Health Worker Shortages and Global Justice

by Paula O’Brien and Laurence O. Gostin
The world is experiencing a serious human resource shortage in the health sector, which the World Health Assembly calls “a crisis in health.” The World Health Organization (WHO) estimates that 4.3 million more health workers are required to meet the health Millennium Development Goals (MDGs)—a global compact to reduce child mortality, improve maternal health, and combat AIDS, malaria, and other diseases by 2015. But even this alarmingly high figure significantly underestimates the global need for human resources because the WHO only accounts for shortages in 57 countries that miss the minimalist target of 2.28 doctors, nurses, and midwives per 1,000 in the population. These 57 countries have “critical shortages,” but the WHO estimate does not take into account the shortages of health workers experienced in countries who provide services in excess of basic immunizations and childbirth attendance. The agency does not factor in the shortages that emerging and developed countries claim to be experiencing. Nor does it factor in the marked human resource disparities among countries and regions, which reveal that shortages in low-income countries are actually much worse.

The global human resource shortage is certainly much greater than 4.3 million health workers. And the shortage includes more than physicians and nurses—extending to health workers across the spectrum, including pharmacists, dentists, laboratory technicians, emergency medical personnel, public health specialists, health sector management, and administrative staff.

The human resource crisis affects developed and developing countries, but the global poor suffer disproportionately, not only because they have a much smaller workforce but also because their needs are so much greater. Of the 57 countries with critical shortages, 36 are in Africa. Africa has 25% of the world’s disease burden, but only 3% of the world’s health workers and 1% of the economic resources. In particular, there is an extreme imbalance in the distribution of the estimated 12 million working nurses worldwide: the nurse-to-population ratio is 10 times higher in Europe than in Africa or Southeast Asia, and 10 times higher in North America than in South America.

These sterile numbers mask the real human tragedy of health personnel shortages. Where there are vastly inadequate numbers of health workers trained and employed, people cannot enjoy the good health that will enable them to flourish. They have fewer opportunities to prevent and treat injuries and diseases or to relieve pain and suffering when they are sick or dying. According to the WHO, in many poor countries, the lack of health workers is a major factor in the deaths of large numbers of individuals who would survive if they had access to health care.1

The WHO asserts that health workforce shortages have replaced system financing as “the most serious obstacle” to realizing the right to health within countries.2 Certainly, health workforce capacity building should not be the sole focus of national and international efforts to improve health. There are numerous competing health agendas, including financing and universal coverage,3 as well as meeting “basic survival needs,” including food, clean water, sanitation and sewerage, vector control, and tobacco control.4 Yet, most health services cannot be assured in the absence of trained health workers. There is little point, for example, in delivering containers of drugs and medical equipment to a country if there are no skilled professionals to deliver these goods to the people who need them.
The causes of the human resource shortages are multifaceted and complex, but not so complex that they cannot be understood and acted upon. The factors that produce health workforce shortages are not the same in all countries or in all parts of countries. In designing solutions, policymakers must take account of local causes and conditions. However, some factors are common across cultures, even if their local manifestation may vary. For example, in most countries with shortages, there is inadequate funding of health worker education and training.

Some of the causes of local health workforce shortages are “homegrown” due to inadequate planning, financing, and policy. However, local shortages can also be caused or exacerbated by conditions in other countries. One country’s domestic and foreign policies can significantly affect health worker shortages in other countries. These policy choices are often made without regard for the potential negative impacts on the health workforce in other countries. Governments may not intend to cause harm outside their borders, but public officials may either be unaware of the effects or simply too focused on domestic political concerns. Developed countries, for example, often rely significantly on foreign-trained health workers to staff their health systems. These developed countries do, or ought to, know that many workers come from countries that desperately need more health professionals themselves.

In this report, we make the case for the United States government to seriously address the problem of the global human resource shortage, particularly in the most disadvantaged countries. The United States has an important role to play in addressing this shortage, as do many other rich countries. By focusing on the United States, we are not suggesting that the United States bears responsibility for the current problem. As we discuss in the report, there are many factors that contribute to the shortage, and the practices in many countries have a profound impact on the global shortage of health workers.

Nevertheless, the United States is well-placed to play a critical leadership role for several reasons. First, an effective response to the worldwide human resource shortage requires global cooperation, in combination with international, national, and local initiatives. Each country must make a contribution to solving this difficult and entrenched problem by examining the domestic and international actions it can take to reverse it. With its global leadership status, the United States can, by its response, become a model for other developed countries.

Second, the United States is a contributor to the global workforce shortage but also has the capacity to make a significant difference in addressing it. The United States has not demonstrated a commitment to pursue a policy of national self-sufficiency (or at least a high level of self-sufficiency) in the production of local health workers. Because of its failure to plan for the education of American health workers, the United States relies on large numbers of migrant health workers to keep its health system fully operational. The United States, as well as Western Europe and other highly developed regions, has become a magnet for foreign-educated physicians and nurses. Although the United States absorbs the largest numbers of foreign-born doctors and nurses in absolute terms, there are many rich countries that, in relative terms, are much more reliant on migrant health workers. Countries like
Canada, the United Kingdom, Australia, and New Zealand all have higher levels of relative reliance on foreign-born doctors and nurses than the United States. Nevertheless, these data suggest that all rich countries, whether their use of migrant health workers is more or less, in relative or absolute terms, must recognize their role in the shortage and take remedial steps as a matter of urgency.

Third, the current policy environment in the United States presents the opportunity for the government to make major commitments to the global health worker shortage. Successful implementation of the Affordable Care Act, which will extend insurance coverage to an additional 30 million people, requires an expanded workforce. Delivering health services to these people requires rethinking the United States’ approach to health workforce creation and retention. The United States need not necessarily train ever-increasing numbers of health workers. Rather, it is the right moment to reconstitute its health workforce composition, determining the best mix of health workers needed to keep Americans well and care for those who are sick.

The current US policy context also includes an overhaul of the United States’ global health assistance program, known as the Global Health Initiative (GHI). The changes promised by the GHI also suggest that it is time to focus on the global workforce shortage. This focus would fit well with the GHI’s core principle of integration across government agencies. It would also be entirely consistent with the “basic health needs” approach that advocates are urging. Such a revision of US global health policy would signal a shift from a disease-specific orientation towards a concern with whole communities having the basic goods and services they need to stay healthy.

Recognizing the moral responsibility and capacity of the United States to make a difference, we offer seven recommendations. We understand that public officials have to make difficult trade-offs among a range of policies and resource allocations. We have selected policy interventions, which, to the greatest extent possible, are supported by evidence or have been shown to be effective through experience. We also acknowledge that there is a need for more high-quality research into the effectiveness of programs and activities.

In formulating these seven recommendations, we consider the scope of the global shortage (chapter 2) and address the underlying causes (chapter 3). We also craft solutions that take into account and carefully balance the rights, interests, and obligations of major stakeholders. We analyze in detail the interests and rights of individuals and communities whose health is at stake and of health workers who are in short supply but should not be seen as tradable commodities (chapter 4). We also examine the interests and obligations of governments (interchangeably referred to as states or countries), but especially the US government, from four perspectives: government responsibility for the health of its inhabitants; government responsibilities for the health of people in other states; government policies toward migrant health workers; and government policy toward health worker emigration.

This “mapping” of rights, interests, and obligations starkly reveals the common and contested ground among the diverse actors. Our recommendations take account of these conflicts of interests and rights, particularly those that may stand as a barrier to the US government in solving complex health workforce problems.
Although our recommendations are directed to the US government, a range of other actors has a
major stake and can assist in finding innovative solutions. These actors include state/tribal and local
governments, health professionals and their trade associations, academia, health insurers, labor, and
business. The federal government must provide leadership, but it will need the full involvement of the
range of interested parties.

The following is a brief description of our seven recommendations, which are discussed in detail
in chapter 5.

**RECOMMENDATION 1:**
The administration, in collaboration with states and other stakeholders, should develop a
strategic plan for addressing the health worker shortage in the United States.

A considered national plan for responding to the domestic human resource shortage does not
currently exist and is urgently needed. In developing the plan for its own workforce, the United States
should consider how it would affect low- and middle-income countries. The plan should outline, with
some specificity, the strategies that will be pursued to meet domestic human resource needs.

**RECOMMENDATION 2:**
The administration, using an “all-of-government” approach, should develop a strategic
plan to address the global health worker shortage.

The administration, in partnership with major stakeholders, should develop a strategic plan for
addressing the global shortage of health workers. The plan should link to the domestic health system
and to migration policy, as well as to foreign development assistance. The plan should adopt an “all-of-
government” approach, involving stakeholders from all levels of government and the private sector.

We recommend that the plan include a commitment to adopt a tool to assess the impact of
domestic and foreign policies on the health workforce in other countries. The plan should embody
the content of recommendations 3–7.

**RECOMMENDATION 3:**
The administration, with congressional support, should provide global leadership in
addressing the global health worker shortage.

The United States should support bilateral and multilateral institutions and mechanisms that are being,
or could be, used to address the global health workforce shortage. In particular, we recommend that the
United States vigorously implement the WHO Global Code of Practice on the International Recruitment
of Health Personnel (WHO Code) and ratify the International Convention on the Protection of the
Rights of All Migrant Workers and Members of Their Families (Migrant Workers Convention).
The United States should use bilateral and multilateral agreements to embody its specific commitments to solving the global health worker shortage. The agreements could cover health workforce self-sufficiency for the United States and partner countries; financial and technical support for health workforce capacity building; managing and monitoring health worker migration between countries; knowledge and skills development programs for migrant health workers; collection and sharing of data on migration; protections for migrant health workers, including portability of payments made to pension plans during service in the United States; and facilitating remittance transfers and the diaspora in the United States to assist with the development of the health systems in migrant workers’ home countries.

The proposed Framework Convention on Human Services (FCHS) currently being developed by the World Bank, in collaboration with the O’Neill Institute on National and Global Health Law at Georgetown University, for the Caribbean Community (CARICOM), provides a model for the United States. Although the process will require buy-in by governments in the Caribbean, the CARICOM FCHS, if successful, will be an international agreement designed to ensure cooperation and capacity building for human resources throughout the region. It would coincide with the new single-market economy providing a common market for trade in goods, services, capital, skills, and free movement of labor.

**RECOMMENDATION 4:**
The administration and Congress should reform US global health assistance programs to increase health workforce capacity in partner countries.

The United States should reorient the focus of its global health assistance programs to health system strengthening. The most important contribution that the United States can make to resolve the shortage of health workers in poor countries is to provide financial and technical support for the training, employment, and retention of local health workforces. This should be a major part of the Global Health Initiative. The United States should support countries with critical health workforce shortages to address the underlying causes of the shortages. Task shifting (being the notion of delegating tasks from more- to less-specialized health care workers who can competently and safely perform the task) and increasing the numbers of community health workers, primary health care professionals, public health professionals, and health care managers and administrators should be key components of these programs.

The designation of 20 “Global Health Initiative Plus” countries offers an opportunity for the administration to evaluate strategies for addressing the difficult and deep causes of the global health worker shortage. For example, finding ways to improve health worker retention would be a valuable focus of such research.
RECOMMENDATION 5:
The administration, together with Congress, should increase financial assistance for
global health workforce capacity development.

The US government has made major new financial commitments to global health for the period 2009–
2014, even though the budget deficit debates place those commitments in jeopardy. The United States
has promised US$63 billion over six years, although the current budget deficits will place a major
strain on foreign assistance programs.

Even if all the financial commitments are fulfilled, they will still fall short of the Institute of
Medicine (IOM) recommendation that the United States double its annual commitment to global
health between 2008 and 2012 from $7.5 billion to $13 billion. The IOM figure is based on three
assumptions: a Gross National Income (GNI) for the United States in 2012 of US$15 trillion; 0.54% of
GNI being spent on official development assistance (with this being the rich country average in 2008);
and 16% of official development assistance being spent on health. We urge the US government to
consider progressing towards the target set by the IOM.

We also recommend that the increased budget for global health expenditure be used to
adequately resource health workforce development programs.

RECOMMENDATION 6:
The US government, in collaboration with its partners, should increase the number of
health workers being trained in US institutions for service in the US health system.

The United States should increase its domestic production of health workers to meet most of the
national demand. Positive first steps can be seen in the Affordable Care Act, which has made large
financial commitments to health workforce development. However, further financial commitments
will be required to meet the demand for health workers in the future.

The private sector should also increase its commitment to training and education. There is a
pressing need for innovation in health worker training to enable the graduation of larger numbers of
competent health workers to meet the national demand.

It is vital to stress, however, that this effort does not simply mean training more physicians and
nurses. Rather, it requires a strategic examination of the health needs of individuals and communities
and the determination of the most appropriate mix of services to meet those needs. Task shifting,
community health workers, primary health care, and public health should be key components of
these strategies. There is good evidence of the success of these methods in providing access to health
care, reducing health disparities, improving quality of care, and capping health care costs.

Innovation is required to ensure that there are increased levels of retention in the health
workforce and that competent professionals are available in poor and rural communities.
RECOMMENDATION 7:

Congress should empower the Department of Health and Human Services or another appropriate agency to regulate the recruiters of foreign-trained health workers.

The federal government should regulate the recruitment of migrant health workers. Protection of migrant health workers is essential. The benefits of migration to development are maximized when migrant workers’ rights are properly safeguarded. The Migrant Workers Convention and the WHO Code should be followed in designing this regulatory model. The Convention should be implemented in full in domestic law. The Voluntary Code of Ethical Conduct for the Recruitment of Foreign-Educated Nurses could also form the basis of a US regulatory regime for the protection of migrant workers in relation to the conduct of recruitment companies.

The seven recommendations outlined in this report would reform policies and programs to improve human resources in the health sector in the United States and beyond. The United States has a clear national interest in reforming its human resources policies domestically and globally. These recommendations suggest how the federal government can best perform this task. The benefits of doing so would flow to Americans and others around the world, particularly to the most disadvantaged.