Desafíos y retos de la confluencia de disciplinas para combatir la covid-19

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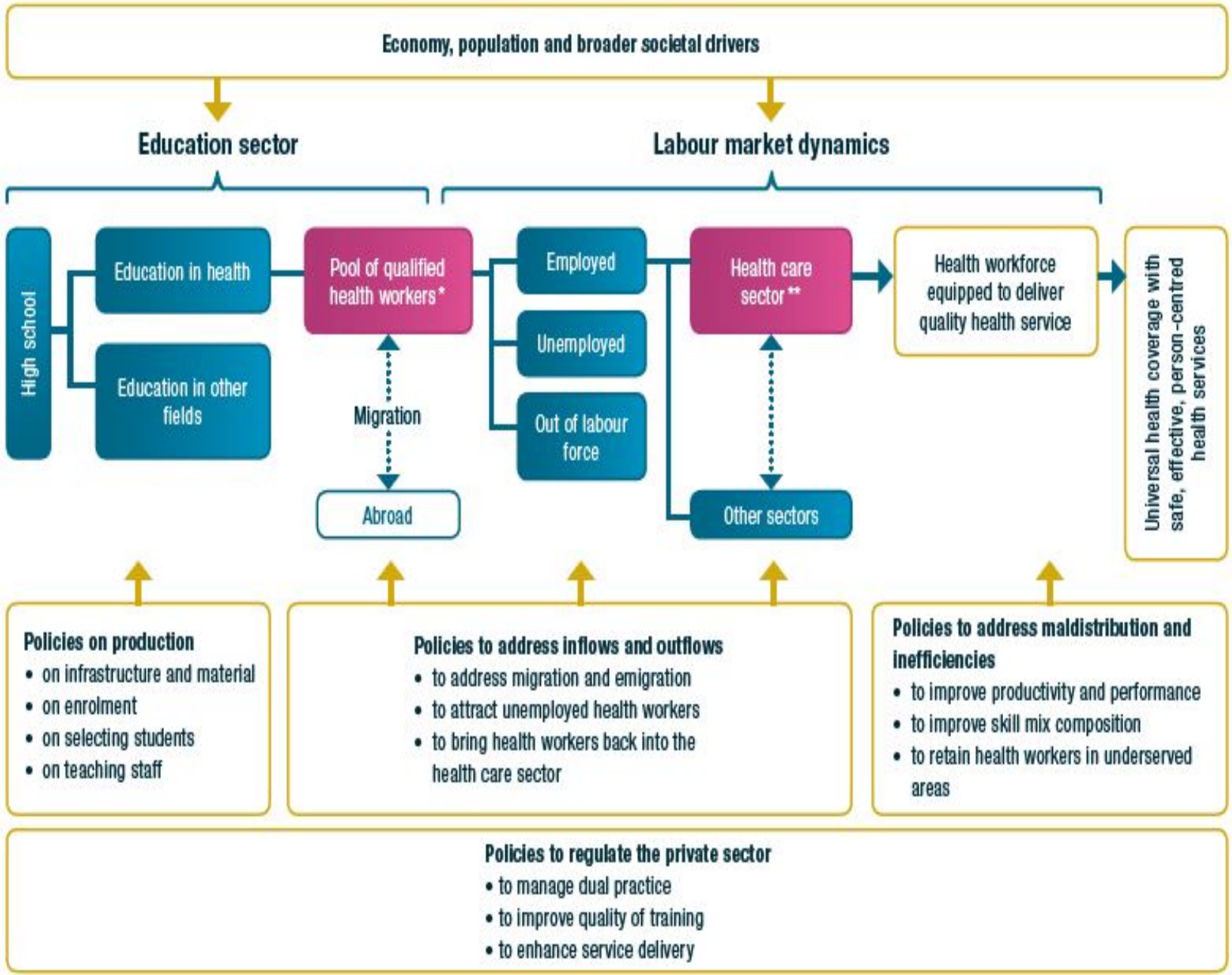
OPS/OMS

PAHO Pan American Health Organization

World Health Organization Americas
REGIONAL OFFICE FOR THE Americas

A modo de introducción con algunas puntualizaciones


Economy, population and broader societal drivers
Education sector
Labour market dynamics
High school
Education in health
Education in other fields
Pool of qualified health workers*
Migration
Abroad
Employed
Unemployed
Out of labour force
Health care sector**
Other sectors
Health workforce equipped to deliver quality health service
Universal health coverage with safe, effective, person-centred health services
Policies on production
• on infrastructure and material
• on enrolment
• on selecting students
• on teaching staff
Policies to address inflows and outflows
• to address migration and emigration
• to attract unemployed health workers
• to bring health workers back into the health care sector
Policies to address maldistribution and inefficiencies
• to improve productivity and performance
• to improve skill mix composition
• to retain health workers in underserved areas
Policies to regulate the private sector
• to manage dual practice
• to improve quality of training
• to enhance service delivery

EDUCACIÓN *

- Creatividad
- Flexibilidad
- Asertividad

Un experimento forzado inesperado y descontrolado

MERCADO LABORAL

- REGULACIÓN
- COMPETENCIAS
- RECLUTAMIENTO
- NUEVOS PERFILES

- EQUIPOS INTER-PROFESIONALES
- PRACTICA COLABORATIVA

- SKILL-MIX COMPOSITION
- TASK SHIFTING / TASK SHARING
- …


Equality
Equity
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DOCENCIA Y PANDEMIA

G.E.R.O.S

JOHA B.

ESTUDIANTES

- 1er año / Otros años

- Fatiga
- Deserción

- “Con ell@s”

DOCENTES

- “Nueva normalidad”
- Agotamiento / “Burn-out”

- Reducción de plantillas
- Principio de voluntariedad y consentimiento informado

INTERNADOS /PRACTICAS CLINICAS

- Casos clínicos virtuales
- Pacientes simulados
- Pequeños grupos virtuales
- Seminarios interprofesionales

- Examenes / evaluaciones orales @ ZOOM
- Examenes /evaluaciones escritas @ Moodle

- “Retorno” prácticas clínicas
- Cambios curriculares

Principio de voluntariedad y consentimiento informado

RESIDENCIAS / ESPECIALIDADES

- Transition from time-based to competency-based, time variable (CB-TV) GME

- ”Reimagining Residency”

Examples of Specialty-Specific Training Time and Minimum Case Requirements.*

Specialty	Selected Specialty-Board Requirements		Time-Based ACGME Program Requirements
	Time-Based Minimums	Minimum Case Numbers	
Diagnostic radiology	PGY-1 transitional year of training (choice of multiple specialties) followed by 48 mo of diagnostic radiology training (option for enfolded fellowships)	3515 cases total: Chest x-ray: 1900 CT abdomen/pelvis: 600 CTA/MRA: 100 Image-guided biopsy/drainage: 25 Mammography: 300 MRI: body, 20; brain, 110; spine, 60; lower-extremity joints, 20 PET: 30 Ultrasound abdomen/pelvis: 350	"[A] minimum of 80 hours of classroom and laboratory training in basic radionuclide handling techniques...." "Residents must have a minimum of 12 weeks of clinical rotations in breast imaging."
Internal medicine	36 calendar mo of full-time internal medicine residency education At least 24 mo of the 36 mo of residency education must occur in settings where the resident personally provides, or supervises less experienced residents who provide, direct care to patients in inpatient or ambulatory settings	No case minimums	"Each resident's longitudinal continuity experience...must include a minimum of 130 distinct half-day outpatient sessions, extending at least over a 30-month period."
Neurosurgery	84 mo, including 54 mo of "core" neurosurgery: 12 mo as chief resident 3 mo basic neuroscience 3 mo critical care 6 mo structured education in general patient care 30 mo of electives	800 cases total, 400 cases as lead surgeon For each of the following three procedures, 30 as lead surgeon, 60 cases total: adult cranial tumor, adult cranial trauma, total adult vascular lesion	"The program must provide 54 months of clinical neurological surgery education..." "[A]t least three months of basic clinical neuroscience education and at least three months of critical care education"

* Information is from the Accreditation Council for Graduate Medical Education, the American Board of Internal Medicine, and the American Board of Neurological Surgery. CT denotes computed tomography, MRA magnetic resonance angiography, MRI magnetic resonance imaging, and PGY-1 postgraduate year 1.

Puntos clave

- Heterogeneidad / Puntos comunes
- Sinergias salud/educación/sociedades científicas (intersectorialidad)

- La división continental: Continuidad vs Retorno
- Colaboración institucional: Glocal vs local

- Plataformas y herramientas virtuales
- Prácticas clínicas (?)

- Adaptación/transformación curricular
- ZOOMbies (variedades)

- Regulación / acreditación
- Examenes / evaluaciones
- Brecha digital / Brecha público-privado

- Estudiantes/internos/residentes
- Profesorado
- Unidades digitales

- Competencias vs capacidades
- Proyectos demostrativos
- Investigación pedagógica (?)

Prioridades

- Retorno seguro y ordenado
- Reingenieria I+D virtual
- Fortalecimiento residencias (especialidades)
- Misión social & EIP *(sui generis)*

- Apoyo a la conectividad
- Redestinación de fondos y pagos
- Bienestar estudiantil y docente
- Gobierno electrónico

- Protección
- Continuidad
- Comunicación
- Investigación respuesta

Transformación de la educación de las profesiones de salud en tiempos del Covid-19

"Es muy difícil hacer predicciones, especialmente sobre el futuro"

"The future aint´t what it used to be" (Yogi Berra)

Todas las innovaciones y experiencias son bienvenidas

… pero con un enfoque de "investigación operativa "

Sustainable Development Goals

World Health Organization

#WORKFORCE2030
and the Sustainable Development Goals

HEALTH WORKERS - A PROVEN RETURN ON INVESTMENT

GOAL 17

Multi-stakeholder partnerships-The design and implementation of effective health workforce policies rests on collaboration across different sectors (health, education, finance, labour) and stakeholders (public and private employers, professional associations, trade unions). Strengthening such collaborative platforms can have positive cascade effects on national and global partnerships for sustainable development.

Data, monitoring and accountability: The Global Strategy on Human Resources for Health: Workforce 2030 calls for investments in strengthening country analytical capacities of human resources for health and health system data.

GOAL 11

The majority of the world's population lives in urban areas. Over 3.9 billion in 2014, of which 828 million live in slum conditions. Equitable access to health care will improve basic services for all.

GOAL 10

Migration and mobility of health workers can result in inequitable access to health care, within and among countries. The *WHO Code of Practice on International Recruitment of Health Personnel* is a framework for guiding national dialogue among sectors and stakeholders to inform solutions to the challenges of health system sustainability and workforce mobility.

GOAL 8

The health care sector is one of the largest employment sectors in most countries. It is a source for full and productive employment and decent work for all women & men and can actively counter high rates of youth unemployment in urban, rural and remote areas.

GOAL 1

Healthy societies are engines for economic growth. Health workers are at the core of health systems ensuring healthy lives and wellbeing.

GOAL 2

Substantive and strategic investments in the global health workforce are essential to provide essential health services including those related to nutrition.

GOAL 3

The health workforce is central in translating the vision of universal health coverage into reality. Goal 3c "*to substantially increase health financing and the recruitment, development, training and retention of the health workforce …*"sets the foundation for the vision and objectives of the Global Strategy on Human Resources for Health: #Workforce2030, which provides guidance and policy options for countries looking to improve the health of their populations.

GOAL 4

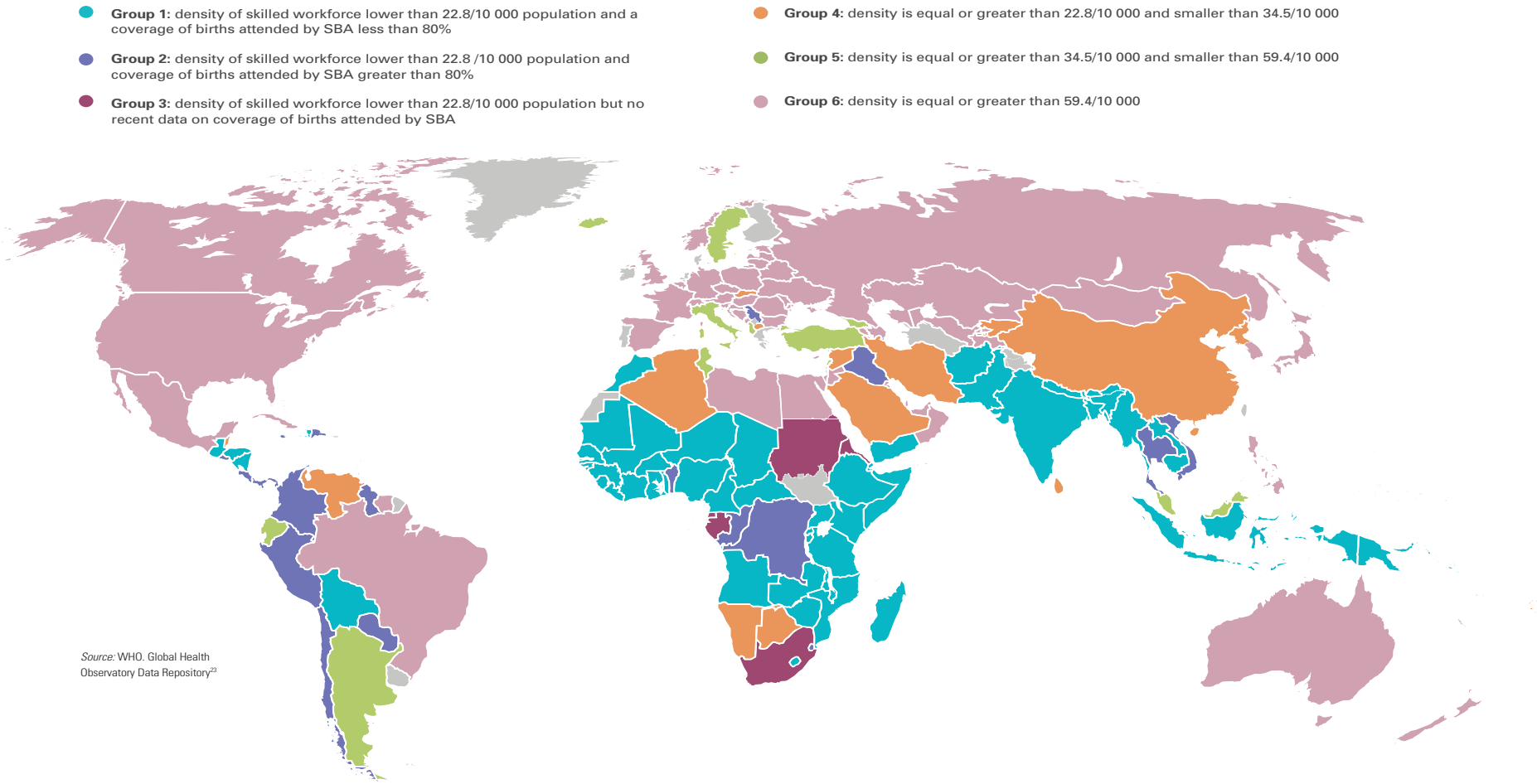
Girls' education is a strategic development investment. Inclusive and equitable education can lead to greater economic growth, better health outcomes, and improved global security. Equal opportunities to affordable and quality technical, vocational and tertiary education will improve the pool of high-school graduates and qualified health workers.

GOAL 5

Women are a large part of the health workforce and obtaining qualified jobs in the formal sector of the economy can be a driver of gender empowerment. However, opportunities for women to engage in high level professions are constrained. Health workers' employment conditions need to be gender-sensitive allowing equal opportunities for career development. Violence, harassment and discrimination during training, recruitment, employment and in the work place must be eliminated.

A universal truth….

FIGURE 4 Workforce to population ratios for 186 countries



Source: Campbell J, Dussault G, Buchan J, Pozo-Martin F, Guerra Arias M, Leone C, Siyam A, Cometto G. *A universal truth: no health without a workforce*. Global Health Workforce Alliance and World Health Organization, 2013.

Strategy on Human Resources for Universal Access to Health and Universal Health Coverage

Pan American Health Organization

World Health Organization
Regional Office for the Americas

VARIABILIDAD

- Entre países / universidades

- Dentro países / universidades

4 RHS

Disponibilidad

Distribución

Calidad

Desempeño

Heterogeneidad/Diversidad
(Des)Regulación
Brechas (+++)APS
Nuevos perfiles

Déficit
(Mala)distribución
Migración

- Competencias niveles de gobierno

- **Compromiso político**
- **Financiamiento sostenible**
- **Infraestructuras**
- **Recursos humanos**

Gender equity in the health workforce:
Analysis of 104 countries

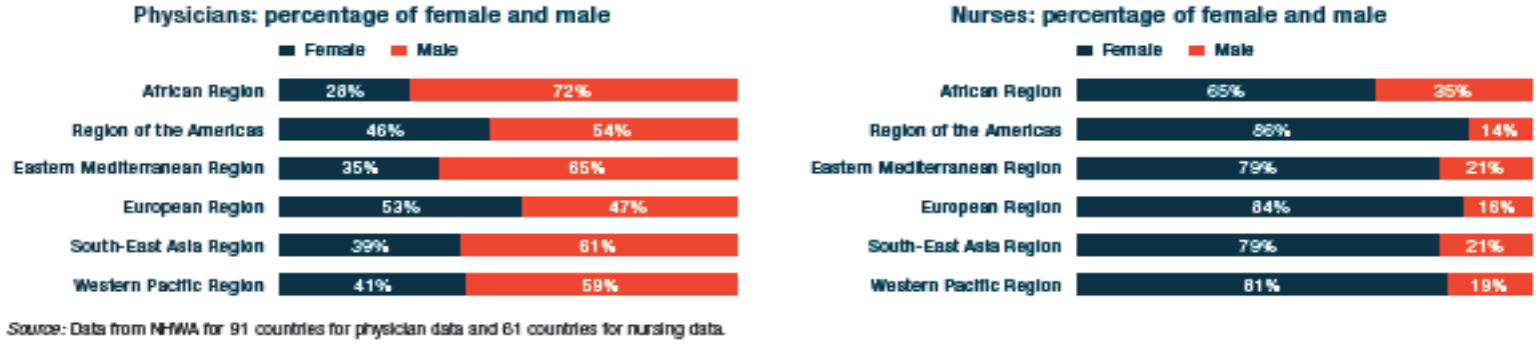
Mathieu Boniol, Michelle McIsaac, Lihui Xu, Tana Wuliji, Khassoum Diallo, Jim Campbell

Health Workforce Working paper 1

March 2019

WORKING PAPER 1

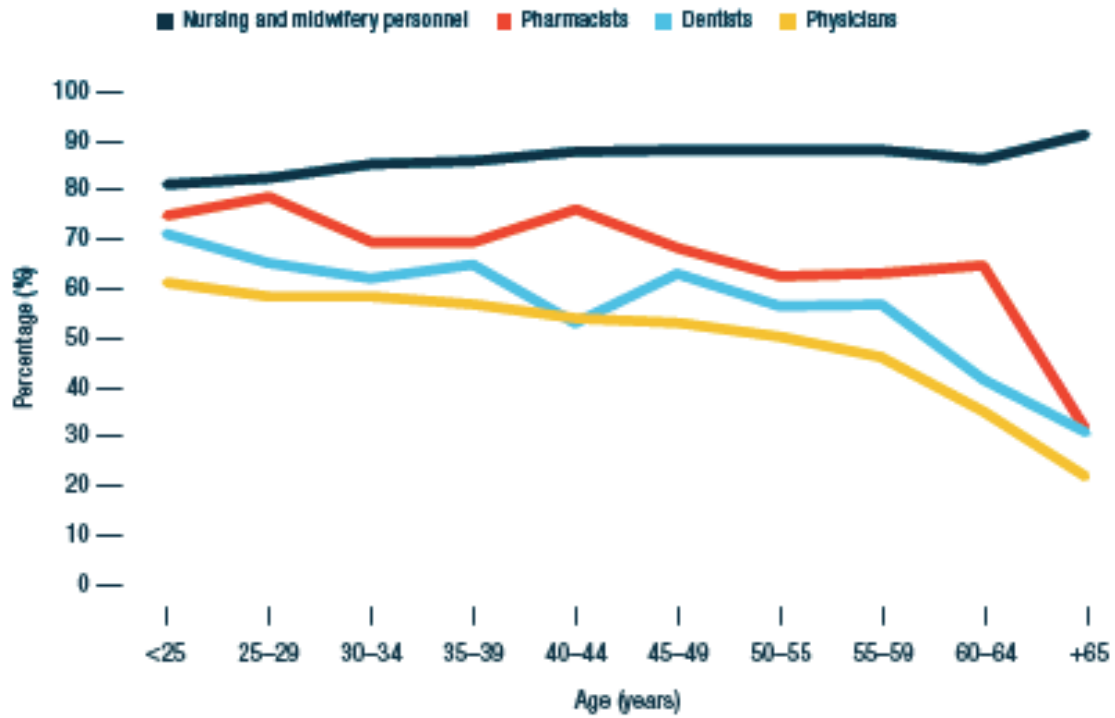
FIGURE 1.
Distribution of physicians and nurses by gender



Source: Data from NHWA for 91 countries for physician data and 61 countries for nursing data.

FIGURE 2.

Share of women health workers by age group for nursing and midwifery personnel, pharmacists, dentists and physicians



Source: LFS data from 57 countries.

UNIVERSAL HEALTH COVERAGE
UN HLM 2019

Moving Together to Build a Healthier World

Key Asks from the UHC Movement

UN High-Level Meeting on Universal Health Coverage

Learn More →

#HealthForAll
#HLMUHC

uhc2030

Ask 1 **Ensure Political Leadership Beyond Health** – Commit to achieve UHC for healthy lives and well-being for all at all stages, as a social contract.

Health is the foundation for people, communities and economies to reach their full potential. Universal health coverage (UHC) is primarily the responsibility of governments, which ensure people's health as a social contract. Achieving UHC is essential for inclusive development, prosperity and fairness, and requires political decisions that go beyond the health sector.

MILESTONE

By 2023, governments incorporate aspirational health-related SDG targets into national planning processes, policies and strategies to ensure everyone can access quality health services without financial hardship.

Ask 2 **Leave No One Behind** – Pursue equity in access to quality health services with financial protection.

Health is enshrined as one of the fundamental rights of every human being. UHC is key to reducing poverty and promoting equity and social cohesion. Governments should invest in everyone's health. Extension of geographical coverage and reaching the most marginalised and hard-to-reach populations are essential to achieving positive health outcomes. A strong system for monitoring and evaluation is needed to ensure accountability and participation.

MILESTONE

By 2023, governments report disaggregated data to SDG official statistics to capture the full spectrum of the equity dimensions of UHC monitoring progress (SDG 3.8.1 and 3.8.2).

Ask 3 **Regulate and Legislate** – Create a strong, enabling regulatory and legal environment responsive to people's needs.

UHC requires a sound legal and regulatory framework and institutional capacity to ensure the rights of people and meet their needs. Governments are the primary duty bearer under the International Covenant on Economic, Social and Cultural Rights, even in cases when they rely on private providers.

MILESTONE

By 2023, governments introduce legal and regulatory measures that accelerate progress toward UHC.

Ask 4 **Uphold Quality of Care** – Build quality health systems that people and communities trust.

Quality primary health care (PHC) is the backbone of UHC and creates trust in public institutions. Expansion of health coverage must be accompanied by investments in the quality of health services. People should be able to access a full spectrum of safe, quality services and products in their community, delivered by well-trained, well-paid, culturally and gender-sensitive health workers.

MILESTONE

By 2023, the coverage of quality essential health services has been delivered to one billion additional people (SDG 3.8.1).

Ask 5 **Invest More, Invest Better** – Sustain public financing and harmonise health investments.

Current funding levels are insufficient to achieve UHC by 2030. Governments need to increase domestic investment and allocate more public financing for health through equitable and mandatory resources. Governments must improve efficiency and equity in the use of existing resources and reduce reliance on impoverishing out-of-pocket payments. Development assistance to health should reduce fragmentation and strengthen national health financing capacities.

MILESTONE

By 2023, governments adopt ambitious investment goals for UHC, make progress in mobilising domestic pooled funding and reduce catastrophic health expenditure (SDG 3.8.2).

Ask 6 **Move Together** – Establish multi-stakeholder mechanisms for engaging the whole of society for a healthier world.

All countries must take active steps to meaningfully engage non-governmental actors - particularly from unserved, underserved or poorly-served populations - in shaping the UHC agenda. Solutions for each country must be tailored to context and population needs. The international community and global health partners should unite to support countries to build a healthier world.

MILESTONE

By 2023, all UN Member States join the UHC Movement and establish multi-stakeholder platforms to ensure the involvement of civil society, communities and the private sector, in regular policy dialogue and review of progress with all government actors.

Salud Universal en el Siglo XXI: 40 años de Alma-Ata

Informe de la Comisión de Alto Nivel

Organización Panamericana de la Salud

Organización Mundial de la Salud
Américas


PACTO 30 • 30 • 30
APS PARA LA SALUD UNIVERSAL
Organización Panamericana de la Salud
Organización Mundial de la Salud
Américas
OPS
Salud universal
Acceso y cobertura para todos
Captura de Pantalla


GOBIERNO DE MÉXICO
Organización Panamericana de la Salud
Organización Mundial de la Salud
Américas
OPS
Salud Universal
Para todos y todas, en todas partes.
Carissa F. Etienne
Jorge Alcocer Varela

Health systems transformations with strategic focus on increased resolution capacity of FIRST LEVEL OF CARE within IHSDN

Mainly Through

First Level of Care

Articulates IHSDN (for what can't resolve)

Public health and actions on SDH

Delivers the majority of health services to respond to health priorities through:

- Adequate health teams
- Accessible medicines and other health technologies
- Infrastructure

Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE Americas

Universal health
Access and coverage for all

Three areas of focus: the three 30s

- Transform health system by 2030, based on PHC
- Reduce by at least 30% barriers to access health.
- Allocate at least 30% of public health expenditure to the first level of care.

Universal health care in 21st century Americas

Christer Fredriksson/Getty Images

Despite considerable progress, the Pan American Health Organization (PAHO) estimates that 30% of the population of the Americas still do not have access to the health care they need because of multifaceted barriers. On April 9, leaders, including Mexico's President Andrés Manuel López Obrador, PAHO director Carissa Etienne, and UN High Commissioner for Human Rights Michelle Bachelet, gathered with academics, activists, and representatives of social movements in Mexico City to hear the report of the Commission on Universal Health in the 21st Century.

The Commission emphasises that achieving health for all in the Americas will only be possible by ensuring effective financing, enshrining the right to health for all in legal and regulatory frameworks, and pursuing models of care that are based on primary health care. These care models must be people centred, account for human diversity, and facilitate genuine social participation. The Commission is unflinching in its acknowledgment of social inequality as a barrier to health. It recommends intersectoral interventions in economic, housing, and infrastructure conditions, and the creation of regulatory and oversight mechanisms for the private sector. However, it notes that the social determinants approach to health, although useful, can compartmentalise these factors without critically examining why these determinants have arisen and whom they are serving. The Commission criticises the consolidation of a worldwide economic model based on globalisation and increasing commercialisation and urbanisation, which it sees has led to climate change, migration, an increase in non-communicable diseases, mental health disorders, road traffic injuries, and violence.

In response to the Commission, López Obrador announced changes that would enshrine the right to health in the Mexican Constitution. PAHO also announced a new Regional Compact, PHC 30-30-30, which sets goals for countries to, by 2030, commit themselves to allocating 30% of the health budget to first-level care and to reduce health access barriers by 30%. By examining health beyond its social determinants, the PAHO Commission not only delivers actionable recommendations with regional impact but also presents the global order of the 21st century as a barrier to health for all. ■ *The Lancet*

For more on the **Commission** see http://iris.paho.org/xmlui/handle/123456789/50742

For more on **PHC 30-30-30** see https://www.paho.org/hq/index.php?option=com_content&view=article&id=15078:phc-30-30-30-paho-s-new-regional-compact-on-primary-health-care-for-universal-health&Itemid=1926&lang=en

¿Qué hacer?
¿Por dónde seguir?

“Education is the most powerful tool that can be used to change the world"

Nelson Mandela

telegraph.co.uk

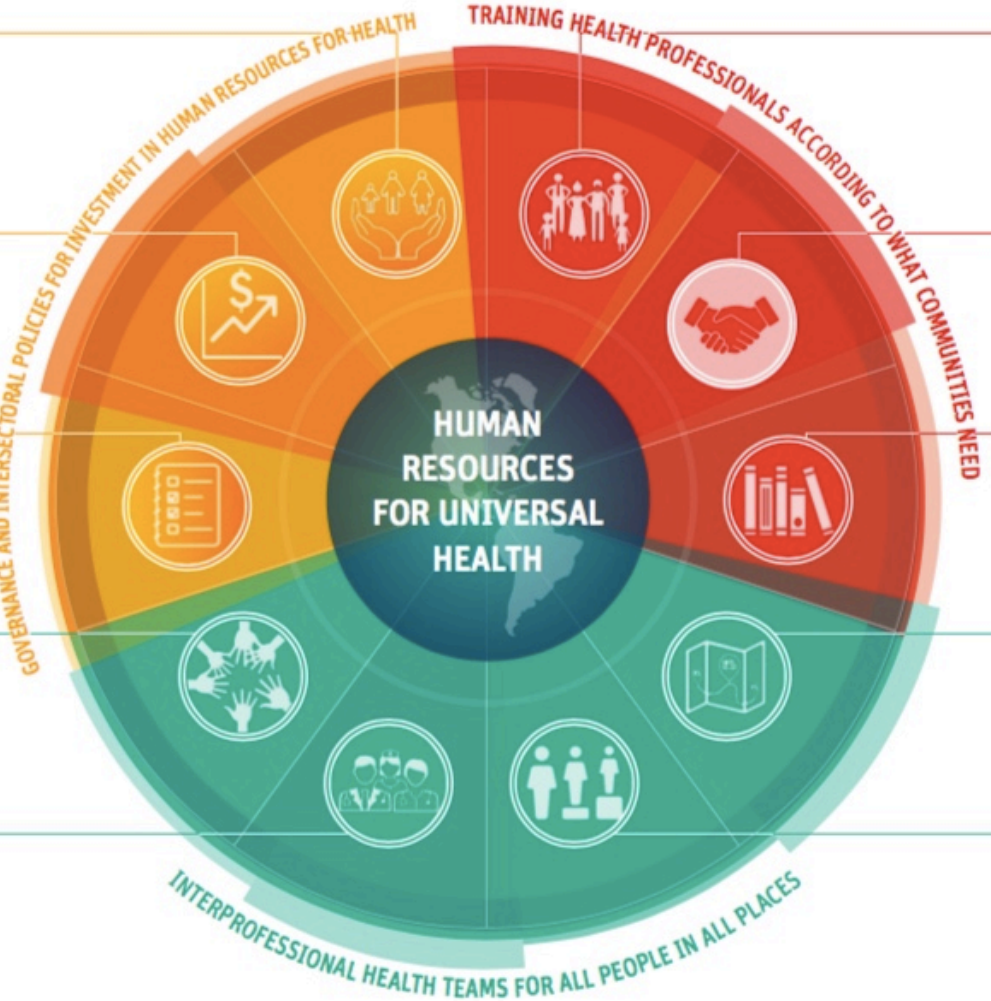
Organización Panamericana de la Salud

Organización Mundial de la Salud
OFICINA REGIONAL PARA LAS Américas

Salud universal
Acceso y cobertura para todos

Human resources for health, for all people, in all places

Universal health
Access and coverage for all



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.

EDUCATION WITH SOCIAL COMMITMENT

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

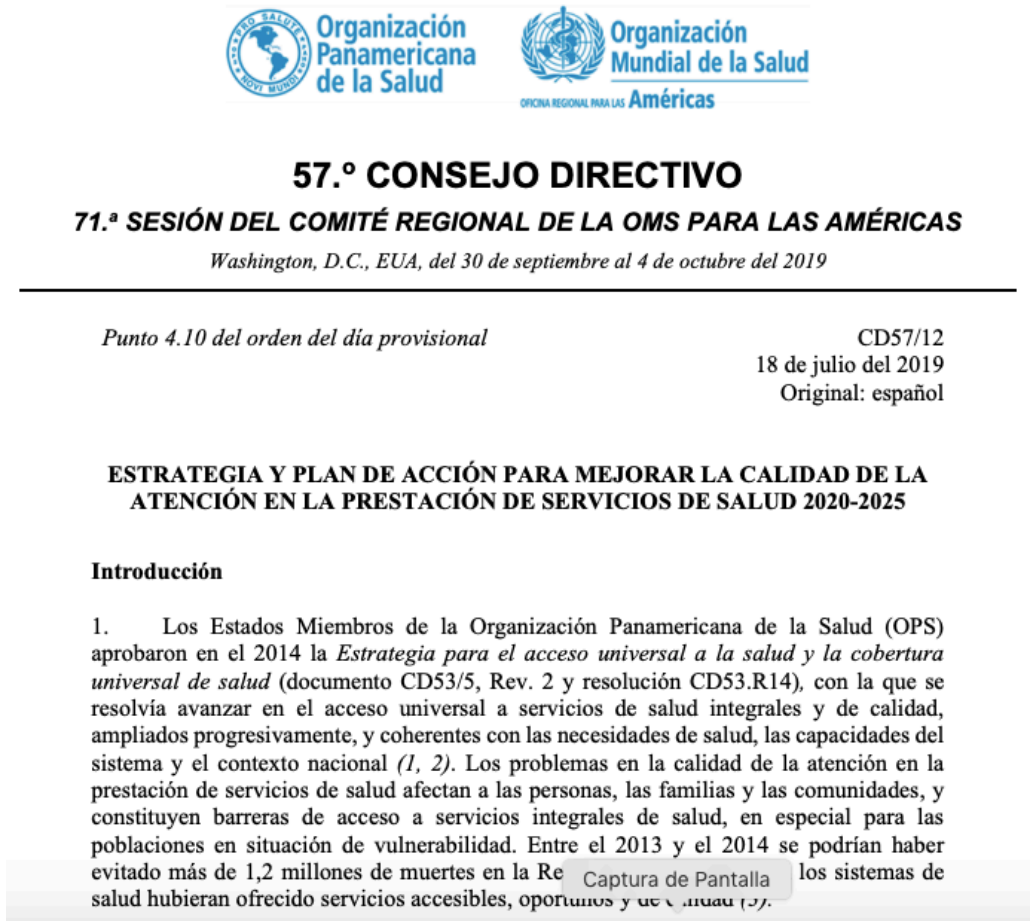
Implementing strategies that motivate health teams – through economic incentives, professional development, and quality of life – encourages retention and continued presence in remote and underserved areas.

GENDER

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

PAHO-2017

OPS/OMS Estrategia y Plan de Acción para mejorar la calidad en la prestación de servicios de salud 2020-2025



Organización Panamericana de la Salud
Organización Mundial de la Salud
OFICINA REGIONAL PARA LAS Américas

57.º CONSEJO DIRECTIVO

71.ª SESIÓN DEL COMITÉ REGIONAL DE LA OMS PARA LAS AMÉRICAS

Washington, D.C., EUA, del 30 de septiembre al 4 de octubre del 2019

Punto 4.10 del orden del día provisional

CD57/12
18 de julio del 2019
Original: español

ESTRATEGIA Y PLAN DE ACCIÓN PARA MEJORAR LA CALIDAD DE LA ATENCIÓN EN LA PRESTACIÓN DE SERVICIOS DE SALUD 2020-2025

Introducción

1. Los Estados Miembros de la Organización Panamericana de la Salud (OPS) aprobaron en el 2014 la *Estrategia para el acceso universal a la salud y la cobertura universal de salud* (documento CD53/5, Rev. 2 y resolución CD53.R14), con la que se resolvía avanzar en el acceso universal a servicios de salud integrales y de calidad, ampliados progresivamente, y coherentes con las necesidades de salud, las capacidades del sistema y el contexto nacional *(1, 2)*. Los problemas en la calidad de la atención en la prestación de servicios de salud afectan a las personas, las familias y las comunidades, y constituyen barreras de acceso a servicios integrales de salud, en especial para las poblaciones en situación de vulnerabilidad. Entre el 2013 y el 2014 se podrían haber evitado más de 1,2 millones de muertes en la Re los sistemas de salud hubieran ofrecido servicios accesibles, oportunos y de

Captura de Pantalla

Educación
(de calidad)
vs/&
Servicios de salud
(de calidad)

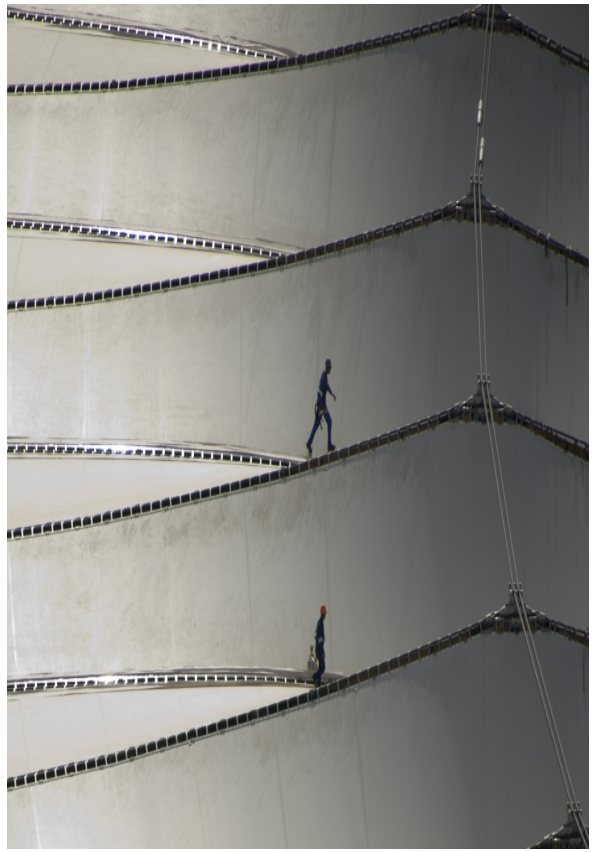
Misión social
Educación interprofesional

Opciones crecientes

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

Fitz Mullan @ JAMA 2017

Acreditación
&
Misión Social
&
Educación Interprofesional



Conclusiones

- La acreditación será el motor de la misión social
- Flexible mejor que prescriptiva
- Emergencia actual de una cultura de misión social
- Inclusión de elementos de misión social (y educación interprofessional) en los sistemas de acreditación

El gran secreto

Estudiantes

THANKS