Partnership: health services and medical education*

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INTRODUCTION

It is a well-established fact that integration between health services and medical education would improve the quality of medical education, would produce a new generation of doctors committed to primary health care, and would help to improve and upgrade the standard of services offered at both the primary as well as the secondary health care level.

The Ministries of Health in the Region have responsibility for the health services, while in some cases the University and/or Ministry of Higher Education are responsible for medical education. In Iran, for example, medical care and medical education are both under the umbrella of the Ministry of Health and Medical Education (as one ministry).

The advance of technology in some medical schools did not consider the real need of the community; in some cases medical school programmes and curricula overlook their direct relevance to community health needs. Although medical schools are attached to teaching hospitals that serve a particular region or area, they have traditionally been urban-oriented and are not involved heavily in community practice, thus medical education in this region did not respond to the needs of the community as it should. Most medical schools are hospital-based, relying on costly medical technology, using very sophisticated and expensive diagnostic procedures which are of interest to specialized medical practitioners only.

As a result of the prevailing pattern of medical education, which is hospital-based, many of the graduates of those medical schools are attached to service in big cities and are not used to managing common health problems in the rural areas. They have even less knowledge about the important managerial and financial considerations of health care.

PRESENT STATE OF MEDICAL EDUCATION

More attention is now needed to focus on the socio-economic parameters of health and its relation to the development of the community and to an improvement in the quality of life. Integration between the health care sector and medical education has been extensively studied by WHO.

The situation in the Eastern Mediterranean Region (EMR) is similar to other regions in the world. The relationship between medical education centres and health services takes the following forms:

1 Active resistance: where medical education institutions and health care services oppose each other actively.
2 Passive indifferences: where neither party cares about what the other is doing.
3 Formal relationships, through formal contacts and communications.
4 Exchanges of representations in councils and committees.
5 Joint appointments where those in medical schools provide health services and those in the Ministry of Health participate in teaching as well.
6 Education institutions are made responsible for all health care services and delivery in a specific area or region.
7 Complete integration of health services and medical education centres.

THE PROPOSED THEME: INTEGRATED APPROACH

The main theme of this paper is to present an integrated model for medical education and the health services which is essential for producing a new generation of doctors capable of meeting the needs of community health and to help through this process to upgrade the health services quantitatively and qualitatively.

This integration has not been possible. Many reasons ranging from political to professional and economic factors were responsible for this failure of integration.

Conditions needed to make integration possible

Before a change for integration is attempted a set of conditions must exist:

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1 A need for a well-developed and well-known national health policy and a plan for the development of human resources.
2 If such a policy is not available, training institutions will be isolated from health services.
3 A committee of medical education centres to review their curriculum and change it if necessary to meet current health needs.
4 Discussions, meetings and debate at all levels should be undertaken between the two parties in order to link ideas and build up consensus.
5 The final decision to integrate medical education and health services is political, which would reflect the desire to raise the quality and standards of both medical education and health care services.

The theme: integration

1 Before we embark on integration between health services and medical education, there is a need that this integration should be preceded by various forms of coordination and cooperation.
2 A simple start would be by having staff of medical schools serve on national planning bodies for health and for the development of human resources, and to have the health services sector represented on the boards of medical education.
3 A more effective method of coordination is for each sector to participate in the activities of the other.
Example: Highly qualified doctors serve as part-time teachers in medical schools, and medical school teachers participate in the delivery of health services to the people.
4 There is a need for a protocol to organize this relationship, taking into consideration financial aspects, compensation, maintenance of quality of service and academic standards.
5 The university teaching hospital could deliver the services to the surrounding community; MOH hospitals and health centres are used as teaching hospitals if they maintain certain standards.
6 A more advanced form of coordination could be when a medical school is given the responsibility of delivering a full range of services to its surrounding community.

Through this, the following could be achieved:

a Students will be exposed to the health problems of the community where they will participate actively in health promotion, disease prevention and control, diagnosis and treatment and rehabilitation.
b It also enables students to conduct community-based epidemiological studies.
c The medical school can provide instruction in primary health care and a more community-oriented training programme.
d The community will benefit from the involvement of highly qualified faculty and students in the delivery of better health care.

Needs for making integration possible

1 It requires the transfer of funds from the Ministry of Health to the university, or the pooling of funds of the two systems. This could create potential problems in the lines of authority and accountability.
2 Additional problems could be encountered if the arrangement affects, one way or another, the pattern of private practice in the community.
3 Creation of a regional health service and medical education boards composed of the two parties. The board would be the responsible authority for policy-making, planning and administration of both medical education and delivery of health services.
4 Creation of this board would help to improve utilization of resources and would have a beneficial effect on both.
5 Creation of this board would help to improve the quality of service, the educational process and the health status of the population.
6 It would allow for experimentation in health care delivery and the conduct of essential Health Services Research.
7 The ultimate goal and challenge is to reach a situation where those who provide services can teach, and those who teach can also provide services, not only at the tertiary level, but at all levels of care.

Obstacles to coordination and integration

1 Historical differences and objectives and responsibilities.
2 Lack of national health policy with no regard to real community health needs.
3 Lack of political support.
4 Traditionalism at centres for medical education and health care providers; the public itself may not easily accept changes in the traditional pattern of service.
5 Financial implications.
6 Doctors in medical education are research-oriented.
7 Place of work.
8 Lack of clarity, communication with decision-makers and lack of follow-up.