

## **CAB II – Inter-Professional Education and Collaborative Practice**

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I thought I would begin this address by establishing the context of what we (health care providers and public health professionals) are about: We are all working in our various countries, communities and institutions to achieve longer and healthier lives for people. We want people to live long lives and we want to enable people to live healthy lives, in which the burden and sufferings of disability are reduced. This is the overarching dream, our vision, our goal, our call to service.

This overarching goal is true here in Canada. It is equally true in Guyana. It is no less the truth in Tanzania, in Ethiopia, in Nigeria, in Ghana, in Barbados, or India or China or Uruguay. It is a common thread since this goal is universal and equally applies to developed countries such as America, Canada, the UK, Germany, France and developing countries such as Guyana, Haiti, Botswana and others. It is embraced as an inalienable right for citizens everywhere in the world.

Through our actions, health care providers have crafted our own HOLY GRAIL – Long lives! Healthy lives! Lives that allow people to work for and achieve their full potential!

As a Minister of Health I have persistently articulated this as our vision in health and the absolute goal of HEALTH FOR ALL. In my Presidential address to the WHA in 2008, I gave context to this vision by bemoaning the fact that decades after we reached a minimum life expectancy of 50 for all countries in the world, we now have more than a dozen countries with life expectancies of below 50. In spite of this I called, as I do again today, for a minimum life expectancy of 70 for all countries in the Americas and in the world by 2025. I called this the 70 X 25 Goal. The premise is based on people living longer and for the lowering of mortality, particularly under-5 and maternal mortalities, for the prevention of vaccine-preventable diseases, for the reduction of morbidity and mortality related to HIV, TB and Malaria, for the elimination of nutrition deficiencies, for the diagnosis and treatment of persons with mental disorders, for the prevention and reduction of disability so that people can work for and achieve their life's potential, for the reduction and elimination of tobacco-related and alcohol-related illnesses, etc.

My call for longer life expectancies and greater freedom from disability must, however, be seen in the context of a surrogate call for a more equitable way to how we train health care professionals, how we address the issue of supply, mix and distribution of human resources and a definition of the system through which we deliver health care. It was then at the 61<sup>st</sup> WHA, it was this year at the 62<sup>nd</sup> WHA, and it is today at the CABII – Inter-Professional and Collaborative Practice, ultimately a call for health equity, health financing and health system strengthening.

For us to derive maximum benefit from the financial input we make in health, we must strengthen health systems. Health Systems Strengthening must not be another set of buzz words. Health system strengthening must be bread and butter issues for Ministers of

Health, for our training institutions, for our health care professionals, etc. For us to improve outcomes, for us to sustain development, HEALTH SYSTEMS STRENGTHENING must be a pillar on which we build our health response and work for long, healthy lives which permit every citizen to reach their potential.

While we can argue, with great justification, that health care financing is one of the more important Health System Strengthening areas and an important barrier to guarantee good health, we cannot deny the imperative of an adequate HR supply. It is at the heart of Health Systems Strengthening.

We can argue, I believe with merit, that Health HR is arguably one of the major bases for the shortcomings of the health systems in developed countries. It is the reason why the Collaborating across Borders initiative assumes such importance in North America. I believe, in fact, that HR is a severe constraint in delivering quality health care to all in developed countries, such as Canada and the US. Truly Health HR is a genuine Health System Strengthening focus area for developed countries.

But there can be no equivocation when it comes to the importance of Health HR in developing countries. We cannot argue, we cannot dismiss the fact that HR is definitely the very essence of the failings of the health systems in developing countries. More than financial constraint, HR represents the biggest impediment towards guaranteeing HEALTH for ALL in developing countries.

The fact is that after so many meetings and debates and dialogue, after the Code of Ethics we collectively articulated through the WHO, a continuing and worsening HR crisis confronts us in developing countries. We all deliver health care with the constraints of HR shortages, within a milieu of a bludgeoning demand for quality health care and amidst new, re-emerging, rapid-spreading and deadlier epidemics to deal with. We do so with the realization of global warming and climate change that wreaks more disasters on populations that are already overwhelmed with health problems. We do so now with the threat of another economic downturn precipitated by a world financial crisis that is not our doing.

Ensuring enough health care professionals are available, addressing the supply side, ensuring the proper mix and distribution for this supply are real challenges that face Ministers of Health and Health Ministries around the world. We get up in the morning challenged by HR constraints in our countries. We go to bed stressed by the inadequacy of Health HR in our countries. We dream of a solution to the HR problems in our countries.

The health sector has become Moses's Dilemma! We are being asked to use straws to deliver stones! I say to you colleagues, we need to act now, not talk more.

**The lack of an adequate health workforce due to several causes, including migration of health workers from developing countries to developed countries, is a major cause of underdevelopment in the world!**

Building and expanding sustainable training programs in developing countries is and must be part of the solution. And a global treaty is necessary to ensure that those trained with national resources must serve a minimum time before they can ever be considered for jobs outside of the national boundaries. This is not an issue of freedom of movement. I do not and will never subscribe to restriction of freedom of movement. But national assets must be subjected to rules and regulations that lead to benefits to the population.

National health systems in developing countries are weak, unresponsive, inequitable and even unsafe. Some of you will say in developed countries too! It is my conviction that the major reason for weak, unresponsive, inequitable and unsafe national health systems is the inadequacy of the HR in these countries. Financial investment in health is not enough, but can we derive more from the financial resources we have now? Even though more technology is needed, are we utilizing optimally those we already have access to? These shot-comings are directly attributable to the continued and the increasing inadequacy of HR, both in number and in appropriateness of skills.

No country, be it a developed or a developing country, is without its constraint related to HR. Indeed, the estimate of a shortage of 4.5M health care providers in the world constitutes a critical barrier to achieving the MDGs, towards achieving the goal of long and healthy lives.

The fact is that 25% of Canadian doctors and about 10% of your nurses come from developing countries. In the USA, almost 30% of their doctors and almost 10% of their nurses come from developing countries. In the UK more than 35% of doctors and almost 12% of their nurses are from developing countries.

The number of Ghanaian doctors, trained in Ghana, but working in OECD countries equal about 30% of the total number of doctors working in Ghana. For South Africa, the number of South African doctors trained in South Africa but working in OECD countries equal 37% of the total number of doctors working in South Africa.

For developed countries, there is no excuse. There is no reason for the developed countries to rely on the supply side of developing countries to satisfy any part of the HR requirement to meet the health needs of populations in developed countries.

The Caribbean, for example needs to train and employ another approximately 5 to 10K nurses to meet their needs. The demand for training exists, we are not in shortage of people who want to be trained as nurses or in any of the health care professional field. The Caribbean does not have a problem finding enough students to train. But if we are going to satisfy our demands and sustain the present migration, we will need between \$US20 and \$US30M more on an annual basis for the training of nurses. In countries where this is almost half of the national budget for health, how do we finance such investments?

Consider this. There are almost 60M health workers in the world. This translates to about 9.5 health worker per 1000 population. More than 39M of these health workers are

located in Western Europe and the Americas. The density of health workers per 1000 population in North America is about 30. In Europe, it is about 20. In Africa, it is under 2.5. In the Eastern Mediterranean, it is 4. In South East Asia, it is 4.3. In the Western Pacific, it is about 6. In the Caribbean and Latin America, it is just above 6. Does this tell a story?

Where do we find the highest rates of child and maternal mortality? Where do we have the greatest mortality associated with either chronic or infectious diseases? Where do we have the least immunization coverage? Where are nutrition deficiencies least? The correlation between health workforce and health outcomes is clear. Health workforce saves lives. People in those countries with the highest workforce density live longer. Life expectancies in these countries are significantly higher than in countries with low density of health workforce. This is the bottom line.

In 2006, we recognized the crisis in health human resources at the 59<sup>th</sup> WHA when we adopted a resolution calling for a rapid scaling up of health work force production. The truth is we always knew this. We confirmed our recognition of this dilemma even as we pronounced Health for All in 1978 during Alma Ata. We reiterated our concerns in 1988 at the WHA. Yet our collective sloth is an embarrassment at the very least. For me as a public health professional and as a Minister of Health, this sloth is more than an embarrassment. It is a scandal.

We have not consistently addressed the issue of establishing a reasonable balance between numbers, diversity and competencies. There is no denying that we have failed to examine class size, training time, strengthening of existing institutions, development of new institutions, and examine regional and international cooperation in addressing the shortages. And we depend too much on bringing in skills into communities and into countries, without trying hard enough to address community needs and sensitivity. And in terms of quality and effectiveness, we have failed to ensure proper accreditation and licensure and we have failed to achieve integration and collaborative engagement among health care providers and professionals, etc.

Unequivocally, then, we must change the way we train professionals for health services and we must change the milieu in which they work. Training for health care professionals are designed and delivered within silos. The services we provide are also largely delivered through siloed centers and hospitals. While we must train, sustain and retain, we must also examine how we train. The development of an interdisciplinary, multidisciplinary, and multidimensional workforce is critical. I posit that our training institutions are presently not designed, nor are they inclined to produce such a health workforce.

The movement for Inter-Professional Education and Collaborative Practice, for which Canada plays a pioneering and lead role, is a movement in this direction. As a Minister of Health in a resource-poor setting, where the lack of adequate and quality HR is a significant part of the resource-poor setting, I am convinced we are not effectively utilizing IPECP as a health system strengthening focus.

The lack of understanding and appreciation has seen HR development identified as a Health System initiative, but nowhere, or only marginally, in the Health System Strengthening debate, discussion or dialogue is Inter-Professional Education and Collaborative Practice identified with HSS. The consequence is that IPECP is not usually a line item for funding in national budgets or identified in donor and technical agencies funding and technical support programs.

In recent years that is changing somewhat, but this area remains a largely neglected one. The WHO identified this issue in 1978 and this constituted an important discussion point at Alma Ata. A decade later, this was an important topic in the World Health Report as the WHO returned to the issue. Two more decades have passed and we are returning to the issue again. But addressing the issue must mean persistent attention and not an occasional glance. It is my position that we have merely paid occasional glances, rather than a determined approach as needed. We have flirted with, rather than romanced the idea.

The fact is we have to work together among health care professionals, across professions to guarantee access to a motivated, skilled, and supported health worker for every person in every village everywhere, in developing and developed countries. Collaboration across Borders is an under-utilized tool in providing solutions to the Health HR problems we confront.

### **A Paradigm Shift?**

We need a paradigm shift in training practices if we are to effectively address the HR challenge confronting us in the developing countries. We must think outside of the box.

Let me immediately posit I believe that hundreds of thousands and indeed millions of dollars are wasted because we have pursued failed models for training. In developing countries, we spend enormous amounts of grant and loan moneys to support consultants and other technical support, without improving our training capacity.

What then is the alternative? I would like to give a few examples of how Guyana is grappling with the problem. These are a few of the examples, not a comprehensive list.

- In an example of south-south collaboration, Guyana has a robust collaboration program with Cuba. This program has resulted in Cuban doctors and other health care professionals participating directly in health care delivery at all levels, including the primary health care levels for the last 40 years. This collaboration considerably enhances health delivery in Guyana. It influences how health care professionals in Guyana and in Cuba work since these providers attempt to bridge knowledge and use best practices from both countries

In addition, it was this Guyana-Cuba collaboration that help to establish the School of Medicine at the University of Guyana which since 1992 has graduated about 250 doctors.

The Cuban collaboration has expanded in such a way as to have an impact of the number of doctors serving in the country by now taking on 700 Guyanese students in a special campus in Havana. These Guyanese students will return to Guyana and complete final year studies between 2009 and 2011. This program will result in a doubling to tripling of the number of doctors serving in the country.

There are now four diagnostic centers in large population centers which provide services in Guyana and these are entirely operated by Cuban health care professionals at the beginning and the hope is that within five years the Cuban health care professionals would be entirely replaced by Guyanese health care professionals.

And through this collaboration, we have established the Caribbean's first stand alone Ophthalmology Full-Service Surgical Center.

- Guyana-China Health Collaboration is another example of collaboration across borders, which is helping to build capacity without involving a huge expenditure in terms of expensive consultants. In this collaboration, approximately 15 consultant level specialists from China provide specialist care, such as ophthalmology, orthopedics, gynecology, pediatrics, laparoscopic surgery, cardiology, etc. for two years. We are now benefiting from the 8<sup>th</sup> batch. In addition, these consultants work with our local doctors. We have also benefitted from Guyanese doctors being trained in China at the post-graduate level. Our lead orthopedic surgeon is now a Guyanese who did post-graduate studies in China.
- A Post-Graduate Surgery Program was developed through collaboration between the Ministry of Health, Guyana and the main hospital, the Georgetown Public Hospital, together with CIDA and various Canadian institutions, including the University of British Columbia, University of Toronto and McMaster University. The program utilizes the Illuminate Web-Based Program to deliver parts of the program through distant learning. For examples grand rounds were conducted out of Canada and Guyana with students and faculty from both countries. We have already graduated five students who are now establishing surgery programs in various Regional Hospitals. Another five students will graduate in November. This is true collaboration and building capacity.
- An Ob/Gyn Residency Outreach program is being done through the University of Pittsburg and we are putting together collaboration with the University of Pittsburg, Case Western and John Hopkins to establish a post-graduate program in Obstetrics and Gynecology.
- Another kind of example is working with a group out of the USA to establish a public-private mix to operate a radiation oncology program in Guyana
- Yet another such public-private mix has resulted in the establishment of a cardiac surgery program at the Georgetown Public Hospital.

- Working with the University of Toronto we have established a Foot-Care program at the GPHC.

- Building Mental Health Literacy among Care Providers and Communities:

- Health Provider Education in Mental Health Literacy and the early detection of common mental disorders

The Ministry of Health continued to drive the process of building capacity within the health sector to support mental health through the delivery of training programs that build Mental Health literacy and promote the early detection of common mental disorders in first contact health providers. In 2008, 110 care providers (general physicians, nurses, Medex, midwives, community workers and social workers) received the training.

- Community Mental Health Promotion Activities

In 2008 the Ministry of Health's weekly television program, Your Health the Nation's Wealth, featured 5 programs dedicated to mental health. Topic areas included depression, anxiety, substance abuse disorders, substance abuse treatment and rehabilitation approaches, and trauma and mental health.

- Building Mental Health Awareness among Peer Health Educators

A half day Mental Health workshop was held for the Peer Health Educators. The workshop focused on building mental health awareness, understanding normal stress, and being alert to signs and symptoms that may indicate that something may be wrong.

- Building Mental Health Capacity in Priority Areas:

- Psychosocial Interventions for Common Mental Health Problems:

The Ministry of Health developed and delivered a basic counseling training program for community and primary care providers that was delivered to 30 health and allied health workers in Georgetown, Guyana.

- Psychosocial and Mental Health Interventions for Youth Exposed to Trauma:

In October 2008 the Ministry of Health, in partnership with the Ministry of Human Services, the Ministry of Education, and UNICEF, introduced the Cognitive Based Interventions for Trauma in Schools (CBITS) program, an established and proven approach to addressing trauma related symptoms in children and adolescents in school or community settings in the United States. CBITS is a skills-based, group intervention that is aimed at relieving symptoms of Post Traumatic Stress Disorder (PTSD), depression and general anxiety among children ages 10 to 15 exposed to traumatic events. This program will help build the capacity of existing health and allied health providers to provide appropriate evidence informed psychosocial and mental health interventions at first responder and referral level for children and youth exposed to trauma or disaster in Guyana. Thirty care providers from Health and Human Services were trained in the CBITS intervention and a CBITS multisectoral committee, lead by Health, was established to oversee the implementation, monitoring and evaluation of the program.

- Psychosocial and Mental Health Interventions for Substance Use Disorders:

In recognition of the need for substance abuse services, the Ministry of Health embarked on a mission to strengthen Guyana's capacity to provide care services to persons affected by substance use disorders in Guyana. In 2008, the Ministry of Health, in partnership with the Departments of Psychiatry at Dalhousie and McMaster University, completed an initial training program in Structured Relapse Prevention (SRP) as an initial step towards building capacity to provide non-residential treatment and rehabilitation services. Following the training the Ministry established a collaborative core group of Ministry of Health and Phoenix Recovery staff to implement the SRP group intervention as a pilot at the GPHC. By the end of 2008 the SRP program had catered for 67 clients. In November 2008, in partnership with FBOs and NGOs, the non-residential SRP program was expanded to the New Amsterdam Prisons and expansion will continue in early 2009 to include Port Mourant and Skeldon Hospitals as well as the Prisons at Camp Street, Temehri, and Lusignan.

- Management of Depression and Anxiety in Primary Care

In partnership with the Guyana PAHO Country Office and Dalhousie University, the Ministry of Health began an initiative to embed clinical care competencies for the early detection of depression and anxiety and the management of depressive and anxiety symptoms in first contact health facilities in Guyana. Health providers in regions 2, 3, 4, 5, 6, 7 and 10 received the training. These activities were supported through the 2008 PAHO – Health Canada BWP grant.

Programs to Support the Health Workforce:

Dedicated care providers are the most important asset of the health sector. 'Burn Out' is common among care providers and is often not detected and not addressed. In recognition of the need to promote the health and wellness of persons dedicated to helping others, the Ministry of Health initiated a 'Stress management: Self-awareness and Self Help' training program for community and primary care providers to promote self-care and healthy lifestyle among health and allied health workers. This program will serve as the foundation for establishing a 'Stress Management and Self-care Program' for the health workforce. 30 care providers from Health and Human Services participated in the training.

Whether we live in developed countries or developing countries, health is important to our citizens. Health is wealth. Health is development. Therefore, resolving the HR problem is an imperative.

For those who treat health as a mendicant, always coming with outstretched hands to receive, we must disabuse their minds. Health is in fact the center of development, without it there is no development.

We can change the world. The dreams of Alma Ata are within grasp, as long as we find solutions to the HR problems. I believe the question is not why we must struggle with a Health HR deficiency. It is for us to see that we can build a Health HR capacity that would be able to deliver health care and make it possible for people to live long, healthy lives, where people can attain their life's potential and ask why not. Let us therefore dream of a better world, a world of justice.

Before I close, health is about compassion and justice. Health professionals have responded to a call for justice and compassion. Two of our brothers are in prison in Iran. I do not know the reason for their imprisonment. I do know they served their sisters and brothers and were dedicated health care professionals. I have joined a group called Physicians for Human Rights which is trying to lobby support for freedom for the Alaei Brothers. Join us in raising your voices so that the Government of Iran may examine this case and perhaps grant mercy so that these brothers could continue their work in public health.

Let us move forward committed to our peoples, wherever they live, living long, healthy lives.

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