The Global Health Workforce Deficit

CSIS Issue Brief

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The following brief is intended as a background piece for discussion at the July 13, 2006, conference "Sustaining U.S. Global Leadership on HIV/AIDS," organized by the CSIS Task Force on HIV/AIDS and chaired by Senators Russell Feingold and Bill Frist. The conference will focus on critical challenges that U.S. policymakers will confront in the next phase of U.S. global AIDS efforts, as PEPFAR's first five-year phase comes to an end.

INTRODUCTION

The global health workforce deficit, the focus of the WHO 2006 World Health Report, *Working Together for Health*[1], both constrains the effectiveness of expanding investments in improving health in low- and middle-income countries and greatly complicates the interrelationship of developed and developing countries in meeting their respective health needs. To sustain PEPFAR's success into the future, beyond its initial five-year phase, U.S. policymakers will need to forge more aggressive and comprehensive long-term strategies to address the growing shortage of health care professionals.

At the March 2006 CSIS Paris Forum "Strengthening Transatlantic Cooperation on Global Health", sponsored by the French government with the support of the Bill and Melinda Gates Foundation, key senior political leaders and health officials from the United States and Europe examined how increased transatlantic cooperation can improve health in low- and middle-income countries. Forum members agreed that the health workers deficit is among the most formidable barriers to promoting health in these countries.[2]

The United States, the World Health Organization, and other international bodies have increasingly acknowledged the human resource shortage and have devised various early, promising efforts to redress it. For example, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) has dedicated an estimated $150 million per annum (out of its $15 billion five-year commitment) to training programs and building health infrastructure. However, dollar investments of this type aimed at building the health

[1] World Health Organization, *World Health Report 2006: Working Together for Health*, Geneva, 2006. http://www.who.int/whr/2006/overview/en/index.html Available at:

[2] Jennifer Kates, J. Stephen Morrison, and Eric Lief, "Funding for Global Health in Developing Countries by the United States and Europe, 2000-2004,"a conference prepared for *Strengthening Transatlantic Cooperation on Global Health*, March 12-13, Paris, France.

workforce still fall far short of current need. According to a recent study by Jennifer Kates, J. Stephen Morrison, and Eric Lief, while total official development assistance (ODA) and official aid (OA), primarily supported by the U.S. and Europe, grew significantly between 2000 and 2004 from approximately $61.3 billion to $104.4 billion, the percentage of health ODA/OA that supported health infrastructure and training activities declined from a mere 3 percent in 2000 to 2 percent in 2004.[3]

The human resource gap poses a complicated and vexing set of policy challenges. Long-term solutions do not come easily. The health disparities between the developed and developing worlds are egregious, and the market demand in wealthier countries for skilled personnel often simply overwhelms efforts within poor countries to build human capacity, leaving these latter countries on a treadmill as they witness the continuous export of newly trained personnel. U.S. policymakers and their partners in both developing and wealthy industrial states are in need of integrated, multilateral strategies that effectively take account of the complex forces of the international health marketplace. That requires balancing the civil liberties of healthcare workers against the imperative to retain adequate staff to meet health emergencies like HIV/AIDS; navigating varied and complex immigration and international legal regimes; preserving the quality of U.S. health care systems—which rely heavily on foreign-trained health workers—while improving the quality of health in developing countries that lack human resources. This latter imperative will require heightened investments in medical training and facilities; improving the health and workplace conditions of the medical workforce; and bridging urban and rural imbalances in healthcare personnel distribution.

THE GLOBAL SHORTAGE

While statistical evidence detailing healthcare migration trends is not comprehensive, the global distribution of health workers is conspicuously out of balance, with steadily increasing migration, particularly of nurses, from rural to urban areas, from poor to rich regions within nations, from developing to developed nations, and from public to private sectors. Sub-Saharan Africa, for instance, holds 11 percent of the world's population, 24 percent of the global burden of disease, and only has 3 percent of the world's health workers.[4] Additionally, 57 countries (most in Africa and Asia) are facing a shortage of health care workers, and there are estimates that 4.25 million health workers will be necessary to fill that gap.[5]

Thousands of health-care workers in developing nations emigrate yearly to wealthier nations, including the United States. Though the decision by nurses, doctors, and other health service providers to leave their home countries is driven in most instances by the search for a better life, their movement in aggregate contributes to a dearth of public health capacity. For example, Africa loses about 20,000 health professionals each year to

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[3] *Ibid.*

[4] World Health Organization, "The Global Shortage of Health Workers and its Impact," fact sheet no. 302, April 2006. http://www.who.int/mediacentre/factsheets/fs302/en/print.html

[5] *Ibid.*

European and American medical facilities.[6] Currently about 25 percent of U.S. medical practitioners are foreign-trained, and indications are that the absorption of foreign skilled personnel is accelerating. [7] Such high losses sap the commitment of governments to fund healthcare services for their own populations as they witness their newly trained personnel move abroad. Some estimate that the global "loss" of investment in training for healthcare professionals is 1 billion dollars per annum.[8]

The transnational flow of health workers from developing to industrialized countries does not entirely account for the shortages seen in developing countries. [9] Severe poverty, unstable labor markets, deficient public funds, and bureaucratic red tape contribute to the underutilization of medical professionals in developing countries.[10] The HIV/AIDS epidemic has also taken a serious toll on the working populations—and therefore on the economies—of developing countries, hurting economies. In many Sub-Saharan African countries, between 18 percent and 41 percent of the workforce is already infected with AIDS.[11] Additionally, the disease has dramatically increased the medical workload of many doctors and nurses and has exposed healthcare professionals to stigma associated with treating HIV-infected patients.

Demand in developed countries for healthcare workers will continue to grow as technology advances, healthcare personnel retire and new health personnel are not trained, and the population continues to age. The health worker shortage in the United States is notable, particularly within the nursing sector. There are approximately 17,000 graduates annually from medical schools in the United States, but this number does not meet current demand, which exceeds this figure by 30 percent.[12] According to the Council on Graduate Medical Education a group authorized by Congress to provide continuous assessment of physician education data, if current trends continue, it is likely that the U.S. will face a shortage of approximately 96,000 physicians by the year 2020. Other studies have estimated that there will be a shortage of between 400,000 and 800,000 nurses in the U.S. by the year 2020.[13]

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[6] High-Level Forum on the Health MDGs, "Health Workforce Challenges: Lessons from Country Experiences," Abuja, December 2004.
http://www.hlfhealthmdgs.org/Documents/HealthWorkforceChallenges-Final.pdf

[7] Sabina Alkire and Lincoln C. Chen, "'Medical Exceptionalism' in International Migration: Should Doctors and Nurses Be Treated Differently?" *A Joint Learning Initiative: Human Resources for Health and Development,* JLI Working Paper 7-3, 2004.

[8] *Ibid.,* p. 10.

[9] High-Level Forum on the Health MDGs, "Addressing Africa's Health Workforce Shortage: An Avenue for Action." Abuja, December 2004.

[10] *World Health Report 2006*, *op. cit.*

[11] Vasant Narasimhan, *et al.,* "Responding to the Global Human Resource Crisis," *The Lancet*, Vol. 363, 1 May 2004, p 1470.

[12] Lincoln Chen and Jo Ivey Boufford, "Fatal Flows: Doctors on the Move," *The New England Journal of Medicine,* Volume 353:1850-1852. No. 17. October 27, 2005.

[13] Stephen Spotswood "Health Care Worker Shortage A Global Phenomenon." *U.S. Medicine*, March 2006.
http://www.usmedicine.com/article.cfm?articleID=1280&issueID=85

International Responses

The Joint Learning Initiative (JLI), coordinated by Dr. Lincoln C. Chen of Harvard University's Global Equity Alliance and comprising over 100 global members, seeks new strategies to cultivate human resources for health and development. Chen presented the JLI's findings at the High-Level Forum on the Health MDGs at the WHO in Geneva in January, 2004. Major recommendations included improving work environments, education, and economic policies that support growth; country-based strategies that engage many sectors; and an action alliance to implement human resources for the health MDGs.[14]

Subsequently, Chen, joined by various U.S.-based and international organizations, led an initiative in January 2006 urging President Bush and members of Congress to increase the U.S. investment in addressing the health worker deficit. They called for the United States to contribute a one third share—$650 million of an estimated total annual requirement of $2 billion—to address the global health worker shortage.[15]

The recently released 2006 World Health Report details the impact of the deficit on the health of nations worldwide and provides evidence of the positive relationship between the number and quality of health workers with child and maternal survival rates, immunization coverage, and primary care outreach. In addition, the report specifically discusses the toll the HIV/AIDS pandemic has taken on the health workforce in many regions of Africa and the need for better strategies to build human resources, ensuring that money and drugs provided by PEPFAR and other foreign aid programs are not wasted. Finally, the report outlines a 10-year plan of action to address management, education, planning, training, enabling policies, and calls for national leadership to respond on the national and global levels.[16] (see Figure A.)

In May 2006, the WHO launched the Global Health Workforce Alliance, a global organization designed to combat the global shortage of health workers by raising political awareness, connecting public and private sectors, and developing country-based strategies. An alliance program called the Fast Track Training Initiative, aimed at increasing qualified workers by mobilizing financial support for training facilities, will establish relationships between schools in industrialized and developing countries, and cultivate support and expertise from leaders in industrialized countries. [17]

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[14] Lincoln Chen, "Harnessing the Power of Human Resources for Achieving the Health MDGs," High-Level Forum of Human Resources for Achieving the MDGs, World Health Organization, Geneva. January 9, 2004.
[15] Health Gap, "Urgent Call for U.S. Initiative on Health Workforce in AIDS-Impacted Countries," January 2006. http://healthgap.org/camp/hcw_docs/HCWcall.pdf
[16] *World Health Report 2006*, *op. cit.*
[17] Official website of the United Nations, "New UN-backed alliance seeks to reverse worldwide doctor, health worker shortage," May 25, 2006. http://www.un.org/apps/news/story.asp?NewsID=18612&Cr=health&Cr1

U.S. RESPONSE

The President's Emergency Plan has dedicated $150 million of its $15 billion to human resource capacity building to address the health worker deficit, which includes efforts focusing on local organization capacity development; workforce recruitment, retention, deployment, and reward; and training activities aimed at providing HIV/AIDS services.

In March 2005, Senators Richard Durbin (D-IL) and Chuck Hagel (R-NE) reintroduced the Public Health Workforce Development Act which seeks to increase the supply of qualified public health workers at the federal, state, and local levels by offering scholarships to those entering health professions and loan repayments to employees who remain in the public health field for a certain number of years. The Hagel-Durbin bill designates $35 million per year for scholarships to encourage young people to enter into public health professions and $195 million per year for loan repayments for those who remain in the sector.

Senator Durbin also introduced a global healthcare cooperation amendment to the comprehensive immigration reform bill that passed the Senate in May 2005. The amendment would require foreign health professionals applying to work as health care professionals in the United States to answer whether they were contractually obligated to work in their home country in exchange for educational support. If so, these health professionals would be required to fulfill the commitment to their home country before being admitted to the United States to perform healthcare work. This amendment would also allow legal permanent resident health professionals living and working in the United States to travel to developing nations to provide assistance with health emergencies without fear of compromising their own immigrations status.

In addition to these efforts, Senator Durbin is currently preparing a bill that authorizes the U.S. government to dedicate up to $150 million in additional funding to help African countries build more effective health systems and train and retain doctors, nurses, and paraprofessionals. The Durbin bill as drafted emphasizes the importance of building health capacity in the battles against HIV/AIDS, malaria, and other challenges. This legislation had not been introduced at the time this brief was written.

In June 2005, Senator Bill Frist M.D. (R-TN) introduced legislation in the Senate calling for the creation of a Global Health Corps, an international health initiative akin to the Peace Corps. The Office of the Global Health Corps would be focused on improving the welfare and development of foreign countries by providing health care personnel and health services to select countries through a corps of paid health care professionals and volunteers from the U.S. The Global Health Corps would comprise U.S. government employees as well as non-federal volunteers (private-sector physicians and nurses) and other trained health professionals. [18] Thus far, this legislation has not been passed.

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[18] S.850, "A bill to establish the Global Health Corps, and for other purposes," sponsored by Sen. William Frist, introduced April 19, 2005. Available on Library of Congress Thomas Web site: http://thomas.loc.gov/cgi-bin/bdquery/z?d109:s.00850:

ELEMENTS OF A U.S. STRATEGY

The United States can build upon existing efforts to combat the growing health workforce gap through a coordinated, multi-lateral approach matched by higher financial commitments. An effective U.S. strategy will respond to immediate healthcare challenges in developing countries while also creating sustainable healthcare delivery models. To do this, the U.S. can turn to several options:

1. Make human capacity-building a priority and strengthen bi-lateral commitments. In order to garner a higher level of financial support, U.S. policymakers should engage on this issue at a senior level, and more closely integrate congressional initiatives with the ongoing work of OGAC. The U.S. can place a greater emphasis on development of health professional capacity in developing countries within its global AIDS work, and beyond—for example integrating capacity-building in other major initiative s like the President's Malaria Initiative and engaging more fully on this issue with multilateral institutions like the World Bank and Global Fund.

2. Develop new healthcare delivery and training models and revise existing human resource policies. U.S. policymakers can devise strategies that expand the field of health workers beyond nurses and doctors to include non-traditional health professionals trained in administering certain basic health services. There is a rich experience emerging from PEPFAR and other projects that should be harvested so that policymakers can begin to synthesize lessons and accelerate systematic adoption of new models. New models can utilize "piggy-backed" services that combine the delivery of certain medical services (such as administering vaccines and vitamins simultaneously) as recommended by the WHO. National and international policies and political and legal regulations can be modified to permit the use of non-traditional health delivery systems within developing nations.

3. Create a health workforce technical working committee within OGAC. The health workforce deficit is a complex issue in urgent need of a focused U.S. approach. A technical working group, similar to that created to address the integration of sexual and reproductive health and HIV/AIDS services, would be a useful mechanism for exploring the various layers of this issue, and providing guidance for the U.S. government. This committee could include experts from a variety of sectors including other U.S. agencies, academia, private corporations, and the NGO community. Any U.S. strategy will need to take account of the U.S. domestic healthcare worker deficit. The United Kingdom has begun to develop a more "joined-up" human resources capacity approach that brings both domestic and international health capacity agendas together. For example, UK NHS has looked at how it can more systematically encourage exchanges of health personnel with developing countries, resulting in a number of win-win arrangements.

4. Coordinate with regional organizations and international bodies to set national human resource protocols. Because of the transnational nature of this issue, the U.S. policymaking community should engage at a national, regional, and international level, to

create health workforce training standards. Protocols could include setting recruitment and placement procedures and training human resource managers, as suggested by Physicians for Human Rights. Tools, such as the WHO international human resource database, can be further expanded and exchanged to give donors an indication of progress in human resource development.[19] Policymakers can coordinate with international organizations, such as the Pan-American Health Organization that already has human resource capacity observatories, or the Health Metrics Network, for example,to strengthen country health information systems so as to measure the success of improved human resource procedures.

[19] A Report by Physicians for Human Rights: "An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa." Boston, MA. June 2004.