THE NEED FOR COLLABORATIVE COMPETENCIES IN COMMUNITY HEALTH AND DEVELOPMENT

Elizabeth Paterno, MD, MPH

I. Context - The Health Situation

A. No significant improvement in the last decades
   1. Infant Mortality Rate
   2. Maternal Mortality Ratio
   3. Life expectancy
   4. Rate of physician attendance at death
   5. Double burden of disease in the 1970s to triple burden at present
   6. Health inequities

B. The Philippine health situation in the global context: Health systems globally not performing as they should
   1. Quote Margaret Chan in the World Health Report 2008
   2. Trends in the global health systems (World Health Report 2008)

II. Primary Health Care

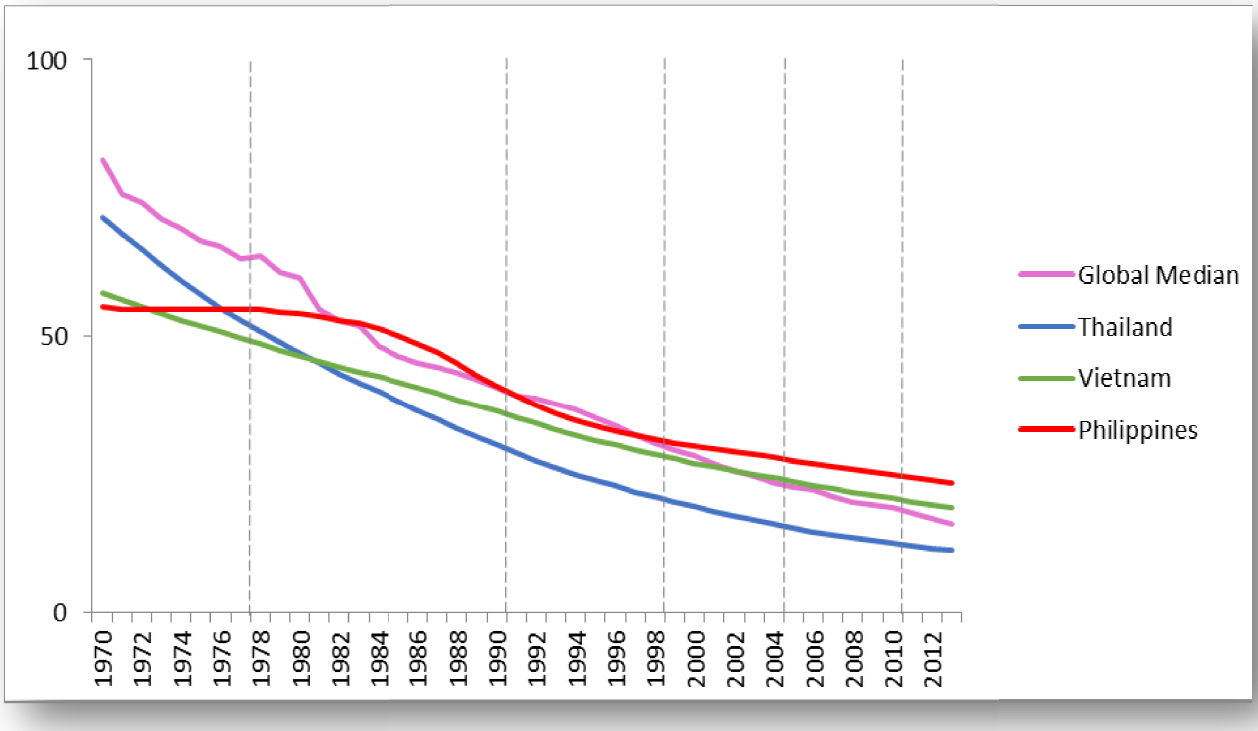
III. The need for Collaborative Practice and Interprofessional Education
   1. Fragmentation of health systems
   2. Challenging traditions in Health Professions education
   3. Brief intro of IPE history globally
   4. IPE initiatives in the Philippines
      a. UP
      b. Angeles Foundation
      c. UST

CONTEXT: The Health Situation

Though the Philippine economy has been steadily growing since the 1970s, poverty and income inequality remain as major challenges. The upward trend in the economic growth has not translated to better and equitable social outcomes, particularly for health status. (Reyes, 2014)

Infant mortality rate in the country has been steadily decreasing but improvement is slow when compared with neighboring countries in the ASEAN. In the 1970s, the Philippines had one of the lowest mortality rates in the region; however, by 2012,

countries like Vietnam and Thailand have shown lower rates. The same trend is seen with other parameters like the Maternal Mortality Ratio and Life expectancy at birth.



Infant Mortality Rate (per 1000 live births). (World Bank, 2015)

In the 1970s the Philippine Department of Health reported that 6 out of 10 Filipinos who died, died without medical attendance. In 2011, the rate of non-attended deaths was still at 66.6%, slightly improving in 2013 to 58.1% (Department of Health, Epidemiology Bureau, 2011); (Department of Health, Epidemiology Bureau, 2013).

In the 1970s, our country reported a double burden of disease, meaning that while communicable diseases have not been controlled, non-communicable or lifestyle diseases have become another major problem. Today, however, the Department of Health reports an additional burden on top of the two already stated, and that is diseases of rapid urbanization and industrialization(Rosell-Ubial, 2016). Tuberculosis remains as one of the top 10 causes of mortality in the country, while cancer, diabetes, heart disease and their risk factors have become the main causes of mortality. Malnutrition has likewise persisted. Injuries, substance abuse, mental illness, and health

consequences of climate change i.e. disasters are now contributing as the third burden of our health system(Department of Health, 2019).

In addition, although our infant mortality rate (IMR) may not compare too badly with other countries, especially among low and middle income countries like the Philippines, what we report is the national average. The IMRs in the national capital region and among the richest quintile of our population are comparable to those in more developed countries. When we look however at the IMRs in the Autonomous Region of Muslim Mindanao and the poorest quintile of our population, the figures double showing the problem of disparities in the health and life situations in the different areas of our country(Department of Health, Epidemiology Bureau, 2013).

The present state of our health system is mirrored in many countries globally. In 2008, Dr. Margaret Chan, then the Director of the WHO noted in her introduction to the World Health Assembly report of that year: "***We see mother[s] suffering complications of labour without access to qualified support, [children] missing out on essential vaccinations, inner-city slum dweller[s] living in squalor.. . . . . These and many other everyday realities of life personify the unacceptable and avoidable shortfalls in the performance of our health systems"***(World Health Oranization, 2009)***.*** This kind of situation was, and still is common in many countries all over the world including well developed countries like the United States where large disparities in situations of different communities still exist. It was clear to the members of the World Health Assembly in 2008 that health systems were not performing as well as they could and should, and called for a renewal of PRIMARY HEALTH CARE, now more than ever.

In 2019, the continuing underperformance of global health systems prompted the World Health Organization to report that "*Nine of the health-related Sustainable Development Goals indicators have explicit targets for 2030, but only 2 of those indicators are on track to meet 2030 targets; that is, those for under-5 mortality rate and neonatal mortality rate. Moreover, it is estimated that on current trends 51 countries will miss the target for under-5 mortality, and more than 60 countries will miss the target for neonatal mortality in 2030"* (World Health Organization, 2019).

PRIMARY HEALTH CARE

Health as a basic human right is one of the main tenets that serve as the foundation of Primary Health Care. The Alma Ata Declaration reaffirms the WHO 1948 definition of health i.e. that health is not merely the absence of disease but a state of complete physical, social and mental wellbeing(World Health Organization, 1978). The term 'social' here does not merely refer to social relationships but rather to the totality of the social situation of each human being. If we accept that each human being has the right to be healthy, each human being therefore also has the right to attain the standard of living required to be healthy. Social and economic development are seen as prerequisites to the improvement in the health situation of populations.

Primary Health Care (PHC) is an approach to or a system of basic health care that was first described formally in the Declaration of Alma Ata in 1978. This declaration was the product of an international convention that was jointly organized by the WHO and UNICEF and it was held in the city of Alma Ata (now called Almaty) in Kazhakstan. It embodied the lessons learned from the collective experience of community based health care workers from the developing world. Countries in Latin America and Asia had been showing outstanding results in improving the health and the lives of populations where this type of program was implemented(Werner & Sanders, 1997).

PRIMARY HEALTH CARE versus PRIMARY CARE

Contrary to what most health professionals worldwide believe, Primary Health Care is not synonymous to or interchangeable with Primary Care, though Primary Care is an essential part of Primary Health Care(World Bank, Bill and Melinda Gates Foundation, 2015). Primary Care provides first contact health care to persons who need it and is the entry point of populations to their national health services. Primary Care provides the most basic health services and is usually provided within easy reach of the population i.e. within their communities. Though Primary Care should not be confined to curative services, in fact most primary care centers limit their services to this, especially those that are privately owned and managed.

Primary Health Care, on the other hand, while ensuring that populations have access to the essential promotive, preventive, curative and rehabilitative health care they need, further advocates for socio-economic development. People's participation is KEY. Organizational structures must be institutionalized so that people can decide on the services and programs they need, and in implementing, monitoring and evaluating such programs. Thus, Primary Health Care involves entire populations to ensure equity in health(World Bank, Bill and Melinda Gates Foundation, 2015).

Primary Health Care is part of total community development where social, economic, political and cultural determinants of health, aside from biomedical causes of ill health are addressed. It not only calls for the collaboration of different health disciplines as a team, but also different sectors working together for comprehensive community development. Without this, genuine and lasting improvements may not be achieved(Werner & Sanders, 1997). Even if introduced by persons outside the community, Primary Health Care must be tailor-fit for each community. It starts with the perceived needs, maximizes available resources, and build up the people's capacity to effect change.

In situations where health professionals are lacking, non-professional health workers are developed as the frontline workforce to bring health care as close to the people as possible. Traditional health workers are also engaged, especially those already accepted as primary health caregivers of the population. Results of relevant biomedical and public health researches are utilized to ensure that programs and services are sound.Lastly, as a reaffirmation of equity in health, Primary Health Care called for a redistribution of resources for the underserved, to eliminate disparities within and among countries(Werner & Sanders, 1997).

UNDERMINING PRIMARY HEALTH CARE

However, Primary Health Care principles were seen as revolutionary and a threat to the status quo. Most successful Primary Health Care programs at one point or another were eventually weakened, co-opted or taken over by national health authorities. Debates

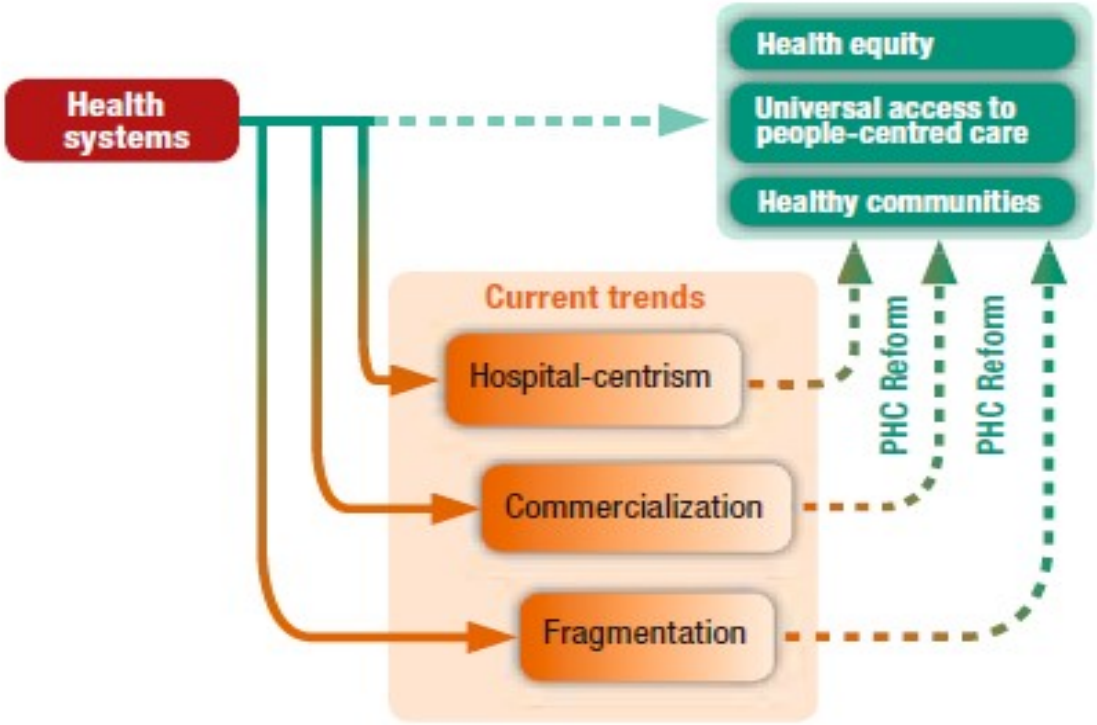
within the international health community likewise followed the publication of the Alma Ata Declaration. These debates eventually forced the WHO to weaken its call for comprehensive development in favor of more ‘realistic,‘ selective, and less costly health interventions that concentrated on targets involving the most vulnerable sections of the population i.e. children. These selective programs notably failed to push for comprehensive social and economic reforms demanded by the Alma Ata Declaration(Werner & Sanders, 1997).

REAFFIRMING PRIMARY HEALTH CARE

By 2008, thirty years later however, the World Health Assemblyonce again realized that to be able to attain significant health outcomes and health for all, we need to go back to the principles of Primary Health Care. The 2008 World Health Report “Primary Health Care, Now More Than Ever” was the result of a global clamor that started in the Americas(World Health Oranization, 2009). The call for stronger efforts towards PHC continues to the present. In October 2018, the WHO called for a global conference on Primary Health Care in Astana, Kazakhstan where the principles embodied in the 1978 declaration were once again iterated(World Health Organization, 2019).

THE NEED FOR COLLABORATIVE PRACTICE AND INTERPROFESSIONAL EDUCATION

One of the important trends in weak health systems as described in the 2008 World Health Assembly Report is fragmentation.



3 worrisome trends of health systems. (World Health Oranization, 2009)

Fragmentation is manifested not only in the vertical programs and other activities and structure of the health systems but more importantly in the relationship among the different health professionals within the system. As early as the 1960s, the fragmentation among the health professionals was already noted by Szasz who stated that there was ". . . ***fragmentation and compartmentalization both of scientific investigation and the approach to human problems…"*** as well as ***". . . poor communication between those who provide different components of the health service"*** (Szasz, 1969)***.***

In 2010, the WHO noted that interprofessional collaboration is a key step in moving health systems from fragmentation to a position of strength. Evidence has shown that

collaborative health care teams provide better health services to patients and communities, resulting in strengthened health systems and improved health outcomes (World Health Organization, 2010). Health professional education worldwide, however has not been producing graduates who are ready for collaborative practice. A globalstudy conducted in 2010 by an independent global commission, the Commission on the Education for Health Professionals for the 21st Centuryshowed that an important systemic problem in health professional education worldwide is the lack of training in teamwork(Frenk, Chen, & Bhutta, 2010). Students are trained in separate silos, independent of each other, often having misconceptions and biases against each other. Both the WHO and the Commission have therefore advocated for educational reforms that would include interprofessional education in the curriculum (World Health Organization, 2010; Frenk, Chen, & Bhutta, 2010).Interprofessional education involves learning with, from, and about other professions to build mutual respect between the health and social care professions with the aim of working together to improve patient care(Forman, 2014); it is the proposed mechanism by which collaborative practice – ready health professionals would be produced.

Interprofessional education (IPE) had been reported as early as the late 1960s to the early 1970s at the University of British Columbia in Canada, through the efforts of Dr. George Szasz. These efforts however, were not sustained to the end of the century, but were renewed in 2003 and continue to the present under the leadership of Dr. John Gilbert. IPE was also started in some universities in the USA and Europe in the 1990s. Notable among these efforts were those in Nevada, Sweden (Linkoping University) and the United Kingdom (Barr, 2014). By 2010 the WHO reported that 42 countries were implementinginterprofessional education(World Health Organization, 2010). In Asia, Japan offers the most publications about their experiences in interprofessional collaboration and education among the health professions. In the Philippines, IPE was first reported at the University of the Philippines(Paterno & Tan, 2014). IPE has likewise been reported within the allied medical professions (occupation therapy, physical therapy and speech pathology) at the Angeles University Foundation in Pampanga.

REFERENCES

Barr, H. (2014). Leading the Way. In D. J. Forman, *Leadership Development for Interprofessional Education and Collaborative Practice* (pp. 15-23). New York City: Palgrave Macmillan.

Department of Health, Epidemiology Bureau. (2011). *The 2011 Philippine Health Statistics.* Manila: Department of Health.

Department of Health. (2019). *Philippine Health Agenda.* Manila: Department of Health.

Department of Health, Epidemiology Bureau. (2013). *The 2013 Philippine Health Statistics.* Manila: Department of Health.

Forman, D. (2014). Introduction. In D. J. Forman, *Leadership Development for Interprofessional Education and Collaborative Practice* (p. 6). New York City: Palgrave Macmillan.

Frenk, J., Chen, L., & Bhutta, Z. e. (2010). Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *The Lancet*, 1923-58.

Paterno, E., & Tan, L. (2014). Developing Community-engaged Interprofessional Education in the Philippines. In D. J. Forman, *Leadership Development for Interprofessional Education and Collaborative Practice* (pp. 162-78). New York City: Pagrave Macmillan.

Reyes, C. e. (2014). *Philippine Health Status.* Manila: DOH.

Rosell-Ubial, J. (2016). *All for Health towards Health for All, Philippine Health Agenda 2016-2022.* Manila: Department of Health.

Szasz, G. (1969). Interprofessional education in the health sciences. *Milbank Memorial Quarterly Journal*, 449-75.

Werner, D., & Sanders, D. (1997). *Questioning the Solution: The Politics of Primary Health Care and Child Survival.* Palo Alto: Healthwrights.

World Bank. (2015). *Mortality rate, infant (per 1000 live births).* Retrieved March 15, 2017, from http://api.worldbank.org/v2/en/indicator/sp.dyn.imrt.in?downloadformat=excel

World Bank, Bill and Melinda Gates Foundation. (2015). Primary Health Care Performance Initiative. *Briefing Document for MA4Health Summit.* Washington D.C.: World Bank, Bill and Melinda Gates Foundation.

World Health Oranization. (2009). *Primary Health Care, Now More than Ever. World Health Report 2008.* Geneva: World Health Organization.

World Health Organization. (1978). *The Alma Ata Declaration.* Retrieved May 23, 2013, from www.who.int/publications/almaata_declaration_en.pdf

World Health Organization. (2010). *Framework for Action on Interprofessional Education & Collaborative Practice.* Geneva: World Health Organization.

World Health Organization. (2019). *World Health Statistics: Overview 2019.* Geneva: World Health Organization.