. It still requires medical doctors, it still requires your nurses is sufficient number for the whole team. It's not primary health care is not - shouldn't be associated pure with a less skilled health workforce set of occupations, which is a second-class service for low-income countries. It is a state-of-the-art health care system. Well, so I think there are, and we've seen, low-income countries where resources, public expenditure, often limited, still put into place effective primary health care systems. And they're building upon those that it's not necessarily - health care systems are never standalone, stationary. They always evolve, and evolve, and people still build upon them and improve. But they are providing prevention promotion, and treatment in greater numbers. We're seeing huge improvements in child health outcomes. This huge burden of communicable diseases being met, which with a growing population is, in many countries, a success in itself. Because the population numbers to maintain your average statistics, it is that's it, that's a success. And we’re even seeing countries improve on it. So yes, low-income countries, middle-income countries, can all be investing in primary health care.

Beatrice Bernescut  39:40
Thank you. That was one of the key messages that we kept hearing at WHA, that we would ask everyone here to reinforce, is that it's not a second choice. It's not a subpar option, primary health care is the primary strengthened system for us to go forward with. I’m looking at the list of questions here. So you have one person who said, data is essential for planning, monitoring and evaluation of the success of policy with regard to this issue. However, data is often distorted, and paints a false reality, for whatever reasons. What measures can we employ to safeguard data for effective policy formulation and implementation?

Dr Jim Campbell  40:38
I’m always very surprised when in many countries policy decisions, financing decisions, are taken with data which is not necessarily the most reliable. We really do need to think about what are the key pieces of data that we need to make investments in? We need to know the burden of population needs, we need to know the distribution of our health care facilities, we need to know the distribution of our health workforce, and within that distribution we need to know who are they? Where are they? What's their education? competencies? How much are we paying, etc, etc. So we do really need some space. And
inevitably, the data is in a country. Whether it’s a high-income or low-income, the data is there somewhere. But it’s not always necessarily captured and consolidated media. But we spend a lot more time worrying about the data of disease that we do about the data on people. People who need access to healthcare and people who provide it. If we put the same level of emphasis on what we put into measuring some of the major communicable diseases, where you can go on to information systems and see the incidence rates of disease x by square kilometer in the 10 high-burden countries around the world. If we had a similar knowledge around the ways our health systems and infrastructure as our people. What’s the correlation between that system infrastructure and the disease burden, you start to build a private health care system immediately because you’re able to correlate systems with population. So it’s not…and invariably some of that data is there, but it hasn’t been ....the level of investment necessary to build those capacities through the system. And this is where technology to be able to bring that data. For the health workforce, I was very encouraged in the Assembly, but also, for the last couple of years Member States have really been stressing that they are committed to having better data on health workers through what the normative information on national health workforce accounts. So that they’re able to describe the number of years of their education, their wages, their terms and conditions of employment, whether or not we’re treating the youth, the women, the men in our workforce appropriately, the social protection, or whether we’re doing lifelong learning and education, building that data. And I will already seen the benefit of this commitment to better data on the workforce. This year, the Assembly, we’ve had more Member States reporting shared data than for almost 15 years, in terms of the level of engagement. It’s really encouraging part of a prominent part of the universal movement.

Beatrice Bernescut  44:23
I think we have time for just two more quick questions. So the first question is, understanding that the optimal multidisciplinary PHC team might be different in different contexts, what might some alternatives be or how might countries be supported in moving from alternative models towards an optimized PHC workforce? What might be the process to get there, to help them formulate the team that would be ideal for their context?

Dr Jim Campbell  45:05
Well, firstly, absolutely agree, it is very much the context. Every country is going to be building from what already existed in practice. If we go back to what we’re talking about a moment ago where you have to understand, first of all, what what are your national policies. And if you have recognition that with your demographics, and the youth may
have 50% population young (under 25), it’s clear that the health care system needs are going to be therefore targeted towards some of the pediatrics or some of the youth and adolescents, towards some of the sexual reproductive health issues, towards facilities. And the other part of your population, you may the greater incidence and prevalence of non-communicable diseases. You can start to get a feel for what your health care system needs to be. And then you have to consider your workforce. We need to get away from the thinking that there is a model off the shelf from... you need one doctor, two nurses, a midwife, an obstetrician, a gynecologist, a pediatrician. It doesn’t work. You have to really understand your needs. There’s good evidence, yes, you are back in a primary health care team the skill mix, an opportunity to have different roles and different practices. There’s evidence, good evidence. And so you can say what traditionally I’ve been doing, it’s for a specialist model of care, especially physician, should now be done for family medicine too. So you have a specialist Family Medicine provider, but with a team of other professions that can do some of these tasks and the essential interventions as well. And you may change your skills, but you’ve got to do your homework on your country, the context for rather than saying 10 of these, four of these, and you have primary health care.

Beatrice Bernescut 47:26
Sort of reinforces your earlier point that a number is fine, but a number out of a context doesn’t do you much good. And for our last question this afternoon. What high-impact initiatives or approaches can be done in terms of PHC workforce, covers everything from training to distribution, tension, protection. I guess, if you have examples of individual high-impact initiatives that people could start rooting for or lobbying for

Dr Jim Campbell 48:11
From a systems perspective, rather than anything else? The impact, we need to create an investment condition. And that’s the one that will have the longest, how do we invest in health care? How do we invest in the people that provide it, the facilities, the environment, the water, the sanitation, the electricity. It’s a minimum standard and minimum norm. That has the biggest impact. And in which case, we have to work our way through some quite simple impact assessment. How educated our workforce and what policies do we have in place. How once they graduate, do we intend to pay them and deploy them. How once they’re in practice do we provide them the environment to be practical, turning up to work motivated and engaged, ready to work. And sometimes these...the things that will have the greatest impact are actually quite simple, boring, policy tasks. But those simple boring policy tasks and questions, if done well, gives you the best impact. It doesn’t have to be innovation, it has to be sometimes are we doing 80% of the basics. Wow. Because if we do, we can work on the 20% for innovation. Got to get the foundations.
Beatrice Bernescut  49:49
Thank you. On that note, I’d like to bring our webinar to a close and say thank you to Dr. Marie-Charlotte Bouesseau. So thank you very much, Dr. Campbell, too, for hosting us this afternoon. To everyone who’s participated, I invite you to send us further questions which we will take under consideration and hopefully address either at another opportunity or in the next issue of the Primary News! our PHC newsletter. It’s very easy to reach us: it’s primaryhealthcare@who.int. Thank you everyone for participating.