

Where do the best come from?

*Global competition in education.
Who trains the competent healthcare
professionals of the future?*

Eva Maria Panfil, Beat Sottas



Thinking about the future of health and care

Healthcare is undergoing a landmark transformation and is facing some major challenges. The healthcare community is becoming more and more interconnected across the world, shifting the traditional boundaries between disciplines, professions, institutions and countries. Similarly, the relationship between the range of services offered and the citizen, the market and the regulator, the doctor and the patient and the service provider and the consumer is being redefined. New approaches and models for strategies in healthcare and in training health professionals must meet all of these challenges if they are to make a relevant contribution for the future. Careum wants to highlight how trends can be turned into specific projects within training policy in conversation with its partners in the training and healthcare sector.

The intention in publishing the Careum Working Papers series is for developments in the healthcare community to be addressed and appropriate impetus injected to stimulate and actively help shape innovative processes in healthcare.

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«Where do the best come from?»

Global competition in education. Who trains the competent healthcare professionals of the future?

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1

Foreword	2
1. Context	3
1.1 Health professionals	3
1.2 Challenges of our health system	3
1.3 The health system and the people in it are changing	4
2. Yesterday is not tomorrow: need for new health professionals	5
2.1 Patient- versus disease-orientation	5
2.2 Inter-professional versus mono-professional thinking	6
2.3 Evidence- versus eminence-orientation	6
2.4 Factual versus power orientation	7
2.5 Communicative, solution-oriented, integrative competencies	7
2.6 Transparency of performance versus freedom of therapy	7
3. Lighthouses, but no relationship between health care reform and education reform	9
3.1 How do you recognize a future-capable health care system?	9
3.2 Reforms of the health care system have little influence on the training reforms	9
3.3 CanMEDS 2005: physician competency framework	10
3.4 Advanced nurse practitioner: the training of nurses at masters level	12
4. The chances of competition are not being used	13
4.1 There is no global product – «future-capable health professionals»	13
4.2 Dispersal of education markets for health professionals, but no benchmark	13
4.3. There is no global market for the consumer	14
5. Conclusion: Create incentives in order not to reinvent the wheel	15

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Foreword

2

Health care professionals are in high demand all over the world. Based on the conclusions of studies, new methods for teaching were developed in the 1970s which concentrated on problem-solving skills and inter-professional teamwork rather than the mere acquisition of knowledge. In the meantime, the so-called Problem Based Learning (PBL) method has become widely established as a standard of training for education in health care professions.

Expenditure for the training of health professionals tends to be high. It is estimated that Switzerland invests approximately a billion francs per year in this field. Three-quarters of this amount is destined for the education and postgraduate training of physicians. However, considering the magnitude of these costs, education economists and politicians should be demanding proof that taxpayers' money is being used efficiently and effectively.

In the industrialized countries the health-related challenges and solutions are becoming increasingly uniform, so that the best pre-condition for training would be international competition and cross-border exchange. Unfortunately, competition exists only amongst trained personnel. Because health systems are nationally limited, each country re-invents its own training program and young health professionals are primarily trained to practice in the domestic market. The potential of cross-border cooperation remains, to a large extent, untapped.

In the working paper prepared for the Careum Congress 2009, the Careum Foundation, which has been concerned with education in the health sector for 130 years, presents suggestions for cross-border cooperation. On the one hand, today's challenges should generate a qualification profile for future health professionals. On the other hand (in consolidation of the four Careum theses for training in the public health sector for 2032) there is a good case for cross-border exchanges: future-capable health professionals will be available if the education and health system abandons the «exception médicale» and the educational establishments set themselves up as competence centers based on the division of labor. Each center would be responsible for just one part of the already considerably standardized training program and could exchange its own competences with those of other excellent partners in order to complete the portfolio.

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1. Context

1.1 Health professionals

3

«Health professionals» is a collective term for different professional groups, including:

- physicians, nurses, midwives, psychotherapists, psychologists, pharmacists, veterinarians, chiropractors
- so-called «therapists», such as occupational therapists, physiotherapists, nutritional therapists, and podiatrists
- those named by the WHO as «enablers» as health economists or in management, services and public health³

In this paper the focus is on physicians and nurses. Both these professional groups are central players within the occupational groups of the public health service. As far as the reforms in their training are concerned, they have developed independent discourses and agendas. The focus of this paper is limited to these two groups, given their reference character and the global competition among these health professionals. However, it should not be assumed that the other professional groups play a less important role.

1.2 Challenges of our health system

**The challenges are similar
in all industrial countries**

The Swiss and all other health systems in the industrialized world face similar challenges: such as demographic development, aging and longer life span, progress in diagnostics, therapy and technology, coordination of service providers, transparency and efficiency, quality and costs, access to the system as well as its financing, and health as consumer goods (Busse and Schlette (2004), Folkers et al. (2006), OECD (2006), Rosenbrock and Gerlinger (2009)). While there is an increasing demand for services, financial and personnel resources are dwindling.

**Chronic diseases are
becoming more frequent than
acute illnesses**

System-related factors, together with the shift of morbidity, represent one of the substantial challenges for providing health services in the OECD countries. The remarkable increase in chronic diseases (e.g. heart insufficiency, cancer, rheumatism, arthritis, asthma, chronically obstructive lung diseases, diabetes, multiple sclerosis and depression) and the requirement for long term support in neuro-rehabilitation following a stroke or cerebral trauma call for other competencies, sourcing methods and financing (see figure 1) (Donaldson 2001, WHO 2002, WHO 2005).

³ In Switzerland approximately 25 professions in health services are regulated.

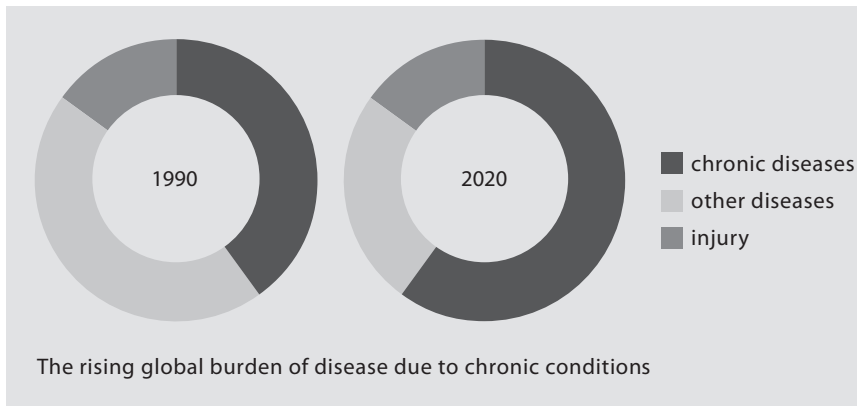


Figure1: The increase of chronic diseases allows the acute medical portion to shrink. Health Professionals must be trained and be prepared for this substantial shift (WHO 2002, 2005).

The focus of the interest has to shift from acute conditions to long term care

1.3 The health system and the people in it are changing

The change in the state of health of the population requires corresponding changes in sourcing methods. For prevention, therapy and supervision other financing and sourcing structures and other forms of therapy must be found. Hospitals, the traditional providers of diagnoses and therapies for acute diseases as well as training facilities for physicians and specialized care personnel, are losing importance with the increase in chronic diseases.

Changing conditions require an adjustment of the system's limitations

It is necessary to investigate how the prevailing concepts (especially the focus on acute medicine and cost pressure), hierarchy, organization structure, workflow management, span of treatment and financial compensation models can meet the subjective and objective needs of this patient category.

Hospital-centered thinking is not optimal

In addition, there have been changes in knowledge and knowledge management among professionals, patients and citizens. The demand for evidence-based practice stands vis-à-vis traditional eminence-oriented practice (see 2.3). At the same time, modern media gives patients access to medical and system knowledge. Thus, the role of the patient is slowly changing from that of the «obedient patient who has all his decisions made for him» to that of the «mature patient» and «smart consumer», who quite often has more expert knowledge than the health professionals.

Therapeutic individualism does not measure up to mature patients and smart consumers

2. Yesterday is not tomorrow: need for new health professionals

Future-capable health professionals need other, broader competencies

Thesis 1: For physicians and nurses, future-capability entails training to acquire the necessary skills and talents to cope with the most frequent and critical health and system conditions in the years to come.

Health Professions have a particular status

Why is there a health care system? Why are there different professional groups which dedicate themselves to different health problems? Not because there are diseases, but because it is the task of a welfare state to provide care for its citizens: in short, there are «people with diseases and need of care». Professionals in the health sector have privileged positions, because treating and overcoming illness and suffering is essential for the continuity of society. Health is a high priority which requires special protection. In order to reach health-related political goals, (in particular maintaining the productivity of the population, damage prevention, patients' safety, fraud protection and the effectiveness and quality of care) the state controls training, competence criteria and the licensing of practitioners as well as their practice.

In order to protect citizens, the state controls the education, competence criteria and practice of health professionals

The central competencies, abilities, and talents of future-capable health professionals will be able to cope with the above mentioned challenges, as well as aspects like patient- versus disease-oriented, evidence- versus eminence-oriented, inter-professional versus mono-professional thinking, factual- versus power-orientation, communicative, solution-oriented, integrative competencies and a transparent, performance-oriented therapy concept.

2.1 Patient- versus disease-orientation

Adherence instead of compliance: autonomous patients negotiate a common diagnostic and therapy program instead of merely receiving a prescribed treatment

From the patient's perspective, having a «chronic disease» means suffering from a disease that «won't go away». This may mean lifelong changes and adjustments of lifestyle and self-image. The term «Compliance» does not correspond with our understanding of modern therapy. Patients are no longer expected to show «therapy loyalty». Nowadays, health professionals, patients and their relatives come to a mutual agreement concerning therapy options and their implementation. This understanding is summarized under the term «Adherence». For health professionals this means turning away from the role of organ-oriented specialists and being concerned about the «person with lung cancer» instead of «cancer of the lungs». The development of a disease will depend on the competencies, abilities and talents of the chronically sick patient rather than on the health professional's understanding of the scientific function and his or her disease-oriented diagnostic and therapeutic competencies. Another issue is the knowledge and handling of multicultural challenges, dynamics in family systems and the freedom of the patient and family members to come to autonomous decisions.

2.2 Inter-professional versus mono-professional thinking

Scientific medicine is based on an intervention paradigm. A knowledgeable therapist leads, in a paternalistic manner, an obedient patient towards healing or alleviation. Therapeutic individualism is important («see one, treat one» in accordance with Flexner, 1910), whereby each situation appears to be unique, thus justifying freedom of therapy and method.

In addition, the scientific argument with health promotes the division of labor and specialization. In the medical field there are specializations in diseases, organs or diagnostic processes (e.g. cardiology, diabetology, radiology, pathology). For nurses, two fields exist: «assisting the physician with the diagnosis and therapy» (e.g. measuring blood pressure, preparation and assistant functions, post-operative supervision, giving of medicine), and the «promotion of the patient's self-management with supervision and support in overcoming the disease».

Now, however, the results and benefits for the patient are achieved thanks to processes where healing and the alleviation of suffering no longer depend on the intervention of one person alone.

The definition and achievement of defined goals of preventive, diagnostic, therapeutic, rehabilitative or palliative procedures and the outcomes are a team result. This requires an optimal and effective interaction of several categories of professionals and persons with different competencies. Inter-professional work is the consequence of fundamental changes.

However, this presupposes knowledge and acceptance of the independent fields of the respective professional groups.

2.3 Evidence- versus eminence-orientation

The call for evidence-oriented health care cannot be ignored. Unfortunately, the term is usually reduced to the available scientific knowledge base. Evidence-based health care is more than this. It incorporates:

- evidence-based research
- the clinical expertise
- patient preferences and
- economic conditions

in decisions concerning the healthcare of individual people.

Therefore, evidence-basing means abandoning the concept of eminence-orientation, i.e. performing to the requirements of superiors because their accuracy and adequacy seem legitimate due to their authority. The ability to identify the

Therapeutic individualism is passé

Inter-professional teamwork is the result of fundamental changes:

Healing is the team result of professionals with different competences

Evidence covers more than the scientific knowledge base and more than knowledge of methods

Reflection of professional know-how and personal limitations

**Ability to communicate
and understanding of the
health care systems**

best available evidence, critically reflect on professional know-how, negotiate, consider the options and reach a common decision (with the patient!) is essential for genuine, evidence-oriented health care. This means knowing how to communicate, use the right language and encourage reflective self competence, as well as having a basic knowledge of health politics.

2.4 Factual versus power orientation

Factual orientation is connected with inter-professional thinking. Challenges in the health care sector can only be solved if the benefit of the patient stands in the forefront and if treatment is economically planned, thought out, and implemented. With chronic disease it is almost impossible to reach goals without involving the person concerned and his or her relatives. People with chronic conditions have needs which are different from those of people with acute diseases.

**Professional competence
rather than professional standing
must apply, not profession or
status**

The challenges associated with the treatment of chronic diseases can be solved neither mono-disciplinarily nor mono-professionally. The division of labor of professionals is the result of past and present negotiation processes, and the various points of view held worldwide have led to differing results. Therefore there is no definitive requirement with regard to processing and determining competencies and tasks. However, one thing is certain: occupational groups, as professionals, have a joint responsibility for finding patient-oriented and economically justifiable solutions.

2.5 Communicative, solution-oriented, integrative competencies

The future-capable profile of health professionals can only be reached if appropriate key qualifications are present. Communication skills are necessary for negotiating with patients, relatives and other occupational groups. Solutions must be found which are acceptable and realizable for all those involved. The conceptions, desires and goals of those involved should be integrated into the negotiation processes.

2.6 Transparency of performance versus freedom of therapy

**In the «new medicine»,
a new therapeutic relationship
develops**

Future-capability requires a fundamental change in the therapeutic relationship. The individual physician or therapist relationship is normalized in such a way that – like the rendering of other services in the health care sector – it basically follows the rules of our consumer world. This represents a transition from the «old medicine» to the «new medicine». In the established self-image of academic medicine – («see one, treat one» as per the Flexner Report, 1910) – there is a (paternalistic) single relationship based on confidence that does not demand

further confidence building. However, the «new medicine» is a cost-intensive mass market with high demand as well as rising specialization and division of labor. Within the perception of consumers, the comparison of services is important, and there should be competition between service providers. Particularly, for the protection of the patient, transparency is an indispensable pre-condition. In this highly standardized field we are not talking about handicraft or art, but transparent performance. Therefore, a therapeutic relationship is obsolete if it is based on an individualistic conception and clinical purism.

In future, the therapeutic relationship will be subject to a measuring of performance

Freedom of therapy and therapeutic individualism are being put into perspective by transparency requirements

3. Lighthouses, but no relationship between health care reform and education reform

Thesis 2: There is not «the» place where future-capable health professionals are being trained

Health professionals are trained for the national job market

Health care systems are national systems. As long as the establishment of training programs depends on the accepted criteria and the ability to work in the respective state, future-capable health professionals can only be trained where trained abilities can be converted into practice – in other words, where the national profile corresponds to the practice of the profession. Therefore, future-capable health professionals should be trained where future-capable health care systems exist. The vast variety of education systems with many different goals feeds the assumption that not all the approaches will meet future challenges.

3.1 How do you recognize a future-capable health care system?

Criteria for a future-capable health care system

Neubauer, a German health economist, suggests the following key points for a future-capable health care system:

- More individualism, less collectivism
- Instead of authoritarian experts, transparency and right of choice for those involved
- Cushioning the demographic risk: capital coverage instead of allocation procedures
- Labor costs neutrality and
- Efficiency increase through competition instead of regulations (Neubauer 2002).

Additionally, this author pleads for a Europe that is a migration goal rather than an escape country for high performing health professionals.

This profile of a future-capable system does not take training into consideration. The analyses often ask only where the health professionals go and not where the best of them, i.e. the future-capable health professionals, are being trained. Do countries from which Switzerland recruits health professionals, e.g. physicians and nurses from Germany and physiotherapists from the Netherlands, automatically stand for future-capable training?

3.2 Reforms of the health care system have little influence on the training reforms

The problems and solutions are similar, but each education system invents its own, non-transferable solutions

Because health care systems are nationally and regionally limited and are oriented according to their respective characteristics, it is not possible to determine which countries can be described as having a «future-capable health care system». For example, in comparison, health economists regard the Netherlands

health care system as favorable. Even if the challenges in the OECD countries and the solutions adopted resemble each other (Busse & Schlette 2007) specific solutions have to be found which can be integrated into the respective systems and cultures. In contrast to (highly) specialized medicine, this applies particularly to the management of people with chronic diseases (Nolte, McKee & Knai 2008).

It should be investigated whether system-related solutions like the introduction of competition (e.g. financing of hospitals through diagnosis-related groups), as well as relevant training and competencies for future-capable physicians and health care professionals, can help to define and formulate.

Neither is it not clear whether and in which way individual strategies such as managed care in Finland (Busse & Schlette 2004), evaluations of public health programs and new technologies by the National Institute for Clinical Excellence (NICE) in England (Busse & Schlette 2004), or decentralization of the responsibility for health-related social security benefits in the Netherlands (Busse & Schlette 2007), will impact on training programs for «the» future-capable health professional.

Comparative indicators and data, as is regularly presented by the OECD, do not lead to the identification of countries with future-capable training programs. Criteria such as the proportion of health costs of the gross domestic product, the number of physicians, nurses or acute beds per inhabitant and infant mortality are multifactorially conditioned; they do not allow causal conclusions on particularly future-capable health care systems and thus education systems. Therefore, in each individual country only exemplary «lighthouses»⁴ with especially innovative training concepts can be found. Only two concepts with a reference character are represented here.

Lighthouses with particularly innovative training concepts do not develop from sourcing necessity

3.3 CanMEDS 2005: physician competency framework

In 1996 the Royal College of Physicians and Surgeons of Canada developed a first framework for physician competency. In 2005 a revision was submitted, based, among other things, on empirical research, social needs, health-political goals, experiences of the members and the consent of universities⁵. CanMEDS has the goal of enhancing professional performing and improving the quality of practice. Henceforth, it describes the term «competence» as a «process which consists of defining the fundamental abilities which permit translation of the available realizations of effective acting into profitable elements for the training (Frank 2005: 1)». Knowledge, abilities and talents are consolidated in «meta-competencies» which describe the professional function of a physician in seven roles (see fig. 2):

Medical profession training: Professional performing and good supply quality require extended competencies

⁴ On the basis of a new understanding of the learning processes since the end of the 1960's, Problem Based Learning (PBL) was developed. The McMaster University in Canada and the University of Maastricht (School of Health Professions Education) in the Netherlands are both considered Light Towers.

⁵ <http://rcpsc.medical.org/canmeds/CanMEDS2005/index.php>

Role of the expert: This central role is the result of the successful acquisition of competencies in all ranges and permits the responsible performance of job-specific activities, the assumption (within one's own limits) of job-specific leadership and the making of effective decisions and evaluations.

Role of the communicator: This covers the structure of trusting relationships in the surrounding fields and the purposeful passing on of information.

Role of the team worker: This covers effective participation in an interdisciplinary and inter-professional team.

Role of the manager: As managers, physicians assume job-specific leadership, contribute to the effectiveness of the organization and develop their own career.

Role of the health advocate: health advocates base their decisions responsibly on expert assessment and use their sphere of influence in order to promote health and quality of life for patients as well as society as a whole.

Role of the student and teacher («scolar»): Efficient physicians are engaged in a lifelong learning process based on reflected practice, as well as

being committed to the development, passing on, and application of evidence-based knowledge.

Role of the professional: Professionals are committed to the interests of health and quality of life for patients and society. They also follow specific professional ethics and take care of their own health.

The high appreciation of the CanMEDS model is based on its holistic view of the activities of health professionals⁶. They need to know and achieve more than a diagnostic-therapeutic expert's assessment. They are part of a highly regulated, complex and cost-intensive health care system and they have to protect the patient's right of self-determination. Therefore, they must also acquire competencies as team workers, communicators, managers, health advocates, students/teachers and professionals. The fact that medico-scientific expertise was rated on a par with so-called «soft-skills» attracted world-wide interest. As a result, the model rapidly became an orientation framework for the training of physicians and handling the needs of patients in the 21st century.

⁶ The role concept of CanMEDS was adapted in Switzerland with regard to the definition of field-specific competencies of the study at the university of applied sciences for occupational therapy, diet consultancy, midwifery, nursing and physiotherapy, see conference of the universities of applied science www.kfh.ch

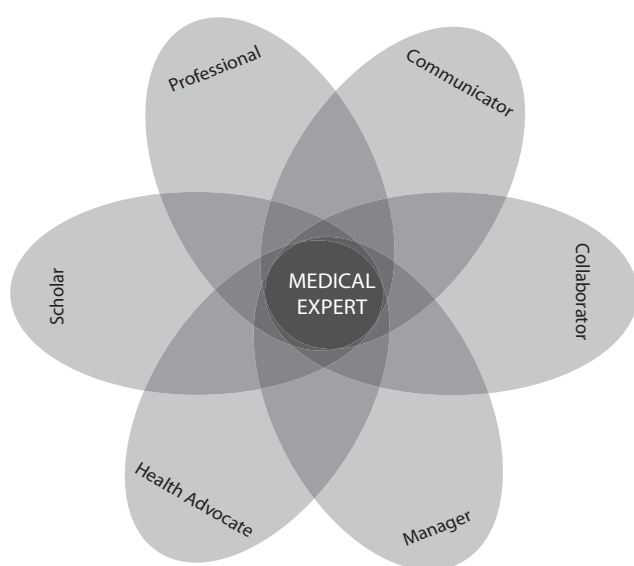


Figure 2: Roles which are indispensable for the effective practice of the profession of physicians (CanMEDS, 2005)

Future-capable health professionals are more than experts of diagnoses and therapy

Health Professionals must acquire just as many «soft skills» such as team workers, communicators, managers or health advocates

3.4 Advanced nurse practitioner: the training of nurses at masters level

Internationally, the basic training of health professionals at university level is widespread, e.g. in Scandinavia, the Netherlands, England, Denmark, Australia, Canada, New Zealand and Singapore. As an answer to the problems of the increase in patients with chronic conditions, the threatened or already-existing lack of physicians, and/or the costs which are connected with medical care, a master's degree program has been developed which trains so-called «Advanced Nurse Practitioners». Degrees and/or job titles are not standardized e.g. terms are used such as «Advanced Nurse Practitioner», «Advanced Practice Nursing» or «Advanced Clinical Practice». Three characteristics distinguish advanced nursing practice from basic nursing practice: specialization, the expansion or acquisition of new knowledge and skills and role autonomy extending beyond traditional scopes of nursing practice, and advancement. Nurses may, for example, specialize in the care of people with heart insufficiency, wounds, diabetes or cancer. Advancement means the integration of theoretical, research-based and practical knowledge. ANP-Nurses promote the theory-practice-theory transfer by implementing suitable research results in practice and suggesting studies.

In the context of extended practice they perform clinical examinations, prescribe aids and medicines or administer the tasks of enterprise or school physicians. Competencies taught are the ability to coach and to lead, to consult, to collaborate and to research. They are trained for roles as experts, instructors, researchers, leaders, consultants, collaborators and organization developers. In practice, they act as role models, catalysts, enablers, personnel developers, practice developers, change agents, change managers, developers and strategists.

Finland and Sweden use ANP-Nurses in nurse-led clinics for the support of patients with heart insufficiency. In England ANP nurses are responsible for caring for people with chronic wounds. Studies prove that this source of labor is more effective and above all lower-priced than the services offered by physicians (Schober & Affara 2008; Nolte, McKee & Knai 2008; Sheer & Kam Yuet Wang 2008).

Nurses with university degrees are in some countries an adequate answer to the challenge of providing quality care

Advanced Nurse Practitioners perform effectively and at lower prices

4. The chances of of competition are not being used

Thesis 3: There is no global competition in the training of health professionals

Global competition presupposes that there is a global product and, with it, a coherent market for provider and consumer.

4.1 There is no global product - «future-capable health professionals»

National politics do not exhaust the potential of health professionals

Our attitude towards health and disease is cultural i.e. also politically formed. The division of tasks and competencies within the occupational groups is likewise culturally conditioned; accordingly, policies differ from one country to another. For example, tasks to be provided by physicians in Switzerland are considered tasks for nurses in Finland (these include first consultations in primary care, specific diagnostic examinations and the prescription of specific medicines). Although western health care systems face the same challenges, they have found different structural and political answers. In scientific medicine there is therefore, neither a global product «health» nor a product «future-capable health professionals»⁷.

The proclaimed «exception médicale» above all promotes isolation

In the health care sector, the «exception médicale» has repeatedly been proclaimed as being unique, with corresponding limitations. This contrasts strongly with the world of industry, where there is global competition in training. This is possible where globalized products exist, i.e. computer technology, the development of electronic devices for cars and airplanes, financial products, the hotel industry, the arts, and even religion. In these fields it may be very important to know at which world-famous school you trained, e.g. MIT, Harvard, London School of Economics, Ecole Hôtelière de Lausanne, or the Vatican. In all industries in which the state-oriented public interest plays a role there is no global competition for training. Thereto belongs the training of teachers, lawyers, and even future-capable physicians and nurses.

4.2 Dispersal of education markets for health professionals, but no benchmark

The EU free movement of persons effectively renders existing competencies irrelevant

Of course, in principle, it is possible to undergo training as a physician or nurse abroad. The European Convention on the Free Movement of Persons has contributed substantially to the dismantling of the (often protectionist and politically motivated) education hurdles. These new rules are simple: if a person acquired

⁷ This is different in highly specialized medicine (e.g. specialization on complementary medicine such as TCM, special education programs for liver diseases, operation techniques, diagnostics, etc.), where global competition in training exists. In accordance with thesis 1, advanced studies are not the same as future-capable.

his or her vocational qualifications in country A, country B must equivalently recognize these qualifications – regardless of the person’s actual competencies. This leads to a job market with mobile workers in which a few formal criteria are decisive. However, the economic advantages of this system are counterbalanced by doubts on the part of political educationalists. In particular, they criticize that this set of rules leads to a lowering of the minimum standards and/or to a leveling downward.

How can the best service providers be identified? So far, there are no recognized benchmarks. The number of diplomas awarded or the length of the publication list are hardly suitable indicators of quality and practice-relevance (and thus the future capability) of the acquired competencies. Also, there are many different accreditation labels. These primarily reflect the structures and processes of training but not the contents and future-capability of the training programs. What you do, you do correctly – however, it remains open whether the right things are done. Self-declarations say little about future-capability – if, for example, the University Hospital of Zürich calls itself a «cadre-training unit» for internal medicine (Vetter & Battegay 2007), or on the Internet the «Top 20 Nursing Schools» are listed according to the amount of third-party funds received⁸ or labeled «World Universities» because of the number of Nobel Prize winners amongst their alumni. Whether or not «future capability» can be taught, remains open. Quantitative ratings do not reflect the capability of health professionals’ preparedness for the initially mentioned challenges.

Accreditation does not consider future-capability

Ratings do not examine the capability of handling challenges evolving from health-politics

4.3. There is no global market for the consumer

Global competition presupposes individual readiness for mobility and a national readiness to acknowledge foreign diplomas. However, unlike student economists or scientists, health care trainees are lacking in mobility. Future physicians and nurses are seldom persuaded to complete their training abroad. This readiness to study abroad can, however, be found in health professionals who are highly trained and want to deepen their knowledge and specialize in one of the «lighthouses» in their field (see above).

Health professionals are usually bound to their national education structures due to lack of mobility

⁸ www.edinformatics.com/nursing/top_nursing_schools.htm [11.08.09]

5. Conclusion: Create incentives in order not to reinvent the wheel

Similar challenges, but nevertheless country-specific training

Where do you find the best? In many industrialized countries sound approaches to the training of future-capable health professionals can be identified, and there are educational institutions which are internationally appreciated as «lighthouses». In industrialized countries, there is a similar lack of systems, challenges and solutions, creating favorable conditions for global competition. It would be obviously advantageous to train health professionals where future-capable approaches and concepts are being developed.

15

Education harmonization and the free movement of persons will create more competition in Europe in the mid term

Additionally, it would clearly be an advantage to cooperate internationally and to exchange important and effective learning contents via a common exchange (and on the Internet). However, the national focus of health care systems and the various country-specific educational and authorization hurdles prevent, global competition in training for the best future-capable physicians and nurses⁹.

Fellows must increasingly follow the funds!

Genuine competition requires a corresponding demand, i.e. the mobility of students. This could be substantially increased with the controversially discussed principle «funds follow fellows». If, instead of the traditional basic contributions for location and infrastructure, those educational institutions were specially promoted that rise to the challenges and priorities of health policies, competence centers might possibly develop (more) rapidly.

⁹ Although, through the education harmonization (Bologna System with bachelor- and master-degree) and through the free movement of persons within the European Union, the hurdles were greatly reduced in recent times, it (still) cannot be answered conclusively whether the education market will become stimulated and more dynamic. Education in the health care system seems, as stated in thesis 2, to be clearly more resilient than in other industries.

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Impressum

Editor / Series

Careum Foundation, 2009

Content

FHS St. Gallen
Careum, Zurich
formative works, Bourguillon

Design

AGENTUR FRONTAL AG, Willisau

Printing

Somedia Production, Chur

Publisher

Careum Publishing

Cover Picture

© denisismagilov – Fotolia.com



9 783037 879054

ISBN 978-3-03787-905-4

