IFMSA
International Federation of Medical Students' Associations

IFMSA Policy Proposal
Global Health Workforce

Proposed by the Team of Officials
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Policy Statement

Introduction
In September 2016, the final report of the United Nations High Level Commission on Health Employment and Economic Growth projected a global shortage of 18 million health workers by 2030, primarily in low and lower-middle income countries. With the growing shortage and no action to prevent it, health workers and health systems will be unable to meet the growing population, longer lifespans and increasing burden of diseases. In light of this crisis, it is urgent to implement the right policies on a national and international level, invest in education and job creation in the health sector and establish strong interdisciplinary and multisectoral collaboration to achieve equality, universal health coverage and social cohesion.

IFMSA position:
We, the International Federation of Medical Students' Associations (IFMSA), affirm that the quality and quantity of the health workforce in any given country play a significant role in improving health outcomes and achieving greater equity in health locally, nationally, regionally and globally. The IFMSA acknowledge health workers as key actors in health systems, who should be entitled to decent working conditions in terms of employment rights, social protection and safe environment and should be actively engaged in the decision making process.

IFMSA calls for **Governments** to:

- Improve and incentivize the collection and analysis of reliable data on human resources for health in terms of needs, demand and supply at a national level, as well as to ensure the tracking of migration trends.
- Set out clear vision, long-term strategies and policy stewardship for their respective health workforce.
- Promote political commitment, aligned between the ministries of health, education and finance, across private and public sectors and educational and training institutions, professional associations, labour unions, development partners, international organizations and civil society.
- Invest and foster investment in the health workforce as well as in the education of future health workers. At least 5% of their domestic GDP should be invested on health, prioritizing the placement of healthcare professionals in adequate number, skills mix and distribution and use of resources efficiently and equitably while ensuring that any external financial support is complementary.
- Guide and stimulate job creation with an aim to convert informal and unpaid work into decent jobs and prevent decent jobs transitioning into informal jobs.
- Provide appropriate training, supervision and remuneration to all community level workers and incentivize remote practice to ensure universal access to essential services at community level, recognizing that mid-level cadres and non-physician clinicians are the mainstay of health services delivery in resource-poor settings.
- Make the WHO Global Code of Practice of International Recruitment of Health Personnel a core component of bilateral, national, regional and global responses to the challenges of health personnel migration and health systems strengthening.
- Improve governance and develop regulatory mechanisms for accreditation and quality assurance of education institutions. Recognize the importance of accreditation of medical education, in accordance with WHO/WFME standards, and ensure their consistent implementation.
- Promote decent working conditions of fair income, security in the workplace, social protection and opportunities for personal development.

IFMSA calls for **Development partners** to:

- Support the strengthening of health systems in developing countries and countries with economies in transition that are experiencing critical health workforce shortages and support their work to implement the WHO Global Code of Practice of International Recruitment of Health Personnel.
- Work closely with governments, alongside the international community and global health initiatives, to form a coordinated mechanism for the purpose of strengthening national public institutions and governance in the health sector.
- Align investments for the health workforce with the strategies and policies that express the future needs and demands of the health labour market and commit significant proportions of financial support for national health plans.
- Support national health workforce data collection, analysis and use for improved planning and accountability, in alignment with the national health workforce accounts framework.
- Build partnerships with local, regional and international NGOs concerned with health care aligned with the health workforce plans and policies of countries in which they operate.

IFMSA calls for **Medical Schools** to:

- Provide transformative medical education to support the scaling up of health workers which are community-, competency- and team-based, and relevant to the population; adapt their institutional set-up and modalities of instruction to respond to transformative educational needs.
- Raise understanding on the role of medical students and doctors in the health systems, not only as healthcare providers, but also on actively taking part in the construction and implementation of health policies and promoting the well-being of their communities.
- Develop standards and promote the implementation of accreditation systems according to the WFME/WHO Guidelines.
- Provide distance learning opportunities as an alternative to education and training abroad. Research and evaluate the role of new technologies to enhance education, training and management of health professionals.
- Ensure that students regardless of their socioeconomic backgrounds, gender and religion have fair access to healthcare careers and to provide education and training opportunities to students from rural and remote locations.
- Build a strong medical curriculum that includes topics on health inequities and social determinants of health and sufficient knowledge about their communities and health challenges.

IFMSA calls for **National Member Organizations (NMOs)** to:

- Participate in and develop awareness, education campaigns and activities on the Health Workforce related topics.
- Engage medical students and civil society in the ongoing debates of health workforce education, conditions and labour market.
- Acquire evidence-based knowledge pertaining to the Global Health Workforce Crisis and be an active advocate in this field.
- Identify stakeholders and work actively on advocating for the quality assurance of Medical Education, to implement accreditation mechanisms that follow the international standards.
- Work closely with governments and health sector planning bodies and advocate for the delivery of quality health professions education and healthcare delivery as well as sufficient government expenditure in the health sector.

Position Paper

Background

The WHO has defined health workers to be all people engaged in actions whose primary intent is to enhance health. [1] This includes physicians, nurses and midwives but also laboratory technicians, public health professionals, community health workers, pharmacists, and all other support workers whose main function relates to delivering preventive, promotive and curative health services. The health sector is employed by both workers in health occupations (HO) and workers in non-health occupations (NHO) which jointly complete the human resources behind healthcare delivery. Without **adequate numbers of** healthcare workers, with the **right set of skills**, and **in the places they are needed**, neither Universal Health Coverage (UHC) nor the Sustainable Development Goals can be reached.

In September 2016, the final report of the United Nations High Level Commission on Health Employment and Economic Growth projected a global shortage of 18 million health workers by 2030, primarily in low and lower-middle income countries. [2] Despite the global financial crisis, the percentage growth in health and social sectors has outpaced most other sectors and contributes to global economic growth. It now represents 10.3% of global wealth. [3] In OECD countries in 2013, 58.5 million people were working in the health and social sectors. [2][4] In total, 43.5 million health workers were directly engaged in the provision of health services in 2013 with over 200 million workers estimated to be contributing to the health and social sectors globally (including unpaid personal care workers, private sector providers, cleaners and caterers). [2][5][6] The demand for health workers is expected to increase even more in the coming years, with around 40 million new health worker jobs created by 2030, particularly in high- and middle-income countries. [2][7]) A sufficient economic investment towards Universal Health Coverage to close the gaps and mismatches could lead to more sustainable health systems and reduce the financial burden of preventable diseases. [8]

Three quarters of the current capacity to educate new health workers is concentrated in high- and upper-middle-income countries, indicating an imbalance in the production of health workers. Sub-Saharan Africa accounts for a 4% share of the global health workforce but shoulders 24% of the global disease burden, a situation that has remained virtually unchanged for a decade. [2][9] Similarly large deficits of health workers are projected in low-income countries in Southeast Asia by 2030. [2][5] While 91% of the global shortage affects low-income countries [10], the health workforce crisis impacts middle- and high- income countries as well, particularly in terms of maldistribution of health workers, which can contribute to a disproportionate reliance on the recruitment of foreign-trained health personnel and a significant shortage of health workers in remote and rural areas. [11]In the United States of America (USA), 9% of registered physicians practice in rural areas where 20% of the population lives. France has large inequalities in the density of general practitioners, with higher densities in the south and the capital compared with the center and north of the country. And in Canada, only 9.3% of physicians work in remote and rural areas where 24% of the population lives. [12][13][14][15] In the SDG era, with a shared commitment to leave no one behind, this cannot continue without global action being taken. The capacity, financing and economics of education systems to meet this demand require coordinated action in countries with the highest unmet needs. As stated in the WHO Global Code of Practice, member states should strive for the creation of *a sustainable health workforce and work towards establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel*. [16] A national health workforce strategy should serve as the foundation for both quality and responsiveness of health service delivery, as well as sustainability and strengthening of health systems. International cooperation surrounding the ethical recruitment of health personnel must also be ensured to help expand workforce supply for UHC, with particular focus on developing countries. [2][16]

Availability

For the global crisis in the Health Workforce to be solved, an adequate amount of professionals need to be produced for which careful planning and coordination on a governmental and political level is a requisite. In light of the current shortfall of the health workforce, an unprecedented employment potential is created: the demand for health workers is expected to increase in the coming years, with around 40 million new health worker jobs created by 2030, particularly in high- and middle-income countries. [2][7] It is important to note that in 2015 there were an estimated 43 million global health workers, including 9.8 million physicians and 20.7 million nurses/midwives. [17] There is, subsequently, a great incentive for the health labour market and respective funding to be mobilized.

Moreover, latest data suggest that investments towards UHC and the needed workforce for its realization have important employment effects not only in the health sector, but particularly in other economic sectors constituting the broader health economy. [10]The data suggest that economic returns of investments in UHC resulting in jobs for health workers will yield high impacts on job creation for non-health occupation workers as well. The current employment potential of addressing existing workforce shortages amounts to globally:
– 18.3 million jobs for workers in health occupations;
– 31.8 million jobs for workers in non-health occupations, particularly in low and middle income countries.

An investment in the health sector clearly translates to job creation across a multitude of other sectors as well. In fact, **each investment in the creation of one HO job has the potential to result in the creation of 1.5 NHO paid jobs**. [10] An additional 2% GDP investment into education, health and social services could **increase overall employment rates by between 2.4 and 6.1 percentage points**. [2][18] The generated incomes from job creation are used and re-used to contribute to the broader economy, furthering employment and economic growth. In addition to playing a fundamental role in achieving improvements in health outcomes and the population's well-being, targeted investment in health systems, including in the health workforce, can promote economic growth along several pathways.

The development of employment in the health and social sector is not only an imperative of international public health but it constitutes a major economic and social opportunity to promote inclusive economic growth and creation of decent jobs, especially for women and youth. It is imperative that the creation of employment opportunities be linked to meeting the national health objectives, such as that of Universal Health Coverage, however, to ensure global and equitable health service delivery.

Accessibility

An important part of the health workforce discussion is the distribution of human resources. Not surprisingly, global shortages are not equitably distributed around the world: Shortages of paid workers concern 96 countries out of the 185 assessed by the ILO. In 89 countries of these countries, a total of 18.3 million health workers are missing. [10] On a global scale, 96 out of 185 assessed countries by the ILO report shortages, with 91% of them concerning lower-middle and low-income countries. Over 56% affect Asia and the Pacific alone, however, the shortages in Africa are the most severe in relation to population size. Moreover, rural areas are the ones suffering the most from the shortage of health workers: **52% of the global rural population is excluded from healthcare, compared to 24% of the global urban population**.[10][19] In low income countries, the situation looks dire: up to 84% of the total population is excluded from access to health care. This is attributed to missing investments in jobs for health workers, which are deemed necessary for the delivery of essential services. In lower-middle income countries, numbers do not differ significantly: related deficits result in the exclusion from access to healthcare for more than half of the total population. [10][20] On the other hand, OECD countries currently experience their largest number of doctors. In 2013, a total of 3.6 million doctors and 10.8 million nurses were employed in OECD countries, up from 2.9 million doctors and 8.3 million nurses in 2000. On average, there was an increase of 20% of

doctors and 15% increase of nurses per 1000 population. These numbers, however, do not clearly reflect the inequitable distribution on the national level that often occurs. [21]

While there is not enough investment for the mobilization of the health labour market and job creation, migration of health workers significantly contributes to the global shortages and disparities. Over the past decade, the number of migrant doctors and nurses working in OECD countries **has increased by 60%**; this figure rises to 84% for doctors and nurses who have departed from countries with serious health workforce shortages. [2][6]

Although many countries have stepped up their education and training of doctors and nurses since 2000, the growing economic demand in high- and middle-income countries is likely to continue to drive health worker migration. Patterns of health worker migration are also becoming more complex, with significant intraregional movement being noted. Better data and information, particularly from source and transit countries, is crucial to understand and manage the international migration of health workers. [21] Countries losing the most health workers must assume urgent action in order to retain their health workforce and destination countries must do more to achieve greater self-sufficiency and sustainability in their domestic supply. The adverse effects of migration need to be mitigated, migrant health workers' rights must be safeguarded and unnecessary barriers to mobility and practice must be removed. The convergence of competencies and quality standards at the international level must be improved, and targeted support provided to source countries and their health systems. What's more, countries must implement a range of policies and programs to incentivize doctors practice in underserved remote and rural areas to close the shortage gaps. Such incentives may be financial and nonfinancial, improvements in infrastructure and greater opportunities for training. Further incentives may include additional allowances for working in a high-cost area or extra payments for working in rural areas.[22][23]

Socioeconomic Dimension

A dynamic health labour market has the potential to create education and jobs, especially for women and young people, social groups that experience the highest rates of unemployment and financial instability [24]. Jobs in the health and social sectors tend to be inclusive of women, and the demographic and epidemiological transitions are likely to further increase demand for women's contributions to health and social care. Women generate wealth creation through their employment in the health economy. In a sample of 123 countries, women make up 67% of employment in the health and social sectors compared with 41% of total employment. [2][25] However, women's employment, especially in health-care related work, is often not measured and not valued appropriately. It is currently estimated that women will take between 59% and 70% of the jobs created by investments in the health workforce, increasing the rate of women's employment by 3.3% to 8.2% and closing the unemployment gap. [2][18]In addition, actions must be taken to tackle gender associations in health professions, and ensure employment opportunities and accessibility regardless of gender. Youth unemployment can also be tackled by the development of the health sector and job creation. Between 2012 and 2014, global youth unemployment stood at 13% with two in five economically active young people either underemployed or working but living in poverty. [2][26]

Another important social aspect in the health workforce discussion is **decent work**, as defined by the ILO, *which involves opportunities for work that are productive and deliver a fair income, security in the workplace and social protection for families, better prospects for personal development and social integration, freedom for people to express their concerns, organize and participate in the decisions that affect their lives and equality of opportunity and treatment for all women and men*. [27] In seeking to promote decent work for all women and men working in the health economy, several issues need to be addressed. [2][28] These include poor wages and benefits, the absence of social protection and unsafe working conditions. In many cases, inadequate salaries may force workers to take on multiple jobs, which can damage both the quality of health services and the workers' welfare. Career planning and development opportunities are particularly important, not least to combat gender inequality. Achieving a decent quality of living requires a focus on issues such as accommodation, transport, the

availability of necessary equipment and treatments, and nullifying the risk of professional and personal isolation and burnout. A vital feature of decent work is respect for the workers' rights, including their ability to influence working conditions through dialogue with health workers' organizations, worker unions and the prevention of all forms of discrimination. Decent working conditions include adequate wages and are underpinned by rights at work such as freedom of association, but also equal remuneration, non-discrimination, social protection and social dialogue.

Currently, a large number of workers in the health delivery service are being suppressed from adequate wages and social protection. Poor working conditions lead to difficulties and result in limitation in the delivery of quality care and fail to attract and retain skilled personnel. [10][29] Sustainable, inclusive growth requires for all health workers to enjoy decent working conditions; this way, the quality of services delivered can be ensured. Jobs providing decent working conditions such as social protection and decent incomes have immediate beneficial effects for the economy e.g. due to improved health and the related productive potential. Against this background, investments should not be limited to achieving solely higher numbers of jobs, but should also consider decent working conditions as an integral part of health employment.

Quality

Investing in the health sector does not alone suffice to unlock the socioeconomic growth. A scheme of appropriate policies, regulatory frameworks and incentives is required to support the investment. Any and all interventions should be coordinated across the education, health, labour, international relations, immigration and trade sectors to create the conditions for decent health sector jobs. Lifelong learning systems must focus less on narrow specializations and more on locally relevant competencies to meet the respective health and social needs, as well as on generalist training. Structural reforms, which address the relevance of the workforce, are urgently needed to increase the health workforce ability to deliver people-centered services. Countries must assume action to prioritize public investments in education in order to increase the pool of qualified health workers and improve their performance and productivity. An important action is scaling up socially accountable professional, technical and vocational education on a national and international level. Socially accountable education includes learning about interdisciplinary teamwork, ethical practice, respect for rights, cultural- and gender-sensitive communication, and patient empowerment with an ultimate goal of producing health workers able to match the health needs of populations and unlock their full potential. [2][30]

As the demand for healthcare professionals increases, it is important that the quality of education is not compromised. It is also important to recognize the challenges faced to deliver high quality education, such as medical education institutions lacking basic infrastructure, equipment and staff, as well as static and fragmented educational methods. Therefore the establishment of accreditation mechanisms for health training institutions can have a profound impact on the quality of education. [2][31] Such mechanisms should aim to ensure optimized performance, quality and impact of the health workforce and to improve the quality of medical education, thus contributing to healthy lives and well-being, effective universal health coverage, resilience and strengthened health systems at all levels. Nonetheless, in many countries, the regulatory systems are outdated and in need of substantive revision, stressing the need for standardized and consistent regulations to be adopted at a global level. An example of such international regulatory action with a global impact has been the decision by the ECFMG® that, effective in 2023, physicians applying for ECFMG Certification will be required to graduate from a medical school that has been appropriately accredited by the Liaison Committee on Medical Education (LCME) or by the World Federation for Medical Education (WFME). [32] This decision marks an important shift towards universally accepted accreditation processes and is expected to incite similar action from other national bodies currently certifying International Medical Graduates (IMGs).

Achieving a fit-for-purpose health workforce is an intersectoral pursuit. It requires interventions across the health labour market: coherent and effective policy actions need to be orchestrated across the

finance, education, health, social welfare, labour and foreign affairs arms of the government through interministerial structures, coordination mechanisms and policy dialogues. These intersectoral structures and processes must engage the public and private sectors, civil society, trade unions, health worker associations, nongovernmental organizations, regulatory bodies and last but not least, education and training institutions.

Bibliography

[1] World Health Organization. The World Health Report - working together for health. Geneva: World Health Organization; 2006 Retrieved from: http://www.who.int/whr/2006/chapter1/en/
[2] United Nations High Level Commission on Health Employment and Economic Growth. Working for Health and Growth - Investing in the Health Workforce. Geneva, Switzerland; 2016. Retrieved from: http://www.who.int/hrh/com-heeg/reports/en/
[3] United Nations High Level Commission on Health Employment and Economic Growth. Working for Health and Growth - Investing in the Health Workforce, Terms of Reference p.66, Geneva, Switzerland; 2016.
[4] James C. Health and inclusive growth: changing the dialogue. In: Buchan J, Dhillon I, Campbell J, editors. Health employment and economic growth: an evidence base. Geneva: World Health Organization; 2016.
[5] Cometto G, Scheffler R, Liu J, Maeda A, Tomblin-Murphy G, Hunter D, et al. Health workforce needs, demand and shortages to 2030: an overview of forecasted trends in the global health labour market. In: Buchan J, Dhillon I, Campbell J. Health employment and economic growth: an evidence base. Geneva: World Health Organization; 2016.
[6] Scheil-Adlung X, Nove A. Global estimates of the size of the health workforce contributing to the health economy: the potential for creating decent work in achieving universal health coverage. In: Buchan J, Dhillon I, Campbell J, editors. Health employment and economic growth: an evidence base. Geneva: World Health Organization; 2016.
[7] Liu J, Goryakin Y, Maeda A, Bruckner T, Scheffler R. Global health workforce labor market projections for 2030. [Policy Research Working Paper 7790]. Washington (DC): World Bank; 2016. Retrieved from: http://documents.worldbank.org/curated/en/546161470834083341/Global-health-workforce-labor-market-projections-for-2030
[8] Summers L, Economists' Declaration on Universal Health Coverage. Published online: The Lancet; 2015. Retrieved from: https://doi.org/10.1016/S0140-6736(15)00242-1
[9] Health in 2015: from MDGs to SDGs. Geneva: World Health Organization; 2015 Retrieved from: http://apps.who.int/iris/bitstream/10665/200009/1/9789241565110_eng.pdf?ua=1
[10] Scheil-Adlung X. Health Workforce: A global supply chain approach. [ESS - Working Paper No.55] Geneva: International Labour Organization; 2016. Retrieved from http://www.ilo.org/secsoc/information-resources/publications-and-tools/Workingpapers/WCMS_537419/lang--en/index.htm
[11] Health workforce and labor market dynamics in OECD high-income countries: a synthesis of recent analyses and simulations of future supply and requirements. Geneva: World Health Organization; 2017. Retrieved from: http://www.who.int/hrh/resources/health-observer20/en/
[12] Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations. Geneva: World Health Organization; 2010. Retrieved from: http://www.who.int/hrh/retention/guidelines/en/
[13] Committee on the Future of Rural Health Care; Institute of Medicine. Quality Through Collaboration: The Future of Rural Health. Washington, DC, National Academies Press; 2005.
[14] Cash R &Ulmann P. Projet OCDE sur la migration des professionels de santé : Le cas de la France [OECD Project on health workforce migration: the case of France]. Paris: Organization of Economic Co-Operation and Development; 2008. (OECD Health Working Paper no.36).
[15] Dumont JC et al. International mobility of health professionals and health workforce management in Canada: Myths and realities. Paris: Organization of Economic Co-operation and Development; 2008. (OECD Health Working Paper no.40).
[16] WHO Global Code of Practice on the International Recruitment of Health Personnel. Geneva: World Health Organization; 2010. Retrieved from: http://www.who.int/hrh/migration/code/practice/en/

[17] Global Health Observatory Data: Health Workforce. Published online World Health Organization; 2015 Retrieved from: http://www.who.int/gho/health_workforce/en/
[18] Investing in the care economy: a gender analysis of employment stimulus in seven OECD countries, March 2016. Brussels: International Trade Union Confederation; 2016. Retrieved from: http://www.ituc-csi.org/CareJobs
[19] X. Scheil-Adlung (ed.): Global evidence on inequities in rural health protection – new data on rural deficits in health coverage for 174 countries. Geneva: International Labour Organization; 2015. Retrieved from: http://www.social-protection.org/gimi/gess/RessourcePDF.action?ressource.ressourceId=51297
[20] Scheil-Adlung et al., Health sector employment: a tracer indicator for universal health coverage in national Social Protection Floors, in: Human Resources for Health; 2015, 13:66. Retrieved from: http://www.human-resources-health.com/content/13/1/66
[21] Health Workforce Policies in OECD Countries: Right Jobs, Right Skills, Right Places. Published online: Organization of Economic Co-operation and Development; 2016. Retrieved from: http://www.oecd.org/publications/health-workforce-policies-in-oecd-countries-9789264239517-en.htm
[22] McPake B, Scott A, Edoka I. Analyzing Markets for Health Workers: Insights from Labor and Health Economics. Directions in development; human development. Washington, DC: World Bank Group. http://documents.worldbank.org/curated/en/787041468155118598/Analyzing-markets-for-health-workers-insights-from-labor-and-health-economics
[23] Rokx, C., J. Giles, E. Satriawan, P. Marzoeki, P. Harimurti, and E. Yavuz. New Insights into the Provision of Health Services in Indonesia: A Health Workforce Study. Washington, DC: World Bank; 2010
[24] World Employment Social Outlook: Trends 2016. Geneva: International Labour Organization; 2016. Retrieved from: http://www.ilo.org/global/research/global-reports/weso/2016/WCMS_443480/lang--en/index.htm
[25] Magar V, Gerecke M, Dhillon I, Campbell J. Women's contributions to sustainable development through work in health: using a gender lens to advance a transformative 2030 agenda. In: Buchan J, Dhillon I, Campbell J, editors. Health employment and economic growth: an evidence base. Geneva: World Health Organization; 2016.
[26] Global employment trends for youth 2015: scaling up investments in decent jobs for youth. Geneva: International Labour Organization; 2015. Retrieved from: http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_412015.pdf
[27] Decent Work. Published Online: International Labour Organization. Retrieved from: http://www.ilo.org/global/topics/decent-work/lang--en/index.htm
[28] An internationally agreed description of decent work is contained in: ILO Declaration of Social Justice for a Fair Globalization, adopted by the International Labour Conference at its 97th Session, Geneva, 10 June 2008. Geneva: International Labour Organization; 2008. Retrieved from: http://www.ilo.org/wcmsp5/groups/public/---dgreports/---cabinet/documents/genericdocument/wcms_371208.pdf
[29] C. Wiskow, T. Albreht, C. de Pietro: How to create an attractive and supportive working environment
for health professionals. Copenhagen: World Health Organization Euro; 2010. Retrieved from: http://www.euro.who.int/__data/assets/pdf_file/0018/124416/e94293.pdf
[30] Known as for example: sector skills councils (India, United Kingdom); industry skills councils (Australia, Bangladesh); workforce development boards (United States); knowledge centres (Netherlands).
[31] Regulation should aim to be proportionate to risks posed, consistent, targeted, transparent, accountable and agile to adapt to anticipated changes [Right-touch regulation]. In: Professional Standards Authority (website). London: Professional Standards Authority; 2016. Retrieved from: http://www.professionalstandards.org.uk/what-we-do/improving-regulation/right-touch-regulation
[32] Medical School Accreditation Requirement for ECFMG Certification. Published online: Educational Foreign Commission for Foreign Medical Graduates; 2010. Retrieved from: https://www.ecfmg.org/about/initiatives-accreditation-requirement.html