

## Human rights-based approaches to health workforce education

Preparing the health workforce for a more just, equitable, and sustainable future

### Summary

The Special Rapporteur on the right to health Dainius Pūras, presented his report on human rights and health workforce education to the United Nations General Assembly in October 2019 (A/74/174). The report urges the uptake of human rights-based approaches to health workforce education so that health workers understand and act in accordance with human rights, and in turn promote inclusive health systems that treat patients and staff with dignity, equality, and non-discrimination. Rights-based education can overcome medical hierarchies that privilege specialization and leave too few workers in primary and community health care. The right to health and universal health coverage, a Sustainable Development Goal target, cannot be achieved without training millions more health care workers for primary health care.

### Flattening medical hierarchies and promoting primary health care

Conventional medical education reinforces the medical hierarchy and a biomedical paradigm that focuses excessively on the diagnosis and cure of diseases and biomedical pathologies, rather than considering health determinants and their impact on health. This creates imbalances and exacerbates serious problems in health care, including excessive medicalization, fragmentation, undermining the principle of “first do no harm”, and power asymmetries between doctors and patients, as well as between doctors and other health workers. This has led to primary health care being undervalued and overlooked.

Neither universal health coverage, nor the right to health, are achievable without primary health care workers. Therefore, it is with urgency that millions more health workers, including doctors, need to be trained, funded, and retained to work in primary health care. Ideally 80% of all health care services can be provided in primary health care. A human rights-based medical education that treats all workers with equality is where transformative change can begin.

Medical schools, often strongly influenced by specialized university hospitals, have emphasized and glorified medical specialties and subspecialties, promoting their position and power. As a result, specialists have too much control at all levels of the health system including in education.

*When health workforce education is grounded in human rights, health workers begin to see challenges and barriers to health care as human rights issues, and themselves as change agents and human rights advocates. This approach to education instils the fundamental human rights principles of equality, non-discrimination, and dignity for all people, upon which all health care should be based.*

### Addressing power imbalances starts in education

Human rights call for a democratic, non-hierarchical, inclusive approach to the health workforce so that the experience, views and voices of all workers are valued. There are many decisions made within health care services, including policy, managerial, diagnostic, preventive, and therapeutic issues, that can be effectively led by nurses and non-medical workers. The training of physicians builds the expectation in themselves and their patients that they have the knowledge and power to make all decisions, including non-clinical ones, with certainty and confidence. Medical schools must equip doctors to recognise and resist power imbalances within their own profession. More training in community settings, away from hospitals, selection of students from disadvantaged communities, and incentives to work in primary health care, especially in rural and underserved areas, all contribute to building more equality in health care. During their education, doctors should receive training to help them recognise human rights failings in diverse settings. This could include identifying the corrupting influence of industry, for example, pharmaceutical company sponsorship of continuing medical education, or commercial bias in research literature. Training must also include recognising and understanding the effects of discrimination on patient care.

### Embracing determinants in health education

Underlying and social determinants of health contribute much to ill health. Medical care accounts for only 10-20 percent of the modifiable contributors to health outcomes. But medical education continues to train a workforce to focus on medical and surgical care rather than on the determinants of health. The power and prestige associated with medical specialisation reinforces biases away from caring for the most disadvantaged and those affected most by poor determinants of health. This includes people living in poverty, persons with disabilities, those requiring palliative care, and those who use drugs, or experience mental health issues.

## Strong accountable health systems and effective workforces

Health workers need all parts of the health system to be functioning well so they can deliver quality health care that is accessible and acceptable to all.

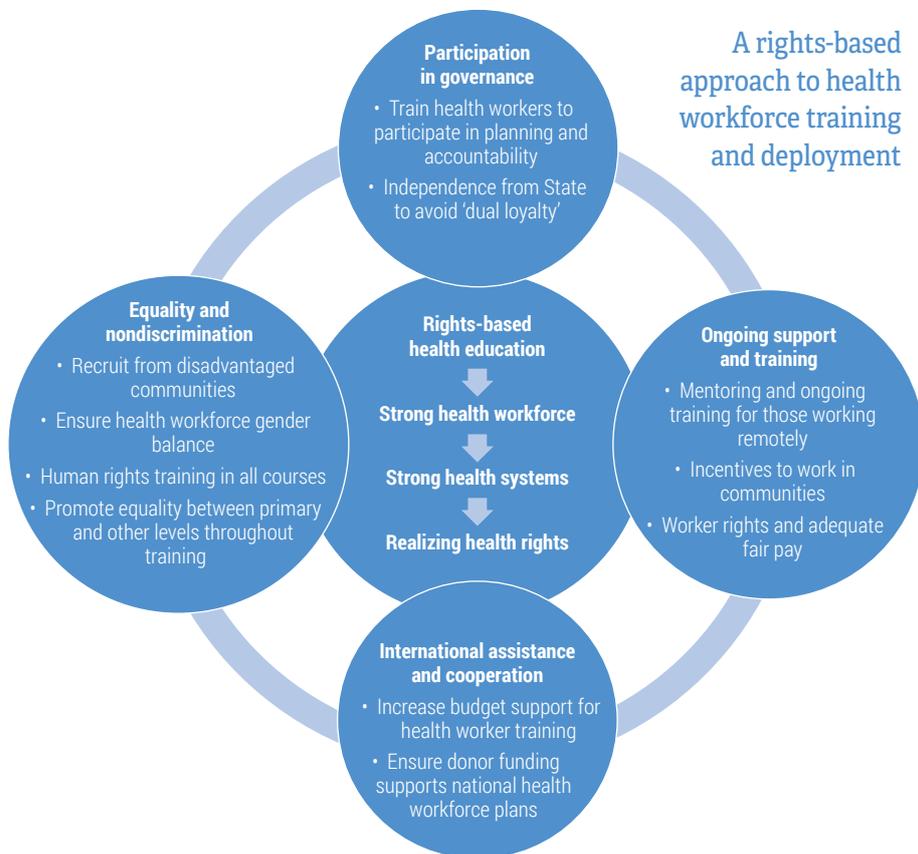
This starts with the human rights of health workers being recognized, ensuring first that they are protected against inequality and discrimination. Community health workers, and the communities they work in and with, often suffer poor health as a result of poverty, being marginalised and discriminated against. States must improve working conditions and address pay inequities for health workers most directly serving poor populations with social needs, as well as developing education campaigns to enhance the image and reputation of all health workers.

Rights-based education of the health workforce trains workers to understand the importance of strong health systems that have transparent processes and are accountable to civil society, patients, and the State.

## Mental health workforce training

Change in mental health training is needed urgently to address the issues of context and its effect on mental health, the narrowness of mental health and mental distress definitions, and the power asymmetry between health-care workers and users of services. The prevailing education approach is based on a biomedical model of disease in which mental health conditions are too often seen as biologically defined abnormalities, irrespective of context. Overreliance on the biomedical model to explain emotional distress favours pharmacological treatment over addressing the core underlying and social determinants of health. Although most mental health care is provided by primary care physicians and other health-care workers, psychiatrists control the definition of mental health through the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases (ICD). This reinforces power asymmetries, allowing psychiatrists to determine appropriate (usually pharmacological) treatment. Mental health workforce training needs to be adapted to emphasize the social determinants of health, redefine mental illness in the context of culture and context, and equip health-care workers with the attitudes, knowledge and skills necessary to build relationships to avoid the inherent paternalism of the system.

A rights-based approach to health workforce training and deployment



## Key Recommendations

### To ensure rights-based policy responses to health education States should:

1. Ensure health education facilities have curricula grounded in human rights and aim to reduce power asymmetries in health care
2. Align training with national health strategies to prepare the health workforce in all competencies, not just clinical skills.
3. Ensure that all health education curricula pay particular attention to groups that are marginalised and discriminated against
4. Ensure health education curricula provide a balance between public health, preventive health, community and social medicine, mental health, palliative care, medical ethics, medical law, managerial skills, communication skills, and human rights
5. Invest adequately in health systems so health workers can provide available, accessible, acceptable and quality health care

### To ensure a rights-based health workforce in practice, health professional organisations should:

1. Ensure all health training curricula are firmly grounded in human rights and right to health frameworks
2. Promote incentives that attract people to primary health care, and to rural or remote settings
3. Ensure members use human rights-based approaches to the delivery of health care and public health

### To ensure rights-based health workforce training, leadership of training facilities should:

1. Ensure curricula reflect national health workforce strategies and emerging public health priorities such as climate change
2. Have all curricula firmly grounded in a right to health framework which promotes an understanding that health workers should engage with marginalised and vulnerable communities including those who have disabilities
3. Select candidates for training that come from areas of deprivation, and rural areas, and reflect all of society
4. Recalibrate mental health research priorities to promote independent, qualitative, and participatory social science research and research platforms, exploring alternative service models that are non-coercive

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Mr. Dainius Pūras, (Lithuania) was appointed by the Human Rights Council as the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. He took office on 1 August 2014. Dainius Pūras is a medical doctor with notable expertise on mental health and child health; he is the Director of Human Rights Monitoring Institute in Vilnius Lithuania, a professor of child and adolescent psychiatry and public mental health at Vilnius University and teaches at the faculties of medicine and philosophy of the same university. Learn more, visit: <http://www.ohchr.org/EN/Issues/Health/Pages/SRRRightHealthIndex.aspx>