Drivers of change in global HWF trends

Francis Omaswa discusses global health workforce challenges

There are currently several movements globally looking at the future of the health workforce (HWF). The WHO recently released Working for Health Action Plan (2022-2030),[1] the African Union and African CDC is looking at the Post-Covid-19 Recovery Plan with dedicated work on the HWF implications and the UK All Party Group on Global Health is looking at the drivers of HWF needs in the UK and globally in the next decade and beyond. I have been privileged to follow and participate in HWF development in the past and these recent discussions and have insights on this topic to share as bellow.

First to keep in mind is that, despite diverse efforts in the last two decades, widespread shortages, maldistribution and poor working conditions persist at the root of all the HWF challenges under discussion. This crisis has been recognised since the publication of the Joint Learning Initiative Report in 2004.[2] There was a massive global response to the findings of this report culminating in the establishment of the Global Health Workforce Alliance (GHWA) at the WHO headquarters under Tim Evans and of which I was the founding Executive Director and Dr Lincoln Chen was the Chair of the Board of Directors. GHWA received strong global support and funding and undertook a number of studies and convened the First Global Forum on Human Resources for Health in 2008 in Kampala, Uganda.

This forum adopted the Kampala Declaration and Agenda for Global Action (KAGA) that recommended six interconnected strategies:

1. Building coherent national and global leadership for health workforce solutions is the very first imperative.
2. Ensuring capacity for an informed response based on evidence and joint learning
3. Scaling up health worker education and training
4. Retaining an effective, responsive and equitably distributed health workforce
5. Managing the pressures of the international health workforce market and its impact on
6. migration
7. Securing additional and more productive investment in the health workforce

Current African HWF status

The take-away message from the KAGA is that HWF planning, education, training and management is a technical field for which there is a shortage of individuals who have undertaken the necessary training and acquired the relevant field experience to guide national and global HWF issues including garnering the political support that is critical for policy and resource mobilisation. In most African countries, for example, HWF leadership and management is led by personnel staff or human resource managers who move around in short spells from one government sector to another. However, they have not been trained and lack the knowledge to match the country's disease burden to the needed HWF skills mix, including quantification and incentives.

As a result, HWF data needed for planning is inadequate and long-term HWF plans are not well aligned to the skills gaps resulting in shortages, maldistribution, poor working conditions, and workers lacking motivation and support. Education and training do not respond to need and have in many countries become privatised with commercial motives which threaten to erode ethical values, with worrying implications for professionalism.

Weak HWF planning means that the needed investments for HWF do not get mobilised. This in turn results in failed timely employment, absorption and retention of graduates. In many sub-Saharan African countries, HWF vacancies co-exist with large numbers of unemployed health workers. Under these circumstances, rich countries are able to offer employment abroad, leading to the phenomenon known as brain drain but which in reality is brain push by weak health systems (see Figure 1).

Drivers of HWF trends

The emergence of health promotion and health creation as a priority in health services delivery as opposed to the current focus on the treatment of diseases, which is what determines HWF skills demand at present. There is a growing global movement calling for renewed health systems that focus on keeping healthy people healthy as opposed to the current emphasis on treating those who have already lost their health. The HWF skill needs for health promotion and disease prevention will increase the demand for public health workers without necessarily reducing on the need for clinical skills of the HWF. The long-term vision is that if health promotion and disease prevention succeed in reducing illness in the population, this will reduce the demand for HWF with clinical skills.

The 4th Technological Revolution will lead to the exponential rise in the application technology in health systems is expected to have a game-changing impact in the way in which health workers practise their professions. Face-to-face physical interactions between

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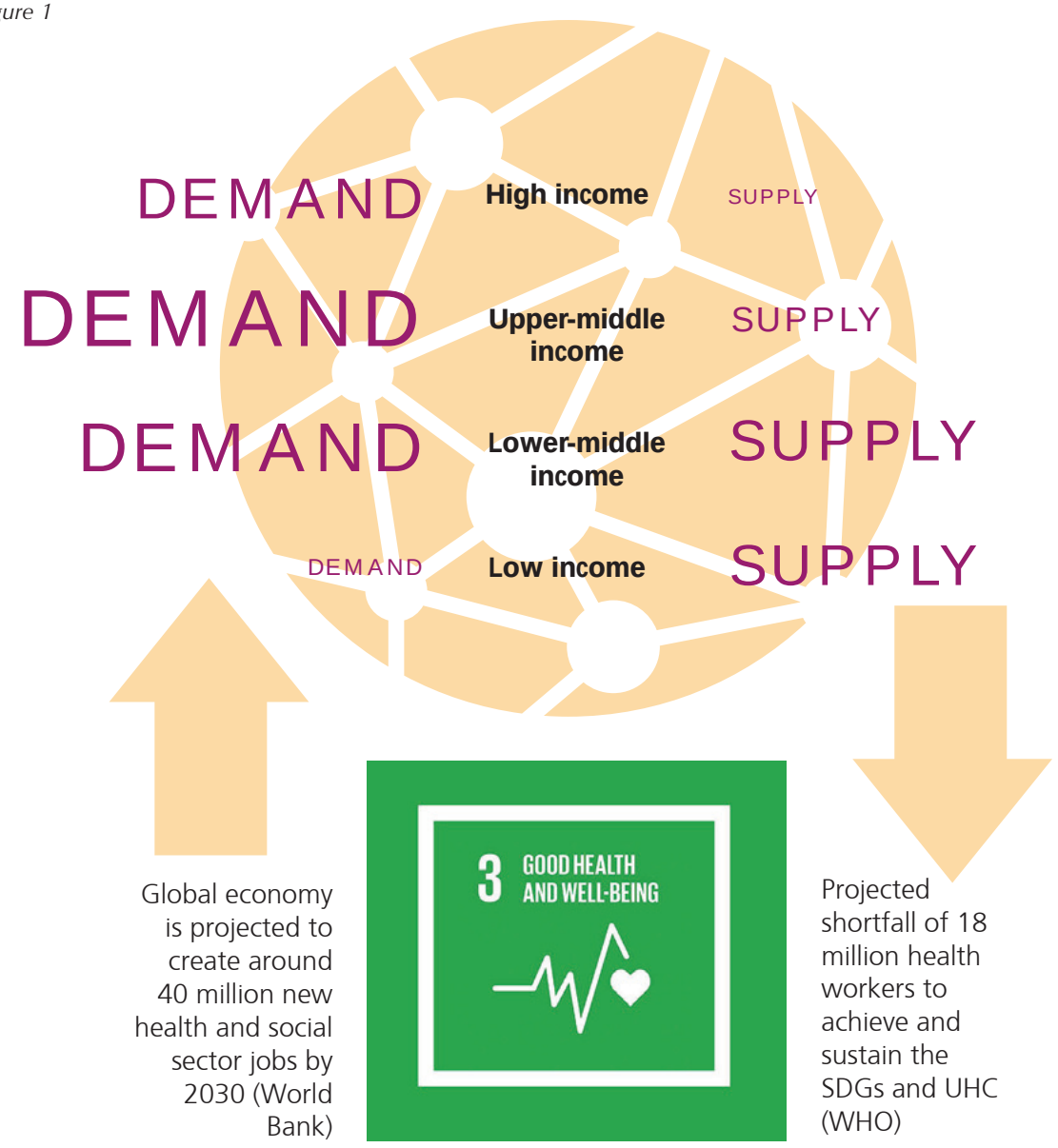
Figure 1



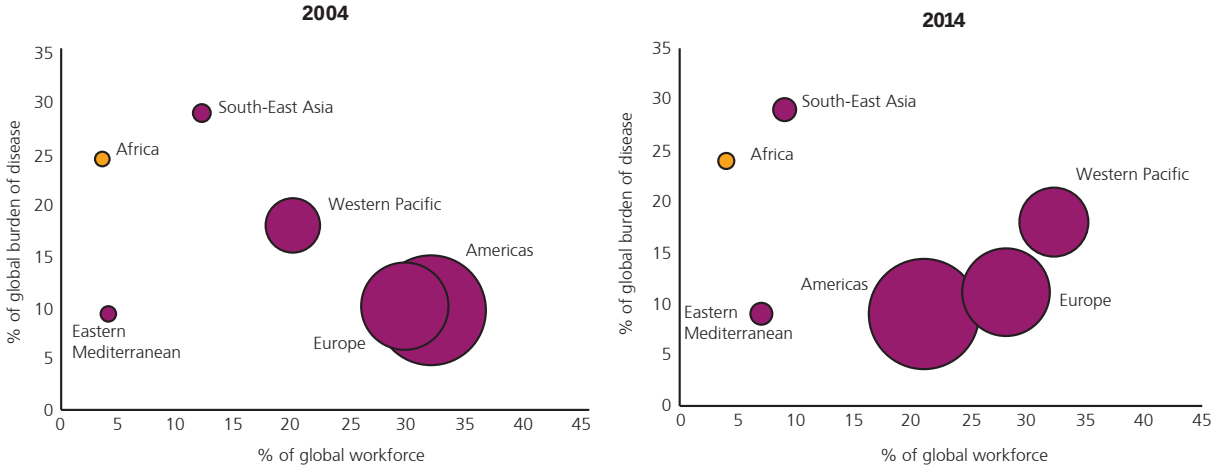
HWF with their patients and the public will reduce. The entire clinical value chain from presentation, physical examination, investigations, diagnosis, treatment and follow-up can be technology mediated. This can extend to technical support supervision of trainees and monitoring the patient and other staff. The impact of these technological applications is expected to reduce the need for clinical specialists such as surgeons and increase the need for biotechnologists to operate and maintain the machines as well interpret the findings and outcomes. The professional, financial and political implications of these possibilities are too complex to predict at this time.

Demographics and population dynamics in countries and regions is another factor that will drive changes in HWF demand. Aging populations mean increased attention to increased needs of aged people. The rich countries with aged populations also simultaneously face shortage of labour with a small pool of young people to address competing needs in all sectors including health services and care of the aged who cannot look after themselves. The developing countries on the other hand have high population growth rates and a huge pool of young people with over 50% aged under 15 years old and heavily dependent on low per capita incomes of their countries. While these young people present an opportunity to provide the HWF needed by their populations, their countries cannot afford to train, employ and retain them in the health services. As a result, they migrate to the rich countries, who have shortages but the capacity to employ. African HWF densities stagnated during the MDG era and beyond (see Figure 2).

Medical tourism has two types. The first is where patients move across borders and continents in search of medical services. This may happen because the

Figure 2

Distribution of skilled health professionals by level of health expenditure and burden of disease, WHO regions



No change... Africa has 24% of burden of disease but 3% of global health workforce

Sources: WHR 2006; Global Health Observatory (2014 update)

services sought are not available in the home countries or because they are available but not affordable or accessible to the population in need. The ability of patients to find acceptable services outside their own countries weakens the incentives in the home country to build the needed HWF capacity. On other hand the cost of accessing services abroad can be an incentive that inspires the development of country capacity and HWF in order to reduce these costs and increase accessibility and affordability of the services in home countries.

The second type of medical tourism is where medical practitioners move across borders and continents on short term missions to provide medical services. This can be done through organised groups or by individuals. In Uganda for example, we found that 15% of all registered medical practitioners are short-term visitors or medical tourists from other countries, mostly developed countries.[3] Some professional associations undertake such activities as part of their normal programmes. This type of medical tourism has the potential to build HWF capacity in countries in need. Their methods of work should be further developed and documented so that all ethical and professional aspects of practice are harmonised and expanded to respond to identified needs.

The health, social and economic consequences of climate change will be a driver of change in the future HWF trends. It is expected that as a result of climate change, we will see more frequent pandemics such as COVID-19. These are attributed to the changes in ecosystems brought about by climate change leading to closer interaction and interface between human and animal activity. Additionally, natural disasters such as floods and prolonged droughts will result in shortages of food, displacement of people and humanitarian emergencies. Accordingly, health systems capacity along with HWF skills to respond to these events will be needed and drive change.

HWF governance will be a key driver of change in trends at national, regional and global levels. The quality and functionality of international, regional and national institutions that govern HWF will be critical to what directions HWF developments will take at all levels.

At the *international level*, WHO headquarters has a major role to play at the present time with the WHO HWF Department also acting as the overseer of the Global Health Workforce Network (GHWN) that replaced the Global Health Workforce Alliance (GHWA) that was autonomous but with the Secretariat at WHO. Implementation to scale of key global instruments such as the WHO Code on the International Recruitment of Health Personnel could have a major positive impact on HWF trends if it is popularised and implemented fully. This code is excellent and envisages and provides a tool for the education, training and sharing a global pool of HWF that can be equitably deployed between countries using the various articles in the Code. On the other hand, if this code is ignored the consequences can be catastrophic especially for poor countries who cannot afford to employ them in the face of demographic realities in the rich countries. There are other important global tools such as the many resolutions adopted by the WHAs on HWF over the years including HWF 2030 that should be implemented to scale.[4]

At *regional level*, as part of the work of the GHWA, regional networks were established to coordinate HWF development within various regions. The Asia Action Alliance on Human Resources for Health (AAAH) with a Secretariat in Thailand, has worked well in the WHO WIPRO and SEARO regions. In the African Region,

Courtesy of Michelle Betton

the African Platform on Human Resources for Health (APHRH) has a Secretariat with the African Center for Global Health and Social Transformation (ACHEST) in Uganda, which in the past had excellent relations with the African Union Commission and the WHO African Region. The work of these institutions will need better integration with new efforts by the Africa CDC to avoid fragmentation and benefit from institutional memory. The Americas and Europe were coordinated through the WHO regional offices of PAHO and EURO.

At *country level*, in Africa HWF governance is generally weak despite the fact that there are tools such as the Country Coordination and Facilitation (CCF) developed by GHWA and provides guidance on inter-sectoral collaboration for country HWF planning, education, training and management. WHO has other tools such as the National HWF Accounts and WSIN among others. Advocacy and support for people led Community Health Systems, including motivated Community Health Workers is a low hanging fruit that that continues to elude that attention of governments in Africa.

Conclusion and way forward

It is evident that the enthusiasm within the global community to respond to the global health workforce crisis has waned while the crisis has persisted and has not been resolved. The funding for the response that supported the GHWA and the many regional and country initiatives are no longer visible. Resources for studies and monitoring the performance of global tools such as the WHO Code on the International Recruitment of Health Personnel and the implementation of the KAGA are lacking and need to be provided to stakeholders. Country level leadership for HWF is weak in most countries. Resources and dedicated efforts to build technical capacity for planning, education, training and management of the HWF will be needed within strong national health systems that are embedded in institutionalised multi-sector collaboration for HWF development. Regional and global mechanisms should also be well funded to build capacity for joint learning and coordination.

The experience of COVID-19 pandemic that brought the world to a standstill is an opportunity that should not be lost to revive and revitalise the global HWF movement. SDG 3 on Health and wellbeing through the life course has gained preeminence as the pillar for the achievement of all the other SDGs. The HWF is central to community, national, regional and global preparedness and response to future pandemics and should be given priority in reforms that are anticipated in the ongoing negotiations.

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