Workforce issues in public health

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Aims

- Relate workforce issues and productivity mix to essential functions of public health
- Highlight issues relating to ‘brain-drain’, ‘brain-waste’ and ethical recruitment of nurses and doctors globally
- Discuss strategies for improving the quality, quantity, distribution and productivity of human resources in the health sector

Results from Australian Delphi Study, 1999 (p28)

Functions relating to quality assurance, human resource development, and organisational structures rated the most highly for the public health management function category (Table 17.6). All of the functions within this category had 75 per cent or more people rating them as always or often public health functions.

Table 17.6 Detailed list of public health functions ranked by "always" percentage – public health management

	Always a public health function (core)	Often a public health function	Sometimes a public health function	Not a public health function
6.4 Developing and implementing quality assurance processes for public health	69.9	23.3	5.5	1.4
6.5 Human resource development in the public health workforce	60.3	27.4	11.0	1.4

Overview of Human Resources for Health issues

- Global imbalance: e.g. oversupply of doctors in Cuba, India, Cuba and Eastern Europe, under-supply in most Sub-Saharan African countries (e.g. 1: 30,000 patients in Ethiopia, Vs. 1: 300 in the EU) and in remote areas of countries like Australia. Ratio is Australia varies from 1:730 to 1: 2860
- 4.3m health workers required in 57 countries
- The major health workers' resource issues are quantity, quality and distribution. Health workers determine output and productivity; they manage other health resources, and a large part of the health budget is spent on health workers (JLI, 2004).

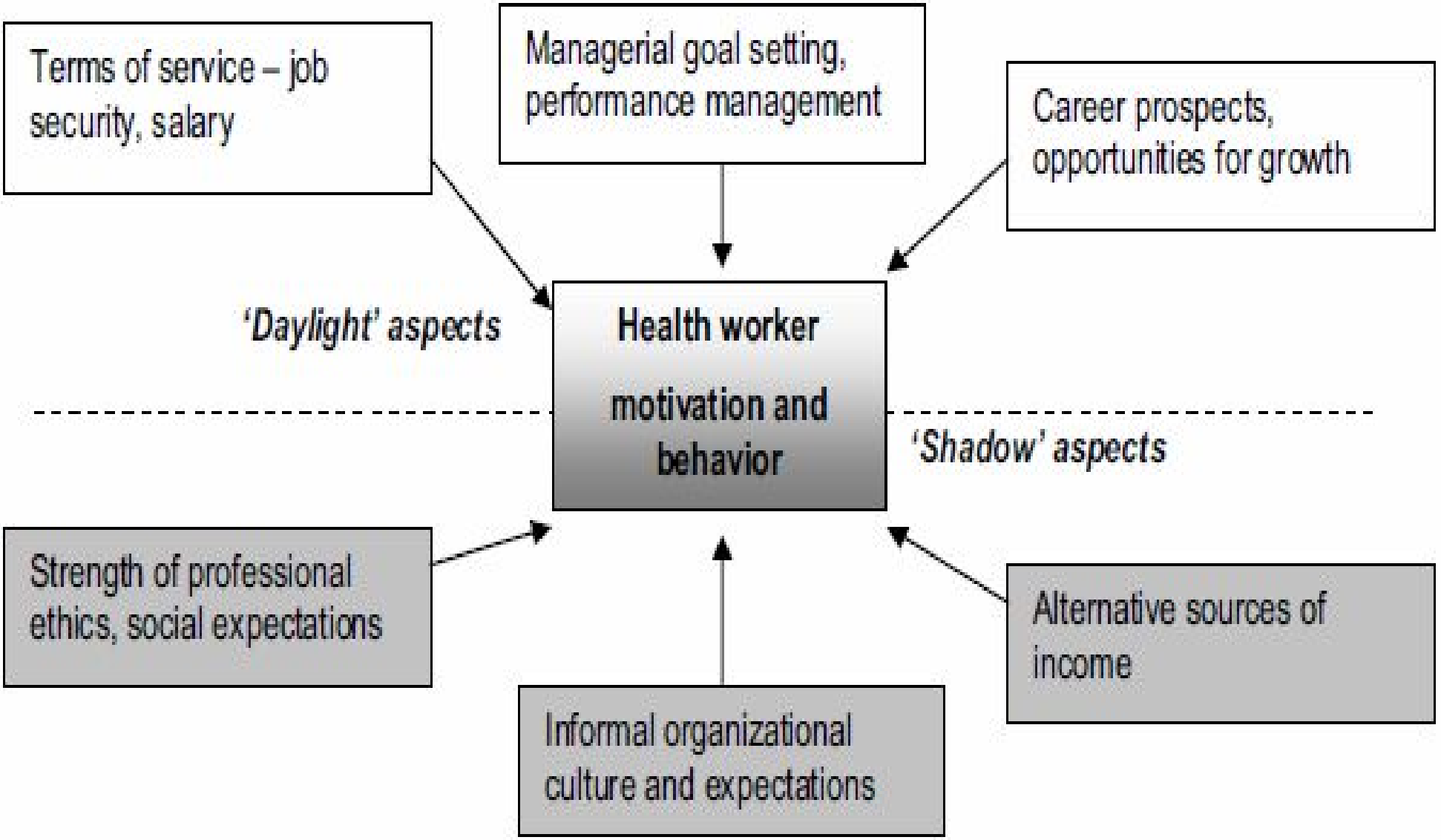
HRH case study: Nigeria

- ~20% of 2000 legally emigrating African nurses are from Nigeria.
- Low salary is major incentive to migrate: e.g. a senior staff nurse in Nigeria is paid ~$350 per month, while s/he could earn around $1500 monthly in the Persian Gulf and $3,000/month in Australia.
- More than 40 per cent of Nigerian-trained doctors are currently based in Middle East, Europe and America
- Other issues: ‘brain-waste’, job dissatisfaction and poor work safety. Importantly, few opportunities exist for overseas-based Nigerian workers who wish to return to work in Nigeria.

HRH case study: Australia

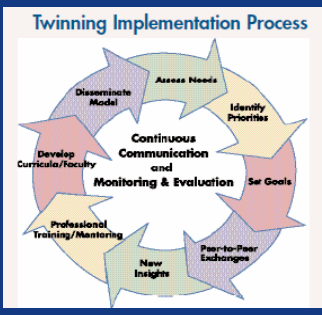
- Number of expatriate doctors arriving in Australia to work in ‘areas of need’ increased from 667 in 1993 to 2899 in 2002. 15% of overseas doctors are from India
- ‘Recommended’ GP patient ratio -1: 1200. Current ratio – 1: 1450. For dentists, current ratio - 1:2000. Higher ratios in rural areas.
- 5000 overseas-trained nurses enter Australia to work annually.
- Contributory factors include inadequate medical workforce and reluctance of Australian-trained doctors to work in rural/remote areas.

Factors influencing health workers performance (Fritzen, 2006)



Sustainable health workforce framework (Dal Poz et al, 2006)

Workforce education strategies (Crisp et al, 2008)



Panel 2: Strategies for improving health-worker education and training

- Reduce attrition among students and teachers, and improve accessibility
- Integrate preservice and in-service training
- Develop common educational platforms for different types of health worker
- Move learning to the community, using modular education and action learning
- Increase use of information and communication technologies
- Improve education through quality assurance programmes
- Build institutional capacity by:
  - Expanding teaching capability
  - Fostering twinning and partnerships
  - Maximising impact through regional approaches
  - Harnessing public–private partnerships