

B9 | THE GLOBAL HEALTH WORKFORCE CRISIS

In its analysis of the global health workforce published in 2004 (JLI 2004), the Joint Learning Initiative on Human Resources for Health and Development (JLI) called for mobilization and strengthening of human resources for health (HRH) as a key strategy to combat the health crises in the world's poorest countries and to build sustainable health systems everywhere.

The JLI report marked the beginning of a short period when, at a global level and in the WHO, the health workforce crisis enjoyed considerable attention. The *World Health Report 2006: Working together for health* (WHO 2006) and the first Global Forum on Human Resources for Health in 2008 (GHWA n.d. a) with its Kampala Declaration and Agenda for Global Action ('All people, everywhere, shall have access to a skilled, motivated and supported health worker within a robust health system') were milestones in this development. In 2006, the *World Health Report* also led to the launch of a 'decade of action' and the creation of the Global Health Workforce Alliance (GHWA).

In 2010, the World Health Assembly unanimously adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel (WHO 2010). The Code is non-binding and can only suggest voluntary standards of behaviour. The WHO has recommended that the Code be incorporated into national policies and laws so that it can become legally binding. However, some states have suggested that a more formal system for monitoring and implementing the Code is necessary for it to become a meaningful response to global HRH recruitment. The adoption of the Code, unfortunately, marked the end of a few 'good years for HRH' in global health policy. The health workforce crisis should be looked at in a systemic way instead of placing it in its own thematic 'silo'. Unfortunately we are far from there. What we see is a desperate attempt to keep HRH on the global agenda by linking it to the current 'big' global issues – such as universal health coverage and the post-2015 agenda. But are these manoeuvres substantively addressing the problem?

The 'big picture' challenges for human resources for health

Current global initiatives on 'overcoming the health workforce crisis', such as presented in the recent Third Global Forum (GHWA n.d. b) in Recife, Brazil, mainly address technical issues within the health sector, propose 'multi-stakeholder' alliances and renew calls for political engagement and financial commitment. But there are no easy 'quick-fix' solutions ahead. The health workforce crisis is part – and mirror – of a deeper health sector and

health financing crisis as well as rapidly changing labour migration patterns related to the global fiscal crisis.

Since the 2006 *World Health Report* and the 2008 Kampala Forum and Declaration, there has not been much new analysis of the political and economic determinants of the health workforce crisis and, at least at a global level, sound proposals for addressing these determinants are still lacking.

However, the scarcity of health workers and the scarcity of funds to be invested in the production, equitable distribution and retention of health workers cannot simply be assumed as a given (Van de Pas 2013). In an interconnected world, globalization and scarcity are closely linked. The fiscal realities that frame available public financing for health systems and health workforce salaries are shaped by such issues as untaxed wealth, capital flight, wealth inequalities, etc. This fiscal crisis (including former ‘ceilings’ on expenditure of the health workforce public wage bill, imposed by the IMF in a number of African countries until 2007) has contributed to external migration, which, in turn, has caused significant savings in training costs to importing countries. For instance, in nine African source countries, the estimated government-subsidized cost of a doctor’s education ranged from US\$21,000 in Uganda to US\$58,700 in South Africa. The overall estimated loss of returns from investment for all doctors currently working in the destination countries was US\$2.17 billion, ranging from US\$2.16 million for Malawi to US\$1.41 billion for South Africa. The benefit to destination countries of recruiting trained doctors was largest for the United Kingdom (US\$2.7 billion) and the United States (US\$846 million) (Mills et al. 2011).

Ninety-six per cent of the additional 1.4 billion people in low- and middle-income countries in 2030 will live in urban areas and by 2050 one in three births will take place in Africa. Giving priority to and delivering equitable health services, responsive to population change, will create new dynamics. Both public and private services will have to respond to demand, but there is an inherent doubt about whether the health market, if left to its own commercial interests, will favour equitable access on the basis of need and universality (WHO and GHWA 2014).

By 2035, an additional 1.9 billion people will be seeking to access and obtain high-quality healthcare. Under this assumption, 107 countries would be affected by gaps by 2035: this would lead to a global deficit of about 12.9 million skilled health professionals. The two WHO regions where the absolute deficit would be highest are South-East Asia (5.0 million), representing 39 per cent of the global total, and the African region (4.3 million), representing 34 per cent of the global total (ibid.).

Flawed analysis and proposals

The analysis provided by WHO and GHWA on future workforce strategies indicates an inherent ambivalence. On one hand we read: ‘The costs of producing

and retaining a workforce fit for purpose and fit to practice will influence the cost-effectiveness of health services. This is a recurrent cost, and investment in public-sector education is required to maintain the capacity, faculty and quality of training institutions. The education sector cannot be left entirely to market forces, as these can put the quality of public sector education at risk.’ In the same analysis we can read that the HRH deficit (in Africa) is related to labour ‘market’ failure. ‘The interaction of health workers as economic agents with institutional employers and patient consumers is an exciting and growing area of work related to results-based funding and incentive systems for performance’ (ibid.).

The latter position is strongly promoted by the World Bank, which argues that we should better understand the health labour market forces in low- and middle-income countries (LMICs). It is argued that instead of looking at supply factors, we should look more at demand-side factors, or the ‘willingness to pay’ on the part of government, private sector and international actors. The Bank further states:

A widely promoted solution for increasing the availability of human resources for health is to expand training and increase funding for public sector employment. But this requires funds, largely from the public purse. Countries such as Ethiopia and Niger, whose macroeconomic conditions prevented them from implementing this approach, chose to invest in community-based health workers, who undergo shorter training and require less pay. In early experiences, these cadres have played a significant role in improving service coverage and health outcomes in underserved communities. Similarly, experiences in Mozambique and elsewhere show that mid-level cadres respond differently to health labour market conditions and are more easily retained in rural areas than physicians. (McPake et al. 2013)

From a human-rights-based approach, it would be relevant to learn from HRH strategies implemented in several LMICs, such as Brazil, Ecuador, Thailand and Sri Lanka. These examples tell us that the building of a public health workforce is a more sustainable path to a strong health system, rather than the commodification and privatization of a scarce common good, as the World Bank suggests.

The health worker crisis is now starting to affect Europe as well. In many European countries, austerity measures (including reduction of public spending and strict ceilings on wage bills for public sector employees – see Chapter A2) have led to a reduction in the public sector workforce. Employee wages, salaries and allowances account for 42.3 per cent of public spending on health and austerity measures have focused on wage cuts for health workers in many countries (Mladovsky et al. 2012). Austerity in Europe is also beginning to spur health workers’ mobility and migration within the region (Wismar et al. 2011), and to negatively affect the availability of qualified health providers in

countries worst affected by the fiscal crisis (Aiken et al. 2014). In Romania, for example, after wage cuts were imposed in 2011, more than two thousand doctors registered for international recognition of their credentials in order to be able to migrate and work in western Europe (Mans 2013).

The recent developments in Europe clearly illustrate the interdependence among health systems: in the context of the economic crisis in Europe, for example, countries have to compete to attract scarce health professionals. It is precisely this recognition – that the health systems of low- and middle-income countries (LMICs) are undermined by the recruitment of their health workers by high-income countries – which led to the adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel (Code) in 2010 (ibid.; WHO 2013).

WHO's Global Code of Practice: fatally deficient

At the 2013 World Health Assembly, when Code implementation was reported for the first time, a WHO assistant director general admitted that progress was ‘painfully slow’ (Schwarz 2013). While the fact that progress in implementation has been slow is a matter of concern, it is important to underline that the Code is also fatally deficient in one very important aspect. The Code provides guidance on ethical recruitment, the rights of health workers and strengthening of health systems. But one obvious element is missing: that of financial compensation (HPA 2013).

During the elaboration of the Code in 2010 the language was diluted to make it acceptable to all WHO member states (including the powerful countries of the North which gain from health worker migration). As a consequence, the mention of compensation to source countries for the costs incurred in training migrant health workers was removed. It is time to repoliticize the discussion and much stronger instruments need to be developed to address countries’ lost investment due to external migration. The feasibility of compensation, e.g. by repatriating taxes paid by ‘imported’ health workers to their countries of origin, should be raised again. Such measures need to be complemented by strategies that can make available significantly enhanced resources to fund health services in LMICs. Health systems are grossly underfunded in most LMICs, in part because of domestic policies, but also in large measure because of power imbalances at the global level and the imposition of neoliberal policies by global institutions such as the World Bank, the IMF and the WTO. Discussions on these aspects must be integrated in the public discourse on the health workforce crisis.

Who is a health worker?

We now turn to a blind spot regarding the health workforce crisis. The *World Health Report 2006* accepts that data available on health worker numbers are generally limited to people engaged in paid activities. It further classifies two



Image B9.1 A health worker examining a patient in the Philippines; a very large proportion of health workers in the Philippines migrate to Northern countries (Patricio Matute)

types of health workers: ‘health service providers’ and ‘health management and support workers’. Thus, only medical doctors, nurses and midwives are counted as professional service providers. When WHO talks about shortage of health workers, it talks mainly about these professional categories.

Community health workers (CHWs) are, in many countries, a crucial element of a people-centred health system, but are not generally counted as part of the health workforce (see Chapter B7). Despite local successes, uptake by governments to have CHWs integrated in sustainable national programmes with proper remuneration and education has remained limited.

Proposed solutions such as the recent ‘One million community health workers’ campaign need to be carefully assessed (One Million n.d.). This initiative proposes the deployment of health workers equipped with high-tech point-of-care diagnostic tools, communicating with national supervisors via broadband access and smartphones, providing standardized care based on consistent supplies of life-saving medicines and easy-to-follow treatment protocols, and trained in short-term intensive courses. The obvious questions are:

- How will this be financed? And what are the plans for a sustainable integration of these CHWs in national health systems? How will exploitation of this ‘cheap’ workforce be prevented?
- What will the scope of work of these CHWs be? How will they be linked with the communities they are intended to serve?
- How will such CHWs function optimally without substantial strengthening of national health systems?

Steps forward in mitigating the crisis

Norway and Ireland (AGHD 2013) – the two recent European winners of the Health Worker Migration Policy Council award – have nevertheless

demonstrated that the Code can provide an anchor for a coherent health workforce policy. Both countries have implemented national measures to ascertain how many doctors and nurses need to be trained and in which specialities. In making these countries less dependent on foreign health personnel, these measures also ensure they will not exacerbate the global and regional brain drain. Alongside this audit and focus on education and training, these countries are also looking at how to retain their own health personnel, for example through education programmes and salary provisions. And if foreign health personnel are needed, they make agreements with the countries of origin regarding the duration of stay, employment conditions, training options and workers' return. Additionally, Norway and Ireland have both adopted foreign policies that aim to help low-income countries strengthen their own health systems, including measures and investments focused on health personnel.

Extending such policies to other importing countries is unlikely to occur without civil society pressure. In order to address the global health migration issue, new alliances are required: between social movements fighting for the right to health, global health advocates and health workers' organizations at all levels. In the HW4ALL project (HW4ALL n.d.), organizations from eight European countries have partnered to raise awareness about the WHO Code of Practice for the International Recruitment of Health Personnel. Efforts include translation of the WHO Code for practitioners and the facilitation of dialogue between the actors involved in training, recruiting, and retaining and deploying health workers.

Scaling up transformative education

The health worker crisis clearly demands rapid scaling up and transformation of the education of health professionals in order to close the widening quantitative and qualitative deficit in health worker requirements. In the following section we briefly present three current proposals and initiatives and discuss their coherence, feasibility and sustainability.

Lancet Commission report on health professionals for a new century The Lancet Commission report published in 2010 highlighted the importance of a competency-based curriculum integrating education systems with health systems, at local, national, regional and global levels (Frenk et al. 2010). In this new model, 'populations', which previously may have been viewed as clients or consumers of a health system, are seen as fundamental stakeholders and contributors to the design of an integrated education and health system that addresses real needs in the workforce.

Although this report is welcome in drawing attention to the global need for reform of health professions education, unfortunately the report's analysis is quite narrow in conception.

The Commission's report starts with a set of global health challenges

which (it argues) are not being addressed because of weaknesses in the global health workforce which (it argues) are due to inappropriate curricula in health professional education. The report calls for competency-based education (in part as a strategy for addressing the divisive effects of professional tribalism); inter-professional education (to promote teamwork); and international accreditation of health professional training (to promote quality). The report envisages conditional funding from large US philanthropies as the principal driver to promote reform globally, which risks entrenching rather than challenging inequity in global health.

The report, thus, treats health professional education without reference to the wider social forces which shape public health, healthcare and practitioner education. There is no reference to the global economic regime in explaining the contemporary health crisis, or to the impact of neoliberal policies on cutting public expenditure on healthcare and higher education and on driving universities as well as hospitals towards increased dependency on user fees. Indeed, the report welcomes private funding (student fees), despite the access barriers such fees impose. This implies an acceptance that public funding of excellent health professional training is not a prerequisite to resolving the crisis.

Initiatives in the World Health Organization At the request of its member states (World Health Assembly resolution WHA59.23), the World Health Organization has been developing, over the last years, evidence-based policy guidelines (WHO 2011) to assist countries, development partners and other stakeholders in efforts to expand the health workforce and improve the alignment between the education of health workers and population health needs. The guidelines were formally launched at the Third Global Forum in Recife, in 2013, but are currently not yet publicly available.

The 2013 World Health Assembly, in an ad hoc exercise led by Thailand and supported by many countries suffering from a health workforce crisis, passed a resolution (WHO 2013) on ‘Transforming health workforce education in support of universal health coverage’ (Resolution WHA66/23). The resolution, also referring to the WHO Global Code, urges WHO member states ‘to further strengthen policies, strategies and plans as appropriate, through intersectoral policy dialogue among the relevant ministries that may include ministries of education, health and finance, in order to ensure that health workforce education and training contribute to achieving universal health coverage’.

While these initiatives are to be welcomed, it is unlikely that most member states of WHO will be able to implement such guidelines vigorously or at scale unless their fiscal constraints are addressed, and, for many of them, their continuing losses of health personnel through migration are stemmed, or they are compensated for this ‘brain robbery’ (Patel 2003). Indeed, while the expansion of medical school places in public sector institutions has stagnated in most African countries – with some exceptions such as Ethiopia – there

has been a rapid growth of private medical schools in the past decade. The Sub-Saharan Medical School Study in 2009 found 168 medical schools of which thirty-three had been created in the previous decade. At that time approximately 26 per cent of medical schools in sub-Saharan Africa were private schools. The first private schools opened in the 1990s and their number keeps increasing, but reports suggest that several of them are of dubious quality.

PEPFAR Medical and Nursing Education Partnership In 2010 an initiative intended to achieve rapid scaling up of the African health workforce was launched by PEPFAR (PEPFAR n.d.). The Medical Education Partnership Initiative (MEPI) supports ‘foreign institutions in Sub-Saharan African countries that receive funding from PEPFAR and its partners to develop or expand and enhance models of medical education’. These models are intended to support PEPFAR’s goal of increasing the number of new healthcare workers by 140,000, strengthen medical education systems in the countries in which they exist, and build clinical and research capacity in Africa as part of a retention strategy for faculty of medical schools and clinical professors. The Nursing Education Partnership Initiative (NEPI) is an allied initiative, developed to strengthen the quality and capacity of nurses and midwives throughout Africa. NEPI intends to strengthen the quality and capacity of nursing and midwifery education institutions, increase the number of highly skilled nurses and midwives, and support innovative nursing retention strategies in African countries.

The MEPI partnership involves medical schools in twelve African countries and is coordinated by George Washington University in the USA with an African coordinating partner, ACHEST, based in Uganda. The respective financial allocations to African and US partner institutions are difficult to find, but there are suggestions that the US coordinating partner receives a disproportionate slice of total MEPI funding.

Conclusion

The availability of a strong health workforce, supported by public funds, is a prerequisite for strong, universal and quality health systems. The current focus on UHC carries the potential threat of reducing the role of health workers to undertaking selective diagnosis and treatment, rather than addressing the health of people and communities in a comprehensive and integrated way, combining public health as well as individual clinical approaches. The concept of comprehensive primary healthcare, as enunciated in the Alma Ata declaration, envisages the latter. However, there is a growing imperative for health workers’ role to be guided primarily by concerns of economic efficiency. This approach inevitably emphasizes treating diseases rather than promoting health and reduces the health worker to a mere production unit. We not only need many more health workers, we require professionals working towards a society oriented to greater equity in health and wellbeing.

References

- AGHD (Aspen Global Health and Development) (2012) 'Health worker migration global policy council announces 2012 innovation award winners', Aspen Institute, 24 May.
- (2013) 'The health worker migration policy council celebrates Ireland and Rwanda for their innovation and leadership', Aspen Institute, 13 November.
- Aiken, L. H., D. M. Sloane, L. Bruyneel et al. (2014) 'Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study', *The Lancet*, 26 February.
- Frenk, J., L. Chen, Z. A. Bhutta et al. (2010) 'Health professionals for a new century: transforming education to strengthen health systems in an interdependent world', *The Lancet*, 376(9756): 1923–58.
- GHWA (Global Health Workforce Alliance) (n.d.)
- a) 'First global forum on human resource for health', www.who.int/workforce/alliance/forum/2008/en/, accessed 8 May 2014.
- (n.d. b) 'Third global forum on human resource for health', www.who.int/workforce/alliance/forum/2013/en/, accessed 8 May 2014.
- HPA (Health Poverty Action) (2013) 'The health worker crisis: Natalie Sharples blogs from the third global forum on human resources for health', 15 November.
- HW4ALL (Health Workers 4 All) (n.d.) www.healthworkers4all.eu/eu/home/, accessed 8 May 2014.
- JLI (Joint Learning Initiative) (2004) *Human Resources for Health: Overcoming the Crisis*, The President and Fellows of Harvard College, www.who.int/hrh/documents/JLI_hrh_report.pdf, accessed 8 May 2014.
- Mans, L. (2013) 'Europe concerned about the mobility of health personnel', *Get Involved in Global Health*, 16 September.
- McPake, B., A. Maeda, E. Correia Araújo et al. (2013) 'Why do health labour market forces matter?', *Bulletin of the World Health Organization*, 91(11): 841–6.
- Mills, E. J., S. Kanfers, A. Hagopian et al. (2011) 'The financial cost of doctors emigrating from sub-Saharan Africa: human capital analysis', *British Medical Journal*, 343(d7031).
- Mladovsky, P., D. Srivastava, J. Cylus et al. (2012) *Health Policy Responses to the Financial Crisis in Europe*, Policy Summary 5, World Health Organization, www.euro.who.int/_data/assets/pdf_file/0009/170865/e96643.pdf, accessed 8 May 2014.
- One Million (One Million Community Health Workers Campaign) (n.d.) 1millionhealthworkers.org/about-us/, accessed 8 May 2014.
- Patel, V. (2003) 'Recruiting doctors from poor countries: the great brain robbery?', *British Medical Journal*, 327(7420): 926–8.
- PEPFAR (US President's Emergency Plan for AIDS Relief) (n.d.) www.pepfar.gov/partnerships/initiatives/index.htm, accessed 8 May 2014.
- Schwarz, T. (2013) 'WHO global code of practice – lost in translation?', *Get Involved in Global Health*, 12 June.
- Van de Pas, R. (2013) 'Human resources for health – a bottleneck for primary health care?', *Get Involved in Global Health*.
- WHO (World Health Organization) (2006) *The World Health Report 2006: Working Together for Health*, Geneva, www.who.int/whr/2006/whro6_en.pdf?ua=1, accessed 8 May 2014.
- (2010) *WHO Global Code of Practice on the International Recruitment of Health Personnel*, Resolution WHA63.16, May, www.who.int/hrh/migration/code/code_en.pdf?ua=1, accessed 8 May 2014.
- (2011) *Transformative Scale Up of Health Professional Education: An Effort to Increase the Numbers of Health Professionals and to Strengthen Their Impact on Population Health*, US President's Emergency Plan for AIDS Relief (PEPFAR), Geneva.
- (2013) *Transforming Health Workforce Education in Support of Universal Health Coverage*, Resolution WHA66.23, 27 May, apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R23-en.pdf, accessed 8 May 2014.
- WHO (World Health Organization) and GHWA (Global Health Workforce Alliance) (2014) *A Universal Truth: No Health without a Workforce*, Geneva.
- Wismar, M., C. B. Maier, I. A. Glinos et al. (eds) (2011) *Health Professional Mobility and Health Systems: Evidence from 17 European Countries*, Observatory Study Series no. 23, European Observatory on Health Systems and Policies, WHO Regional Office for Europe, Copenhagen, www.euro.who.int/_data/assets/pdf_file/0017/152324/e95812.pdf, accessed 8 May 2014.