

The Global Health Initiative and the Health Workforce

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Abstract

The United States Government (USG) strategy for global health is embodied in the Global Health Initiative (GHI), announced by President Obama in 2009. The GHI addresses the array of US global health programs and concerns. There is laudable recognition of the health workforce crisis as a major barrier to achieving the Millennium Development Goals and the USG's global health goals. Significant funding is provided to train health workers and conduct other activities that may be seen as addressing the health workforce crisis.

Unfortunately, the USG approach to the health workforce is not guided by a coherent strategy. In sharp contrast to its approach to more traditional, disease-specific programs, the GHI fails to articulate objectives, technical approach, metrics, organization, staffing or resource allocation with regard to the health workforce. The result is a series of projects unguided by any framework.

This article outlines a health workforce strategy for the GHI. It proposes objectives, a technical approach, key indicators of progress, structural reforms and resource requirements.

Introduction

Since the release of the 2006 World Health Report, there has been widespread understanding that the health workforce deficit in low- and middle-income countries stands as a fundamental barrier to achieving the Millennium Development Goals. Where there are no health workers, improved health is difficult or impossible. While primary responsibility for developing the health workforce rests with the developing countries and their governments, donor nations and multilateral institutions must play their part in a coherent and thoughtful manner. The Joint Platform for Health Systems Strengthening is the designated vehicle by which the major multilateral organizations (The World Bank; the Global Alliance for Vaccines and Immunization [GAVI]; The Global Fund to Fight AIDS, Tuberculosis and Malaria; and the World Health Organization [WHO]) propose to strengthen health systems, including the health workforce. The Global Health Initiative (GHI) is the overarching United States global health framework and includes strengthening the health workforce as a goal.

This article lays out a strategy for strengthening the health workforce within the GHI. However, the principles set forth here – effective leadership, priority countries, clear objectives, integration and coordination, regional and global approaches, sound technical approach and measuring progress – could be equally applied to other elements of health systems strengthening and by other donors.

It is remarkable that President Barack Obama chose to assert global health as a priority for his Administration during the first months of his presidency. The United States (US) can already take great pride in its contribution to global health. US technical leadership and financial contributions have been critical to achieving historic gains in child health, maternal health and family planning, as well as reducing the impact of malaria, combating HIV/AIDS and fighting tuberculosis. The GHI builds on this history.

One of the more intriguing elements of the GHI is its commitment to strengthening health systems. While less glamorous than explicitly fighting deadly diseases, strengthening health systems is essential to long-term success in all areas of public health. The means of preventing and/or curing many of the major causes of disease and death are well known and highly cost-effective, for example, vaccines, antibiotics, antiretrovirals, insecticide-treated nets and antimalarials. However, the systems for delivering these life-saving interventions are often quite weak: the cure never gets to the patient. These health systems weaknesses are explicitly recognized in the GHI: “Achieving sustainable health outcomes requires a purposeful effort to strengthen country health systems and transition to country-owned health delivery platforms, overcoming barriers that constrain the delivery of effective health interventions” (United States Global Health Initiative 2011).

Of particular importance is strengthening the health workforce. There is abundant evidence supporting the common-sense conclusion that increasing access to health workers improves health outcomes. For example, one cross-national study found that every 10% increase in the health workforce was associated with about a 5% decrease in maternal mortality and a 2% decrease in both infant and child mortality (Anand and Barnighausen 2004). The GHI concurs with this conclusion, calling for “Increased numbers of available and trained health service providers, public health workers and community health workers, appropriately deployed in the country and providing quality health services” (PEPFAR 2011: 19).

Fifty-seven countries fail to attain even the bare minimum ratios of doctors, nurses and midwives relative to population

The dimensions of the problem are dramatic. A billion people will never see a health worker (Global Health Workforce Alliance 2011a). Fifty-seven countries fail to attain even the bare minimum ratios of doctors, nurses and midwives relative to population (WHO 2006). Health workers are often concentrated in urban areas where they care for the relatively affluent, leaving those in rural areas and the poor badly underserved. The education of health workers is often weak, both in terms of the capacity to train the needed numbers and in the quality of the education provided. Health workers are often badly managed and supported, and the basic mechanics of a personnel system (i.e., recruiting, hiring, compensating and supervising) are often in shambles. Typically, countries lack even the most basic information about their health workforce – how many, where they are, what education they have received – which greatly inhibits informed policy making and planning. Health-worker productivity and the quality of care are frequently low as health workers cope with poor work environments.

The US spends a great deal of money on the health workforce. Training is embedded in virtually every US global health program, ranging from tuberculosis to child survival. There are very good global and bilateral projects focused on the health workforce. Dedicated experts in the US government (USG) are doing their best to address the health workforce crisis.

That said, the rudiments of a coherent health workforce strategy are absent from the GHI. The Lantos-Hyde legislation reauthorizing the United States President’s Emergency Plan for AIDS Relief (PEPFAR) has a clear goal of training and retaining 140,000 new health workers (GovTrack 2008). Beyond that, the GHI has failed to define the following with regard to the health workforce: objectives, priority countries, resource allocation, technical approach, organizational structure, leadership, staffing, metrics or approach to monitoring and evaluation. It is impossible to discern how much the

USG is spending on the health workforce. The United States Agency for International Development (USAID) report to Congress on health systems acknowledges that its mechanisms are ill-suited to aggregate and report on expenditures aimed at strengthening health systems (2009). In short, the USG is spending a large but unknown sum of money on a set of projects that, however individually laudable, are not guided by a coherent approach.

The ambiguity surrounding the USG health workforce “program” stands in sharp contrast to the GHI approach to disease-specific (“vertical”) programs. In areas such as maternal and child health, family planning, HIV/AIDS, malaria and tuberculosis, there are clear numeric goals, focus countries, evidence-based technical guidance, and well-defined structures for leadership and accountability, as well as metrics for assessing progress. These programs are, in principle, adapted to the needs of each country.

Some argue that clear biomedical markers make it easy to set goals and indicators for disease-specific programs (e.g., percent of children immunized, contraceptive prevalence and number of people receiving antiretroviral treatment for HIV/AIDS), while unambiguous markers of success for health workforce strengthening are missing. This line of reasoning is unconvincing. Measurable objectives for the health workforce can be set. Enormous effort has gone into developing health workforce indicators; see, for example the Handbook on Monitoring and Evaluation of Human Resources for Health developed jointly by the WHO, The World Bank and USAID. These indicators reflect the stocks and flows of health workers. There is no compelling intellectual or practical reason why health workforce stocks and flows are beyond enumeration. What is most needed is the willingness to set and be held accountable for unambiguous targets.

The current political environment gives added urgency to the need for strategic coherence. In this age of fiscal austerity, the US Congress will surely demand answers to basic questions about the health workforce program, such as, “What are the goals?,” “How is progress being measured?,” “What are the priority countries?,” “Who is in charge?” and “How much money is being spent on this program?” The GHI cannot currently provide meaningful answers to these questions.

Proposal for a GHI Health Workforce Strategy

Here is a modest proposal for a GHI health workforce strategy that consists of seven key elements: (1) establishing leadership, (2) identifying priority countries, (3) setting clear objectives, (4) encouraging integration and coordination, (5) supporting regional and global approaches, (6) defining a sound technical approach and (7) assessing progress.

1. Put Someone in Charge

The GHI health workforce strategy needs a leader and dedicated staff. No one in the USG has responsibility for the health workforce, and no one is accountable for progress. This diffusion of responsibility is very different from most USAID programs, such as HIV/AIDS, maternal and child health, family planning, malaria, tuberculosis and neglected tropical diseases. In each case, a clearly identified manager has responsibility and authority for the program. The health workforce, like other health systems issues, is handled by committee. It is hard to imagine how a vigorous, well-coordinated response to the health workforce crisis can be achieved when no one is in charge.

The GHI should establish the position of Health Workforce Coordinator, give the Coordinator the needed budgetary and management authority and provide him or her with adequate staff.¹

2. Identify a Set of Priority Countries

A health workforce strategy should build on and complement investments made in other areas. Fortunately, priority countries have been identified for most of the USG’s vertical programs. So one starting point is to identify the overlap between those countries that are of high priority for multiple vertical programs and those countries that have been identified by the WHO as having a health workforce crisis (WHO 2006). The following 25 countries meet these criteria: Afghanistan, Angola, Bangladesh, Benin, Cambodia, Democratic Republic of the Congo, Ethiopia, Ghana, Haiti, India,

Indonesia, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, Pakistan, Rwanda, Senegal, Tanzania, Uganda, Zambia and Zimbabwe. This list includes 18 African and six Asian countries as well as Haiti, while incorporating six of the eight GHI-Plus countries² – Bangladesh, Ethiopia, Kenya, Malawi, Mali and Rwanda (PEPFAR 2011).

Focusing on these 25 countries would have several advantages. Combined, they have a population of 2.4 billion and represent much of the world's underserved population. Since multiple USG programs are already under way in each country, there are opportunities for pooling training and other health workforce resources from the programs to maximize efficiencies and impact. Focusing on a particular set of countries would also create new opportunities for partnerships with bilateral and multilateral donors aimed at the common goal of health workforce strengthening.

3. Set Clear Objectives

The 25 countries listed above have a collective shortfall of about 3.8 million health workers. However, India and Indonesia are special cases, as neither can plausibly claim to lack the domestic resources to train and deploy the needed health workforce. It would be hard to make the case that the US taxpayer should invest large sums in developing the health workforce of either country, though they may need some highly specialized technical assistance that the US could support. The other 23 countries have an aggregate deficit of 2.3 million health workers. Historically, the US share of major development challenges has been proportionate to its share of global GDP, which now stands at about 25%. Using that as a barometer would leave a goal of training, deploying and retaining about 580,000 health workers.

This cannot be achieved all at once. Following the lead of the WHO Task Force on Scaling Up Education and Training of Health Workers, a 10-year time frame might be set for meeting the goal. Some scaling up of the goal would be needed to compensate for population growth, which ranges from 1.3% in Zimbabwe to 3.0% in Benin.

Simply increasing the health workforce is not enough. More health workers could be badly deployed, poorly managed and unproductive. With that in mind, the GHI health workforce objectives could be reformulated as follows:

- Train, retain and equip 580,000 health workers over 10 years;
- Increase equity of access to health workers;
- Increase the capacity of countries to produce appropriate health workers;
- Increase health worker retention; and,
- Improve health worker productivity.

Additional objectives may be appropriate for a particular country context.

4. Encourage Integration and Coordination within Country Programs

While the vertical programs support health-worker training, they tend to focus on short-term in-service training that helps achieve service delivery goals. This creates two problems: Strengthening the health schools that increase the supply of new health workers is generally neglected (though the Medical Education and Nursing Education Partnership Initiatives are welcome exceptions). The vertical programs have little incentive to support increased output of health schools because they are focused on achieving near-term gains in use of specific services. But increasing the output, quality and efficiency of medical, nursing and other health schools is the only sustainable solution to increasing the health workforce.

The vertical approaches also tend to distort in-service training. Each program offers courses, workshops and other training opportunities that are largely not tied to any national strategy for systematically upgrading the competencies of health workers. A better approach would be to support the development and implementation of comprehensive in-service training strategies that meet the needs of health workers and the populations they serve. Integrating and coordinating the

workforce development efforts of the multiple USG programs in a country to strengthen health schools and achieve more strategic in-service training would ultimately yield higher impact than a set of disjointed courses. The USG contribution should be coordinated with the inputs of other donors and domestic sources, all serving a single national strategy for upgrading the competencies of the health workforce.

More broadly, there are many aspects of vertical programs that contribute to strengthening the health workforce, including improving supervision, leadership, equity of access to services, retention of health workers and gender equity that, if strategically integrated, could achieve both efficiencies and greater impact.

5. Support Regional and Global Approaches

Regional and global institutions that are addressing the health workforce crisis include the Asia-Pacific Action Alliance on Human Resources for Health, the African Population and Health Research Center, the African Platform on Human Resources for Health and Partners for Population and Development, among others. At the global level, the WHO Human Resources for Health department and the Global Health Workforce Alliance are making important contributions. USAID should expand its support for strengthening the capacity of regional and global institutions engaged in South–South cooperation. Regional approaches would build upon natural affinities (e.g., Francophone Africa, southern Africa, south Asia) and increase efficiency in providing technical assistance, training and other essential services.

6. Define a Clear, Evidence-Based Technical Framework

A high level of technical rigour has marked the most effective US global health programs. The knowledge and experience gained over many years has been distilled into core technical guidance documents that shape the formulation and implementation of programs ranging from child survival to HIV/AIDS to malaria. Comparable technical guidance with regard to the health workforce has not yet been published by USAID or other US agencies contributing to health workforce strengthening.

The body of evidence on key issues in health workforce strengthening should be distilled into a technical framework that serves as a resource for USG field programs and provides a standard against which programs can be assessed. Of course, gaps in knowledge remain, the evidence will continue to evolve, and every program must be adapted to the country context. The technical approach should evolve to keep pace with the state of the art.

Let me suggest the key elements of such a framework:

Building the Constituency for Global Health

The health workforce issue cuts across many sectors and actors. To ministries of health must be added the ministries of education that oversee health schools, civil service agencies that regulate public employment, ministries of finance, professional councils, nongovernmental organizations, faith-based organizations, for-profit health schools and health providers, donors, and organizations representing health workers. Addressing the health workforce crisis requires mobilizing a broad coalition of actors. The Global Health Workforce Alliance is promoting the creation of country coordination and facilitation groups that bring together the concerned stakeholders to oversee development and implementation of health workforce strategies. The USAID-funded CapacityPlus project has developed stakeholder leadership guidelines to help with the management of these coalitions. The GHI should support the development of country coordination and facilitation groups or similar stakeholder groups.

Optimizing Policies, Plans and Management Systems

According to a survey carried out by the Global Health Workforce Alliance, only 24 of the 57 health workforce crisis countries have evidence-based, fully costed plans for the health workforce (an additional 20 countries have some type of plan) (2011b). The GHI should help priority countries develop sound plans that can guide action.

Even more important than plans that may end up on the shelf are policies and systems for bringing about change. One critical element is structuring multidisciplinary health teams that address the most important health needs of underserved populations. These teams bring together doctors, nurses, midwives, community health workers, pharmacists, laboratory technicians and other health workers. In some countries, innovative health cadres, such as surgical technicians in Mozambique, will be needed. Responsibilities should be optimally allocated among team members to maximize equitable access to essential care. Developing health teams will sometimes require changes in laws and regulations to ensure that different cadres of health workers have the legal authority to carry out needed tasks.

Health teams must be supported by strong human resources management systems. In many countries, the human resources department in the ministry of health is understaffed and ill-equipped for its nominal responsibilities. The mechanics of human resources management, such as recruitment, hiring, deployment, supervision and compensation, are often weak. Basic information about the health workforce is frequently lacking, and functioning human resources information systems are rare. Strengthening human resources management systems is essential to addressing the health workforce crisis. The importance of such systems is illustrated by the case of Kenya, where nursing vacancies in rural health posts were largely the result of the inability of the bureaucracy to hire trained nurses even though budgets had been allocated. A management reform led to hiring 830 nurses and placing them in 200 rural health facilities in about six months (Fogarty and Adano 2009).

Educating and Training Health Workers

Health schools in countries with health workforce crises lack the capacity to produce enough of the right kind of health workers. Three lines of action are needed. First, there must be greater investment in educating health professionals. More is needed from developing-country governments and donors. But the public sector is only one source of capital. Nongovernmental and faith-based organizations already make important contributions to educating health workers, and public policy should encourage their increased contributions. Similarly, there is a burgeoning private school movement where an appropriate mix of incentives and regulations to ensure quality and equity are needed.

Second, health schools must become more efficient. Up to 30% of African health school students drop out before graduating (Global Health Workforce Alliance 2008). More attention must be paid to the nuts and bolts of school management – budgets, financial management, facilities, libraries, equipment – to ensure that limited resources are used to best effect.

Finally, there must be a shift toward educating students from rural areas in the skills needed by underserved populations in schools located outside the capital city. Educating urban elites in the capital, using models appropriate to developed countries, is not a solution to health-worker deficits in rural areas. Students from rural areas are more likely to serve where they are most needed, especially if they attend schools near their homes (WHO 2010a). The allocation of educational resources should be aligned with health teams that can meet the health needs of the population to be served. As a practical matter, this means giving prominence to mid-level and community health workers who, if properly supervised and supported, can alleviate much of the disease burden facing underserved populations. Curricula and teaching methods must also be adapted to focus on the needs of the poor and underserved.

Mali provides a good case in point for educational reform. The Gao School of Nursing is located in an underserved rural area. The curriculum and pedagogy have been adapted to match the health needs of the population of the Gao region. Students are nominated by communities from the surrounding area and are actively encouraged to stay and serve their home areas upon graduation (Capacity Project 2008).

In-service training of health workers is another area needing attention. In-service training is frequently no more than a pastiche of workshops, courses and seminars offered by an array of donors and nongovernmental organizations. Attendance is more often dictated by whose turn it is to collect per diem rather than any coherent training plan. The GHI should support the development and

implementation of strategic approaches to in-service training that reflect an evidence-based assessment of the training needs of current health workers.

Attracting and Retaining Health Workers

The out-migration of health workers from developing countries to developed countries (including the US) has received a great deal of attention. One study of African medical schools found that out-migration is the leading cause of loss of faculty (Mullan and Buch 2010). In 2010, this culminated in the adoption of the Global Code of Practice on the International Recruitment of Health Personnel. The Obama Administration is to be commended for its support of the Code, which calls for signatory countries to adopt voluntary standards of practice consistent with the Code. The GHI could play a leadership role in spurring adoption of standards of practice for international recruitment of health personnel by the US.

Attracting and retaining health workers in underserved areas is even more of a problem than international migration, with huge disparities in health worker densities between urban and rural areas. In part, the solution lies in training new health workers who are from the areas where the need is greatest. To this must be added crafting incentives that will induce health workers to move to and stay in rural and remote areas. The most important lesson learned in crafting an incentive package is, "Ask the health worker." Health workers have complex motivations, and salary is only one factor. Housing, schooling for children, social isolation, gender discrimination and educational opportunities are all considerations for health workers. The WHO global policy recommendations for rural retention identified 16 categories of health worker incentives (2010b). Attracting and retaining health workers depends on developing context-specific incentive packages that respond to the motivations of health workers.

The incentives that attract and retain health workers also tend to be those that help health workers be productive and offer good quality care. These include supportive supervisors and the supplies and equipment needed to be effective.

Addressing Gender Inequity

Gender inequity in the health workforce is ubiquitous. It affects access to education and training, choice of health profession, recruitment and hiring, compensation, career paths, incentives and workplace climate. The health workforce is disproportionately female. Any serious effort to address the health workforce crisis will have to redress gender imbalances.

7. Assessing Progress

Progress against these objectives must be regularly assessed in the priority countries. The following indicators could be used to monitor progress against each of the five objectives:

- *Increased number of health workers*: Total number of health workers (by category)/total population;
- *Increased equity of access to health workers*: Total number of health workers (by category) in rural areas/total rural population;
- *Increased capacity of schools to produce health workers*: Number of health school graduates/total number of health workers;
- *Increased health worker retention*: Total number of health workers leaving the health workforce/total number of health workers; and
- *Increased health worker productivity*: Number of specific tasks performed (e.g., immunizations, surgeries)/total number of health workers.

Health workers are the linchpin of any health system. Every other goal of the GHI depends on having enough of the right kinds of health workers where they are most needed. The USG deserves credit for its efforts to address the health workforce crisis. But the hard work of many talented people

is not being guided by a thoughtful strategy that sets priorities and allows progress to be assessed. Reasonable people may disagree with the outline of a health workforce strategy proposed in this article. No doubt it can be improved. However, the absence of a strategy is a sure recipe for failure. Developing and implementing an evidence-based, comprehensive strategy for health workforce strengthening is therefore a matter of urgency if the ambitions of the Global Health Initiative are to be realized.

Notes

- ¹ Ultimately, the Health Workforce Coordinator might report to an overall leader for health systems strengthening.
- ² GHI-Plus countries have been designated for additional technical, managerial and financial support to accelerate implementation of the GHI strategy.

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