Health workforce planning, retention, migration and financing in Africa

Delanyo Dovlo on lessons learnt since independence and the way forward

African countries need to work towards creating unique workforce models that serve their general and specific needs. The Sustainable Development Goals (SDGs) are a good starting point. Some of the core SDGs must form the foundational principles for workforce planning, training, and development. The principles to bear in mind are poverty eradication, equity and 'leaving no one behind'. Perhaps even more important is the notion that 'each country has primary responsibility for its own economic and social development' and therefore, for how it plans and prepares a workforce for its health. SDG Goal 3 provides a focus on 'healthy lives and wellbeing', an inter-sector approach that has implications for how our workforce is designed. Adequate focus must be given to health promotion and disease prevention.

Trainee nurses.

Issues and challenges

Africa is undergoing a number of transitions that may require a fundamental rethink of our approach to health and therefore its workforce. These transitions include those in demographics, epidemiology, the triple burden and non-communicable disease (NCD) burden, economics, socio-cultural, environment/climate change and health security. NCDs and nutritional lifestyle changes as well as accidents and injury now constitute about 50% of the disease burden and disability-adjusted life years lost. An estimated annual loss of about US$2.4 trillion will be reduced by about 45% if we meet the SDG goals in Africa. Therefore, a well-crafted investment in health and a well targeted workforce is not just about the social and public good of wellbeing, but also a substantial economic gain.

Not all is gloomy, even though that is how we are often expected to feel about health in Africa. The investments by Global Health Initiatives, and some of the restructuring and reforms towards better donor behaviour and more effective health promotion and prevention has resulted in many measurable gains, even if many health Millennium Development Goals were not met. There has been a significant expansion in medical and nurses production in particular and perhaps less significant in terms of an expansion in allied and support health workers.

However, the SDGs are even more challenging in scope and cross-sectoral need. A lot more is required of the workforce.

And so, what workforce models should support the goal of attaining healthy lives and well-being? What models fit Africa's very different contexts well and avoid the trap of reproducing colonial blueprints? To get the health workforce right we need to start at a strategic level, working through an understanding of our needs and our resources and matching the two well. Doing this will involve the following:

- A workforce must be aligned to the priority health issues and needs affecting a country, and results desired for the entirety of the population (not just for the elite).

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- It is important to align needs with resources, especially domestic resources with a firm understanding of what the gross domestic product of a country can afford and how to enhance cost-effectiveness and cost-utility of the health workforce.
- The health sector and workforce strategies must start with a longer-term strategic horizon with clear intermediate-term goals, and it must be shaped to contribute to (and not undermine) overall national development goals. Sometimes the pressure to fund the sector may undermine funding for education and economic growth in other sectors.
- Training of the workforce must therefore be for a purpose and not only based on historical or international organisation norms, some of which may not be fully based in evidence.

Overall, attaining healthy lives and well being is a cross-sectoral effort and this must be well understood and the utility of related sectors worked into getting to results.

One should not under-estimate the value of good governance (not only in health but generally) for effective human resources for health (HRH), including improving management, supervision, incentives and motivation and running an effective health sector.

Financing the workforce is closely linked to overall financing of health. Domestic resources are estimated at about 65-70% of the financing of health in Africa but the fractious mobilisation, pooling and disbursement or purchasing inefficiencies renders the 70% neither as effective nor as visible as the donor 30% contribution.

The salary costs of the domestic proportion of health budgets are overwhelming, leaving little for services delivery. A workforce is not useful if it cannot deliver services. Attempts to provide incentives through top-ups and performance-based incentives tend to lead to a balkanisation of the workforce into 'Haves' and 'Have-nots'. Sudden withdrawal of external funding, or the tragedy of having reached 'middle income status' by World Bank estimates, can bring ruin through requirements to now fully fund vaccines and medicines previously funded by global health initiatives and donors.

The sustainability of financing for the workforce therefore needs careful consideration on sustainability over creating perverse incentive and indeed an inflation in the health economy.

Critical ongoing issues include the following:

- There are still huge and deliberate workforce shortages globally and political changes in the global north which mean that Africa shall remain vulnerable to losing its workforce to richer countries. Taking measures and creating innovations that mitigate loss and improve retention will be crucial.
- Scaling up innovations like task-shifting and e-digital health will be critical for meeting the gaps. Even with existing HRH a lot more could be achieved through improving the quality and productivity with which services are managed and delivered and by utilising effective and cost-efficient teams and skill mixes.
- In planning HRH, we must always remember other important and catalytic cadres essential to productivity of the core health professionals. A well trained surgeon can be ineffective without an anesthetist and operation room nurses, etc. The diagnostic support services (labs, imaging) are crucial to effectiveness and efficiency. Running the operations well is as important as having the right technical skills.
- It is important to continue working to invert the workforce pyramid towards communities (both urban and rural) and towards balancing primary health care and curative services.
- More effort should be made for planning and developing managerial and leadership cadres and placing and motivating them well. A health service without good leadership and management wastes skills and resources.

There is always a 'chicken or egg' dilemma around reforms of the health workforce and making those important paradigm shifts and so we should have a 'chicken and egg' process so that righting a wrong paradigm does not result in creating another wrong.

Getting people who work for our health

Our workforce is a function of our overall development and socio-political environment. What is the health workforce needed for Africa?

A health workforce should be planned with an appreciation of the major upcoming challenges to health and a planning process that takes into consideration lessons from the past efforts, including from the Ebola outbreak in West Africa. We must desist from just copying workforce models serving countries different from our own. Our workforce models should aim to solve our problems, and not simply follow global models. A long-term approach is needed, understanding that health workforce and health sector development needs to take a stepladder approach and not just seek out easy wins. It must not only be about focusing as usual on doctors and nurses and internationally inter-changeable cadres but also on critical non-traditional cadres that support and ensure that the technical workforce is effectively and efficiently run, including allied professionals, the innovative cadres, such as Assistant Medical Officers, Non-Physician Practitioners etc., as well as others who may not be numerous but are essential to productivity.

A well-planned leadership and management workforce is the ultimate priority. Developing and selecting health leaders by chance will not help move the health and its workforce agenda forward towards PHC and UHC. Management and supervision is going to be critical to getting results and motivating good quality and productivity.

We must be clear as to what measurable results we expect from applying our workforce and set up the training systems and the results chain needed to get there. But we must be also innovative and strategic about retention against migration and workforce theft by richer countries, avoiding the trap of only training cadres that can be utilised better by developed countries.

Health is created in communities. A workforce that engages communities to make them more aware and responsible for their health is critical.