The Declaration of Tokyo
The Declaration of Tokyo

Report of a WHO Conference on "Towards future health and medical manpower: new strategies in education for the XXIst century"

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1. INTRODUCTION

Health institutions, particularly health training institutions, are today faced with the challenge of responding adequately to society's changing needs. The preparation of suitably qualified health manpower, adequate to the task of achieving health for all by the year 2000 based on primary health care, calls for a number of policy and strategy changes.

It is imperative that training institutions carefully review their mission in order to anticipate and respond to the rapidly changing socioeconomic environment. Other institutions and bodies able to influence the training and utilization of health manpower should critically examine their role and responsibilities in this respect.

A series of factors, which could be categorized under the general heading of "resistance to change", inhibit institutions from making the necessary adjustments in harmony with the primary health care philosophy. These factors relate to the socio-political environment, the deeply engrained cultural, academic, institutional and other traditions, professional exigencies and interests, and technological advances in the field of communication.

It is essential, therefore, to identify such factors and to understand how they can be influenced so as to facilitate institutional change and thereby enhance the effectiveness of the health systems in their efforts to achieve the goal of health for all through primary health care. This was essentially the purpose of the Conference on "Towards future health and medical manpower: new strategies in education for the XXIst century".

2. OBJECTIVES

The objectives of the Conference were:

(1) to analyse factors (social, cultural, organizational and
administrative) which facilitate or impede the acceptance of change in institutions such as health training institutions, as well as the interaction of such factors;

(2) to suggest a course of organizational administrative, technical and political actions, relevant to the national context and to the prevailing local conditions, which will yield the greatest chances of success with respect to the introduction and acceptance of changes in existing training institutions intended to ensure relevance and participation in community health work;

(3) to provide Member States and WHO with an initial framework to guide and monitor developmental activities for the reorientation of training institutions towards the improvement and maintenance of effectiveness.

3. ORGANIZATION

The Conference was held from Tuesday, 9 April, to Monday, 15 April 1985, at the Sasakawa Memorial Foundation Hall in Tokyo, Japan.

3.1 Participants

Participants were drawn from the following categories:

- pioneers in introducing changes in training institutions, particularly in the areas of medical and nursing education;
- health administrators concerned with health policy, health manpower and health services;
- scholars and researchers in the fields of social change theory and organizational development;
- parliamentarians or high-level decision makers in education, professional organizations and developmental sectors.

Participants came from such fields as medical education, behavioural sciences, educational planning, organizational development and health management.

The Conference was not intended to be representative of all countries in the Region, but was rather composed of experts charged with suggesting a process to facilitate the introduction of change and advising WHO on what it can do to facilitate these changes in Member States.
3.2 Overall process

The first day of the Conference was held in plenary session to introduce participants to the nature of the problem. A case illustration provided an example of how change was introduced in medical school, and was followed by the description of a framework for analysing the strategies of institutional change (see details of the agenda in Annex 1).

The following three days consisted of group discussions. The participants were divided into three groups, which dealt with the following topics:

(a) What are the changes in training institutions, faculty and programmes needed to support a primary health care-oriented system?
(b) What are the changes required in the broader system to support international training institution change?
(c) What integrative and follow-up actions should be pursued?

The final day of the Conference was a plenary session for the review and adoption of three basic documents:
- the summary of discussions (see section 4)
- a set of recommendations (see section 5)
- a Declaration (see section 6)

3.3 Briefing of participants

Participants were requested to carefully study briefing notes before the group discussion started as everyone needed to understand and agree upon the nature of the main thrust of the Conference, which was twofold:

- implications for training institutions in a primary health care-oriented health system;
- institutions and forces in the environment (both internal and external) influencing training institutions.

4. SUMMARY OF DISCUSSIONS

Primary health care as defined by the Declaration of Alma-Ata in 1978 and endorsed by the World Health Assembly in 1979 is "essential health care based on practical, scientifically sound and
socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community."^1

It is tempting to consider a health system based on the primary health care approach as only appropriate in countries with limited resources which are the least developed. However, as health services and economic conditions improve and health problems of an elemental sort are controlled, new problems take their place. These new problems may reflect those brought about by industrialization, an aging population or changing life-styles. Some may be problems created by the health system itself, such as excessive dependence on health services or the complications of treatment. These problems are characteristic of the "developed" countries. There is, therefore, a transition that occurs in the type of health problem experienced by countries as they evolve.

The Conference affirmed that a primary health care orientation is as relevant to these new problems as to the more urgent ones in developing countries. A primary health care approach applies to countries at all stages of evolution.

As health problems change, so also must health services and health personnel development to ensure that such problems receive an appropriate response. Thus, coordination and integration between health needs, health services and health personnel development are essential.

While some progress has been made, it is generally recognized that the reorientation of health services toward a primary health care approach and the subsequent necessary reorientation of health personnel development still need further strengthening. Regional meetings of deans of medical schools have reinforced this concern for adequate progress in the reorientation of medical education in particular. It was for this reason, therefore, that it

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was decided that a regional conference would be both necessary and timely and should address the problem of bringing about change in training institutions for health personnel. In addition, the conference should focus on those factors which historically have impeded, and are still impeding, changes in the planning, training and management of health personnel, with a view to facilitating future health personnel development as the twenty-first century approaches.

The meeting was called to consider how the reorientation of health manpower development for the future development of health systems oriented toward primary health care could be enhanced. Discussions were supported by a number of background papers and a keynote presentation. The main work of the meeting was undertaken in group discussions organized to consider successively the following topics:

1. changes within training institutions, faculty and programmes needed to support a primary health care-oriented system;
2. changes external to training institutions needed to facilitate internal change.

Integrative and follow-up action necessary to bring about the desired changes was considered together with the discussions.

4.1 Internal changes in training institutions

Although the Conference recognized that a primary health care-oriented system requires coordination and team work, the major emphasis in the discussions was on the training of doctors. Non-physician faculty were extremely valuable in emphasizing the requirements of community orientation in their own profession. The Conference considered changes necessary in attitudes and skills, student selection and curriculum content, process and organization.

4.1.1 Necessary attitudes and skills

The Conference recognized that the curriculum must be based on well-defined skills which are needed by a doctor or by any other health personnel working in a health system based on the primary health care approach. The health system envisaged must be an integrated whole and, although different parts will provide
different levels of care and doctors will work at these different levels, all physicians should have skills, attitudes and values that are responsive to the comprehensive needs of individuals and communities. This is true even if medical schools have their own unique identity. It was affirmed that a doctor working at the point of primary contact, usually outside the major institutions, should not receive less consideration than one working at secondary or tertiary levels. The skills needed are different but equally important.

The skills should include the ability:

- to establish a dialogue with the community for the purposes of mutual understanding and education;
- to identify the needs of the community and to adapt the provision of health services to those needs;
- to develop insights and sensitivities to cultural and social priorities within communities and their impact on health;
- to help both individuals and communities to identify and assume appropriate responsibilities for their own health and to seek together appropriate solutions;
- to promote a healthy lifestyle, to prevent disease, unnecessary suffering and premature death.

The Conference noted that these skills have not been explicitly attended to in traditional medical education.

The Conference also affirmed that, in postgraduate and continuing education, such skills should be strengthened and extended irrespective of the part of the health service the doctor is working in.

The Conference acknowledged that the skills and attitudes described above cannot be developed without practical exposure and the opportunity for students to learn for themselves the nature of health problems and the priorities of their community. It is, therefore, essential that students learn within the community, early in their training, so that all subsequent learning can be placed in the context of community priorities. Faculties must participate with ministries of health in the provision of a full range of health services and thereby establish community settings for student experience. Learning in such settings must not simply take the form of passive understanding but must involve active participation and the task of problem solving with communities.
4.1.2 Student selection

The Conference emphasized the importance of interpersonal empathy, community and social attitudes and aptitudes, and relevant motivation for service to a community. While it acknowledged the difficulty of identifying such skills and attitudes, particularly in young applicants, but it considered that the selection of students on the sole basis of academic achievement might not provide the full range of skills appropriate to a community’s need. It therefore recommended the exploration and use of additional criteria beyond those traditionally used for selection and a clear assessment of the results of such selection.

4.1.3 Curriculum content, process and organization

The Conference recognized that it is within faculties that there is often the most stubborn resistance to change. However, since concern for the patient and the community must take precedence, the training institution must adapt its curriculum content, process and organization to meet that priority. New medical schools can cope best with their ideas. Older institutions may wish to initiate experimental tracks for small groups of students and then compare their results with those of the traditional tracks.

A strengthening of selected disciplines particularly relevant to the broader needs of the community and a shift in the balance of the curriculum to reflect the contribution of these disciplines are required. Content changes should include an emphasis on:

- clinical epidemiology;
- behavioural and social science;
- health economics and management sciences (e.g. cost-effective decision making);
- planning, management and evaluation of health services;
- medical ethics (e.g. issue of resource allocation and priorities).

It was recognized that these additional disciplines will have no effect if their contribution is merely token. While some knowledge in depth of each is needed, students must also integrate such knowledge for complex problems to be solved through their application. This integration cannot take place solely within the students’ heads but must be reflected in the design
of the curriculum and therefore requires integration at the faculty level.

The traditional departmental structure reinforces disciplinary separation. The Conference strongly recommended faculty integration, in teaching and in research (especially in community health problems), through coordination of educational and research programmes and through formal restructuring. In the long term, the benefits for education from cooperation in research and training that result from integrating outweigh the apparent disadvantages of loss of autonomy. All disciplines should accept responsibility for the community orientation of the faculty through its involvement in community education, service and research.

Specialists based mainly in hospitals should extend their activities to support and stimulate health care education and research based in the community. Priorities for research in particular must be rebalanced to emphasize research in health systems, preventive health care and health education. The careers of staff working in these fields must receive support equal to that provided to staff in the basic sciences and hospital specialties.

These proposed changes will together support and reinforce the desired orientation of education towards the community, an education which requires the active participation of students in exploring the needs of the community and will prepare students properly for their future work.

Although the Conference concentrated to a large degree on the training of doctors, it recognized that future doctors and other health workers will work in health teams representing different disciplines. The necessary attitudes and skills can only be developed if the various health workers and health students are trained as a team and acquire experience in community problem solving. It is therefore crucial that effective health teams incorporating faculty be created so that teachers also can model the desired behaviour through their own participation.

The changes in curriculum process, in organization and in the team approach proposed are essential if faculty are to teach as much by example as by precept, i.e. if they are to be significant role models of the practitioners that students should become.
Finally the student evaluation process, as exemplified by the interim and final examination, must reflect the detail and balance of the reoriented curriculum.

4.2 Changes external to training institutions

It was fully recognized that changes within training institutions could not be effective without supportive changes outside. The following were identified as of immediate importance.

4.2.1 The health system

The health system must be reoriented at the same time as the training system to primary health care. Without such a reorientation there will be no relevant setting in which students can be trained, no valid model, no career structure. The changes in the health system, even though countries may be at different stages of development, must take into account all these factors, including the establishment of health teams, the capability to respond to community needs, and the creation of appropriate working and living conditions and job security as well as robust and rewarding career structures. The latter must include appropriate continuing education and retraining programmes, incentives (financial and social), and salary structures that encourage work directly responsive to community needs, with benefits and status to match.

To achieve parallel changes in training and the health system, it is essential that the ministries of education and health establish a continuing dialogue for manpower development. Universities should become directly involved, through the activities of their teaching staff in the provision of health services and research into their efficacy.

4.2.2 Political representatives

Political representatives, whether national or local, have a role at many levels and need to be informed and to orient their priorities to the broad health needs of communities. At the local level, this may require the creation of new structures to integrate the diversity of intersectoral contributions to health development. Health professionals should accept the responsibility for articulating priorities for such representatives, if they wish to influence them.
4.2.3 Professional associations

Professional associations have responsibilities in the development of individual professions. However, associations must also be responsive to the long-term priority needs of the community and nation as a whole. This may have to take precedence over the short-term protection of the apparent interests of the profession. Professional organizations must, therefore, focus on social responsibility and scientific development as well as guild interests. This may involve a need to face and resolve some difficult conflicts.

4.2.4 Government and government ministries

Primary health care requires the integration of the efforts of many sectors of government. As has occurred in many countries, this may require a formal coordinating body chaired at a senior level, possibly by the prime minister. This is important if the role in health development of ministries other than the health ministry is to be fully acknowledged.

4.2.5 Communities

In a primary health care-oriented system, the community assumes a major responsibility for its health and welfare. This requires the community to be well informed. For some communities, the development of an identity is an important first step. Since communities may be based on a geographic location, a commonality of interests, a common set of social norms or ethnic characteristics, these different types of community must be recognized for the development of primary health care-based services to be appropriately addressed.

In general, even at limited levels of development, communities rapidly become accustomed to look for high technology responses to health needs. However, these expectations will need to change. Otherwise, they will drive the health system to a short-term curative response instead of a long-term response based on health maintenance and preventive care and, given the limited resources, this will defeat the fight for social equity.

4.2.6 Financing institutions

Where the financing of health care is other than through government, influence should be brought to bear so that health
insurance funds are channelled towards the prevention of disease and the maintenance of health rather than the cure of disease once established.

4.2.7 The media

Increasingly, public media shape public opinion and values. The health system should harness their influence. Programmes and articles devoted to health education may certainly be effective but greater impact may be gained by introducing health maintenance themes in popular media. The mass media are already very effective in enhancing public awareness of complex issues of health and life-style. The advocacy role of media should be harnessed in support of the establishment of primary health care-oriented health systems.

4.2.8 Industry and corporation

Major employers generally accept both curative and preventive responsibility for the health of their employees. Health education, facilities for health maintenance, and financing support of primary health care have already been developed by many industries. These should be encouraged and incentives created by governments for their further development. Environmental hazards created by conditions of employment and industrial products may be limited by government regulations, but cooperation between industries, communities and occupational health agencies is often more effective and results in solutions more responsive to community concerns.

4.2.9 The legal system

Health regulations need constant revision in the light of changing circumstances. Health regulations have both health and legal implications. Effective implementation requires coordination of both health and legal contributions.

4.2.10 Universities

The World Health Assembly affirmed in 1984 that universities have a clear responsibility which they should accept for the promotion of health for all by the year 2000. Many faculties other than medical and health science faculties have a direct impact on
health. In the same way that intersectoral cooperation is encouraged between relevant ministries, cooperation should be established between relevant faculties of universities and other health training institutions.

4.2.11 Teaching hospitals

The Conference recognized that most teaching hospitals conduct their educational and service activities as tertiary referral hospitals with little explicit coordination with the rest of the health services. Such a role does not promote the development of an integrated primary health care system nor does it contribute to the kind of teaching settings recommended. It would be detrimental for work in the community to be seen as divorced from the responsibilities of the teaching hospital.

Teaching hospitals should, therefore, be encouraged to provide services for an immediate catchment area. Specialists within the teaching hospitals should project their own activities out into the communities, seeking preventive care and health maintenance solutions to the problems that are presented to them within the hospital. The supportive role of clinical epidemiology and the direct involvement of specialists in community programmes will provide both a quantitative rationale for this activity and a role model for students and post-graduates to follow. Tertiary care should therefore back up secondary and primary care, so that the entire health infrastructure is coherently used in the spirit of the primary health care approach.

4.2.12 Accreditation and certifying authorities

Authorities responsible for hospital accreditation and professional qualifications must alter their criteria to respond to the needs of the primary health care-oriented health system. Specialty qualifications that ignore preventive health care, a community focus, and early management and health maintenance are no longer appropriate to the needs of the current reorientation of health services. A realignment of specialty examinations and accreditation requirements would lead to a radical alteration of training programmes and organizations and the functions of teaching hospitals.
4.2.13 World Health Organization

The World Health Organization and other international agencies have all contributed to the early implementation of a primary health care-oriented health service and related manpower development plans. The World Health Organization should continue consultative meetings and advisory services and should be explicit in its advice to governments.

5. RECOMMENDATIONS

The Conference made recommendations which are addressed to Governments, to training institutions and to the World Health Organization.

5.1 It is recommended that GOVERNMENTS should:

5.1.1 develop national plans for the reorientation of health manpower development in consonance with a primary health care-oriented health system;

5.1.2 support the formulation and implementation of research and development projects for the development of health personnel in a primary health care-oriented health system, and encourage universities and other training institutions for health personnel to develop, in conjunction with the ministries concerned, research capabilities in community health diagnosis, epidemiology and health services research;

5.1.3 conduct operational research to determine the appropriate use of the kind, number and mix of health personnel in given health settings and situations;

5.1.4 design, test and implement information systems to assess the requirements for adequate health manpower development, and monitor progress in the implementation of health manpower development plans;

5.1.5 support selectively universities and other training institutions for health personnel so as to encourage the reorientation of their training programmes towards the requirements of a primary health care-oriented health system;

5.1.6 encourage all training institutions for health personnel, in particular medical schools, to be involved, in close coordination with the ministries concerned, in community health services so
as to enhance the relevance of their training and research activities and to enable them to contribute to health development;  
5.1.7 encourage all those able to influence the training and management of health personnel to support manpower policies for a primary health care-oriented health system;  
5.1.8 plan career development opportunities for graduates corresponding to their primary health care-oriented training programmes, and make changes in health systems accordingly.

5.2 It is recommended that TRAINING INSTITUTIONS should:  
5.2.1 urge all training institutions for health personnel to ensure that graduates possess a set of skills and attributes enabling them to work effectively in a primary health care-oriented system;  
5.2.2 select students more appropriately on the basis of criteria reflecting their future role in a primary health care-oriented system;  
5.2.3 use and evaluate a teaching/learning process which will enable students to integrate the available knowledge in health sciences for solving health problems effectively;  
5.2.4 give students ample opportunities to be involved in a range of learning settings reflecting their future practice, including both the hospital and the community;  
5.2.5 reorient the reward systems so as to encourage and support teachers to function effectively in a team and in a community setting and to serve as role models to the students.

5.3 It is recommended that the WORLD HEALTH ORGANIZATION should:  
5.3.1 disseminate widely the Declaration of Tokyo to institutions and bodies able to influence health manpower development in a country as a statement of guiding principles for health manpower in support of a primary health care-oriented system;  
5.3.2 constitute regional task forces to advise on and foster the implementation of strategies to introduce changes in accordance with the Declaration of Tokyo;  
5.3.3 sponsor national and international meetings with different target groups: policy makers, policy influencers, training insti-
tutions, professional associations, community representatives. These would have two purposes: to analyse their actual and potential contributions to the implementation of change in the training and management of health personnel who will serve in a primary health care-oriented health system, and to prepare action plans;

5.3.4 ensure technical support to Member States or institutions and bodies in the implementation of innovative strategies in the training and management of health personnel for primary health care-oriented health systems, particularly through technical manuals and learning materials;

5.3.5 improve the level of exchange of information and experience between countries or areas of the Region and between the regions of the world on the analysis of future needs and on the introduction of change in the training and management of health personnel for the twenty-first century.
6. DECLARATION OF TOKYO

The Conference on "Future health and medical manpower: New strategies in education for the XXIst century", meeting in Tokyo this fifteenth day of April in the year Nineteen hundred and eighty-five, deeply concerned about future health manpower development and expressing the need for urgent action by those institutions and persons concerned with the planning, training and utilization of health manpower, hereby makes the following Declaration:

I

The Conference affirms that the reorientation of health systems towards primary health care and social equity, as recommended by the International Conference on Primary Health Care, held at Alma-Ata in 1978 and as globally agreed upon by the World Health Assembly, can best be achieved through a fundamental reorientation of health manpower planning, production and management.

II

The reorientation of health personnel will be determined not only by the natural evolution of health systems, but also by planned intervention directed toward health systems based on primary health care. This orientation will require innovative efforts to obtain systematic information for future development, to delineate new responsibilities among and between relevant institutions, and to establish mechanisms for implementing the necessary changes.

III

Requirements for future health manpower in terms of number, types, roles and skills, as well as the relationship...
between health personnel, need to be clearly defined according to the emerging political, economic, social and health needs of future societies.

The fulfilment of these requirements calls for the mobilization and coordination of the vital forces of the nation or community.

IV

In order to meet the requirements of health systems based on primary health care, which entails above all social equity, community participation, intersectoral action and appropriate use of technology, health personnel will need to possess special skills and attributes. In particular, they must be able:

(1) to respond to the needs of communities;
(2) to work as effectively in complex organizations, communities and groups, as alone, with appropriate managerial capabilities;
(3) to function effectively in multidisciplinary teams as a member as well as a leader;
(4) to communicate and negotiate with community leaders, the public and the consumers in order to obtain their involvement in health programmes and activities;
(5) to promote healthy life-styles through health promotion, disease prevention and health education programmes on an individual and a community basis;
(6) to keep abreast of the latest developments in health sciences and to critically assess the appropriateness of technologies;
(7) to make complex clinical and managerial decisions, balancing individual expectations, cost to the society and ethical considerations;
(8) to ensure comprehensive individual care that considers the total needs of the patient.
V

Training institutions should be responsive to the changes in the health systems and should accept accountability for carrying out activities that are relevant to the policies and plans commonly agreed upon. Fundamental changes should occur so that curriculum content and process assure the students of capabilities in the identified skills. In addition:

(1) Students should be selected on the basis of criteria reflecting their future role in the primary health care-oriented health system.
(2) The curriculum should be so restructured that human development and social factors in health and disease are integrated with biomedical factors.
(3) The curriculum should provide ample opportunities for students to learn in an environment similar to the setting of their future practice.
(4) The most appropriate educational methodology and techniques should be used to make students more responsible for their basic and continuing education.
(5) Faculties should possess and display the capabilities expected of graduates so that they can serve as role models.
(6) Faculties should be encouraged and supported in their new roles by changes in the training institution’s reward system. A shift in the reward system is required in order to achieve a better balance between teaching and research and between community health and biomedical research.

VI

Governments, jointly with training institutions, professional associations and consumers, should be responsible for planning the training and management of health
personnel with the aforementioned features. Governments should formulate, in conjunction with relevant institutions and bodies, national policies to anticipate future requirements in health personnel.

VII

Governments and training institutions should be closely linked and contribute their complementary resources to:

1. the analysis and identification of both the future health needs and the planned direction of the health system;
2. the coordination of health manpower planning, health manpower production and health systems development;
3. the establishment of career development opportunities which will encourage both faculty and health personnel to acquire the skills and attitudes required to function in the future health system.

VIII

Innovative mechanisms are critically needed to ensure the proper planning, production and management of health personnel in harmony with the primary health care philosophy. Whereas the need for an active participation by the governments, training institutions, professional associations and consumers is widely recognized, the establishment of linkages through incentives is essential to initiate and accelerate coordinated movement in the desired direction.

1. Governments and local communities should support those training institutions which choose to participate actively in the design and implementation of primary
health care-oriented health systems and health personnel policies and plans.

(2) Governments and local communities should support those individuals who wish to acquire skills, to embrace careers and to participate in programmes in consonance with the desired type of health service.

(3) Professional associations should be encouraged to legitimize new professional roles and careers by setting standards and according them status and recognition.

(4) Career development and job opportunities within the health system and within training institutions should be altered to reflect the priority now given to the acquisition and practice of the newly desired skills and roles.
ANNEXES
Ladies and Gentlemen,

I first wish to express my deep appreciation to our host country, which has most graciously provided a beautiful setting for this meeting. I would next like to welcome each of you to this Conference, to which we attach the greatest significance. It deals with a most challenging topic: How to introduce change into health training institutions in order to prepare personnel relevant to the changing needs of the health system. As leaders in your countries, you face this great responsibility and challenge. We at WHO look forward to sharing with you the tasks ahead.

Why is the topic before us so pressing and challenging? At the Alma-Ata Conference, our Member States collectively agreed to transform their health systems on the basis of primary health care. It was and is an awesome task, demanding redirection of resources, total coverage with emphasis on the disadvantaged, teamwork, a carefully designed intersectoral approach, application of appropriate technology and full community involvement in all actions to improve health.

Doctors must lead in this transformation process but, to do so effectively, their current role must be reconsidered. Traditionally, a doctor's role was straightforward – treating the sick using the best clinical means available for diagnosis and cure. But as certain kinds of health care responsibilities have shifted towards the community health worker to expand coverage, doctors have moved increasingly towards specialization within vertical disciplines. This trend toward isolation from day-to-day health care is clearly at odds with the need for partnership with the community in planning and action for better health.

Reaching our common goal of health for all by the year 2000 demands a critical mass of active leaders trained in consonance
with real needs and reoriented health care systems. The great
challenge of health for all by the 2000, and beyond, is the re-
orientation of strategies for health development, the redirection
of resources, and the development of skills among health person-
nel for solving community health problems.

This challenge cannot be met without profound changes in
the kinds of people produced by training institutions and there­
fore in the training institutions themselves. It is consequently
imperative that training institutions review their mission so as to
anticipate and make needed changes. Yet training institutions
are often part of the establishment in any country, part of the
entrenched power structure, and thus are slow to change. Exis­
ting career structures are inevitably threatened by the notion
of new ones. Often training institutions are not structured to
respond quickly to the changing needs of society.

As leading scholars and practitioners in manpower develop­
ment, many of you will be facing common problems in the
future. They will have many different manifestations, but they
will all in essence require hard decisions on how to make the
most of scarce resources and how to keep within reasonable
limits the ever increasing cost of health care.

With only a decade and a half to go before the year 2000,
it has become critical, therefore, for WHO to call this Conference
of both practical and theoretical experts to begin thinking toge­
ther about strategies to ensure that new health systems will be
in place by the end of this century, and that the kinds of people
needed will be trained to work in them. You will note that we
are focusing here, not on the quantity of people needed, but on
the quality.

Will this be a landmark meeting, laying the foundation for a
lasting reorientation of health services towards primary health

care? Perhaps, as at Alma-Ata, we can together succeed in chart­
ing a course for the future that will stir the imagination and
stimulate action in the health systems of the world.

I should emphasize that the purpose of the Conference is not
to codify knowledge on how to bring about change. That knowl-
edge already largely exists. The purpose of this Conference
rather is to pinpoint critical steps which can and must be taken
to bring about change in the training and management of health
manpower. As such — as a concrete exercise in using the theory
of change - this Conference cannot be an isolated event. Rather it must be the beginning of a continuing process, a process which will require long-term effort and hard work to be effective. We can together formulate and specify that process so that we leave this Conference knowing better the direction in which sure steps should and must be taken. Without a genuine consensus and collective resolve, all our work here will have been in vain.

May I invite you to advise WHO, first, on changes that may be required in its role in the direction and coordination of international efforts in health manpower development; second, on the details of future collaborative programmes with Member States geared towards action strategies for changes in training institutions. The Conference report will itself be widely disseminated as a step to facilitate change.

The task before us is not an easy one. This is a complex subject. The future is unpredictable, and it is much easier to talk than act. But I am confident that your words here will not only set the guiding principles for change, but will be an irresistible force for action — even into the twenty-first century.

I would like to thank you once again for coming together with us. I sincerely hope this will be a successful beginning to a historic odyssey.
GUIDELINES FOR GROUP DISCUSSIONS

TOPIC A: INTERNAL ENVIRONMENT

What are the changes in training institutions, faculty and programmes needed to support a primary health care-oriented system?

That task for the day is to consider what changes are needed in:

- new types of professionals
- faculty consultation/services
- faculty research
- continuing education for professionals
- continuing education for non-professionals
- undergraduate curriculum
- postgraduate curriculum

It may be helpful to address these changes by considering:

(1) Who are the key people?
   How may these be involved?
   What problems do they present?

(2) What are the key forces, both positive and negative, which may influence the conditions needed to bring about the changes you have identified as required?

ACTION QUESTIONS

1. How can these people/forces be altered to create favourable conditions for change?
2. What change approaches/methods may be effective?
3. When should you not attempt change because the right conditions do not exist?
4. What specific resources are required for change?
5. What transitional steps may be required to move toward desired end results.
6. What role should WHO play?
What changes would you advise for WHO regarding:
- resources/expertise
- information systems
- relationship to Member States
- programmes

**TOPIC B: EXTERNAL ENVIRONMENT**

Required changes in the broader system to support internal training institution change

The broader system contains (at least) the following institutions:
- health ministries
- civil service and related sectors
- universities
- community
- health-delivering public sector/private sector
- professional associations

The purpose is to consider the broader system, external to the training institutions, and see how it can be influenced to create favourable conditions for internal change in training institutions to take place. What part does the broader system play in providing the necessary conditions for change?

**ACTION QUESTIONS**

1. What information do the institutions need that they do not possess? How might it be supplied? By whom? To whom?
2. What activities/values do they need that they do not possess? How might it be supplied? By whom? To whom?
3. Who and how should they be involved in any change process?
4. Who should be responsible for influencing whom in the institutions?
5. What are the facilitating/constraining factors in producing change? How might these be favourably influenced? By whom?
6. What resources (skills, consultation, etc.) may be needed to produce change? Finances, skills, legitimation, etc.?
7. What role can WHO play as a resource? What changes in WHO approaches would you recommend?

TOPIC C: INTEGRATION AND FOLLOW-UP

WHAT INTEGRATIVE AND FOLLOW-UP ACTIONS SHOULD BE PURSUED?

A tentative general framework for a follow-up process is outlined in question form.

ACTION QUESTIONS – INTEGRATION

1. What integrative mechanisms already exist and what is their value? For example, do health manpower plans do the job?
2. Who should be involved?
3. What issues should be addressed?
4. What new integrative approaches might be of value?
5. What resources would these require?
6. What role should WHO play?

ACTION QUESTIONS – FOLLOW-UP

1. What next steps should be recommended to individual countries and to WHO?
2. Should country teams meet periodically to address development?
   i.e. Should they develop alternative scenarios for their future local environment?
   i.e. Should they develop strategic planning for their country's manpower needs and/or for their training institutions?
3. Should regional or sub-regional teams meet periodically to address intercountry resource development and support?
4. Should there be intercountry meetings by professional groups (e.g. doctors/nurses) to work on common problems and issues and to facilitate country changes? Included could be sharing research programmes, sharing results, sharing products and materials, sharing media approaches...

5. Should there be a periodic review and evaluation of the overall process, if adopted, by, for example, country teams, regional teams or issue groups?
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