McMaster University | HEALTH FORUM

Evidence Brief

Addressing the Global Health Human Resources Crisis

6 July 2023

Box 1: Approach and supporting materials

This document was prepared to inform an international stakeholder dialogue, which provides individuals – specifically those who will be involved in or affected by decisions about addressing the global HHR crisis – with an opportunity to deliberate about the problem and its causes, elements of an approach for addressing it, key implementation considerations, and next steps for different constituences. A separate document contains six appendices:

1) background and methods for preparing the evidence brief
2) jurisdictional scan of efforts at the global, regional and country level to recruit ethically, make workplaces 'excellent' and share more and better HHR data
3) evidence syntheses relevant to recruiting ethically (element 1)
4) evidence syntheses relevant to making workplaces 'excellent' (element 2)
5) evidence syntheses relevant to sharing more and better HHR data (element 3)
6) references.

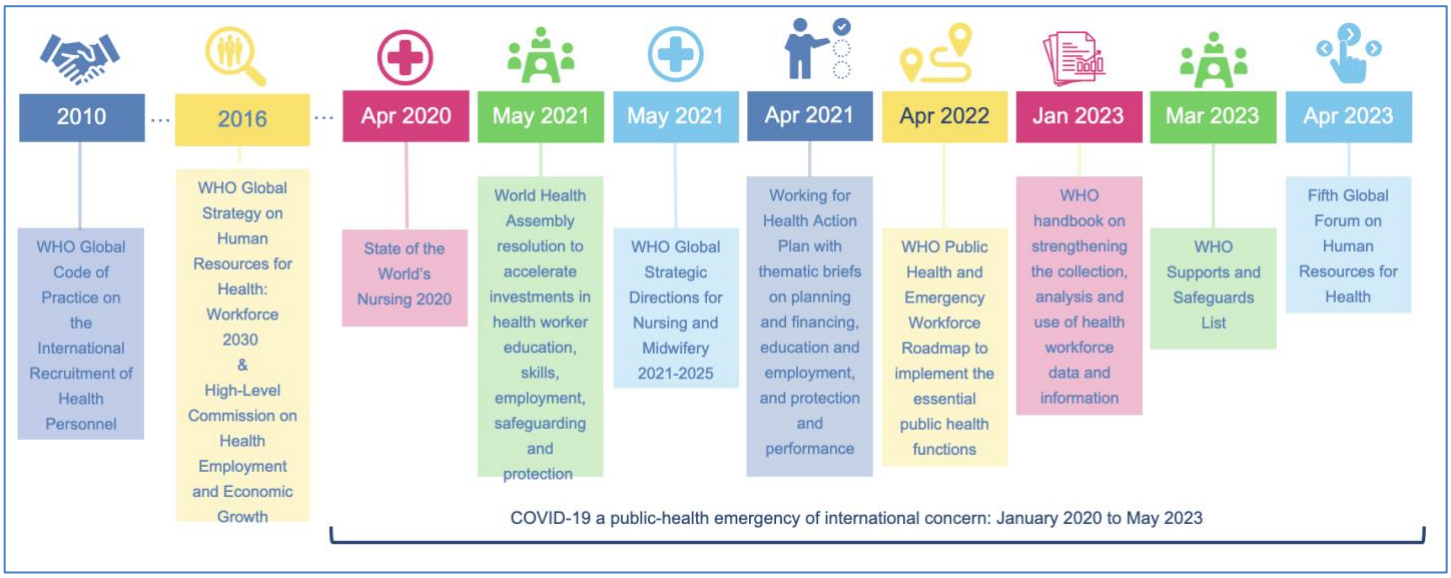
Context for the brief

Governmental policymakers and system and organizational leaders in almost all countries are grappling with the best ways to manage the global health human resources (HHR) crisis, which has worsened during the COVID-19 pandemic. This crisis is characterized by:

- high rates of burnout, attrition and turnover among nurses and many types of health workers (1-2)
- shortages and workforce distribution issues (e.g., the World Health Organization estimates a projected shortfall of 10 million health workers by 2030, mostly in low- and middle-income countries)(3)
- migration issues (e.g., it is estimated that globally, one in eight nurses are migrants, typically migrating to more developed countries)(4)
- lack of timely access to essential care for those most in need.(3)

The global HHR crisis has long and deep roots. Little has been done in a substantive way to prepare society, health and social systems and workforces to address unprecedented levels of predicted demographic changes. In fact, government policymakers, system and organizational leaders, professional leaders and researchers have over many decades developed a broad policy framework to address the HHR crisis – including the components of planning and development, deployment and service delivery, and support and retention – albeit with some variation over time in language and approaches to categorization. What we have not seen is transformative change based on this framework.

Several global initiatives have been advanced in recent years to bring about change (see timeline below). These initiatives have built upon foundational documents such as the World Health Organization (WHO) Global Code of Practice on the International Recruitment of Health Personnel (henceforth called the 'WHO Code of Practice') which, although established over a decade ago, is still considered essential in framing discussions about global HHR issues. Taken together, these initiatives suggest that, while the pandemic exacerbated global HHR challenges, it also created a sense of urgency among decision-makers around the world to advance international discussions about how best to address HHR challenges as part of broader health-system transformation efforts – in particular about how to recruit, retain, reskill and support health workers, and about what kind of organizational and skill-mix changes can support and enhance the delivery of more efficient and integrated models of care.(5)

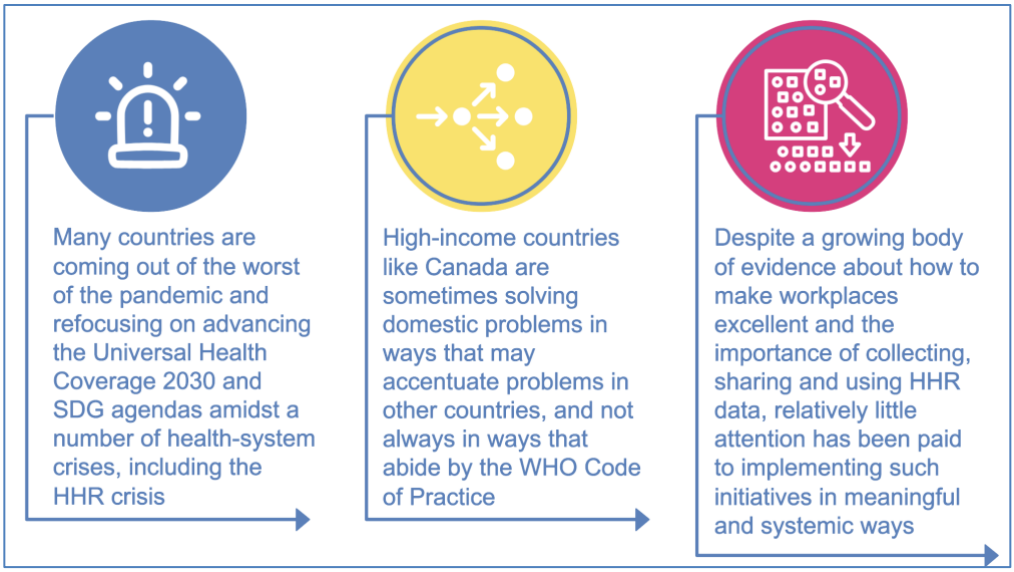


The urgency associated with the HHR crisis has resulted in a growing awareness that it poses a serious threat to equity, health systems and global health, and presents an obstacle to achieving universal health coverage (UHC) and the Sustainable Development Goals (SDGs).(2-3) At the 152nd WHO Executive Board meeting in January 2023, Dr. Tedros Adhanom Ghebreyesus, WHO Director General, identified the health workforce as an international priority for the next five years, further amplifying the importance of finding solutions to the crisis.(6)

This evidence brief draws on the best-available research evidence and insights from a jurisdictional scan to describe key aspects of the problem, elements of a potentially comprehensive approach for addressing it and implementation considerations that can inform next steps. When appropriate, it will direct attention to how the issues affect the nursing workforce, which is the largest among all health professions globally,(4) and from which lessons learned may be applicable to many other types of health workers.

The problem: HHR is one crisis among many and the crisis has many dimensions

There are at least three major dimensions of the global HHR crisis, which we discuss in turn below.



Many countries are coming out of the worst of the pandemic and refocusing on advancing the universal health coverage 2030 agenda amidst a number of health-system crises including the HHR crisis

Our collective emergence from the worst of the COVID-19 pandemic presents a unique opportunity for government policymakers, system and organizational leaders, professional leaders and citizens to reinvigorate equitable and sustainable progress towards universal health coverage – the main goal of the UHC2030 initiative – as well as towards achieving the SDGs. Unfortunately, most countries are not currently on a path towards achieiving these global goals,(7) with a recent report from UHC2030 indicating that the COVID-19 pandemic stalled what was already slow progress towards achieving UHC.(8) The UN has also indicated that the world is 'tremendously off track' in its collective efforts to achieve the SDGs by 2030.(9)

The HHR crisis is both a threat to progress towards achieving these goals, and a challenge that needs to be considered alongside many other health- and social-system crises facing decision-makers (e.g., those driven by geopolitical tensions and global economic uncertainty). This multitude of interrelated crises means that decision-makers are forced to selectively focus their attention on a few prominent policy issues at a time, while struggling to build momentum to address targeted challenges like the HHR crisis, as well as the broader societal challenges for which HHR is key, including UHC2030 and the SDGs.

High-income countries like Canada are sometimes solving domestic problems in ways that may accentuate problems in other countries, and not always in ways that abide by the WHO Code of Practice

Efforts to manage the health workforce often involve decisions that have global implications, with strategies adopted in one jurisdiction (e.g., increasing efforts to recruit internationally educated nurses) leading to the creation of challenges in another (e.g., an inability to retain nurses to achieve goals such as UHC).(10)

Increasingly, initiatives such as the WHO Health Workforce Support and Safeguards List – which identifies 55 countries with low health-workforce density and a low UHC service coverage index, and as such are particularly vulnerable – are acknowledging this and emphasizing the need for government policymakers and system and organizational leaders to manage the workforce with these international dynamics in mind.(10) While managing the health workforce ought to be approached with collective benefit as a guiding principle, this is often not the case.

In particular, high-income countries have been recruiting nurses and other types of health workers from low- and middle-income countries for decades, particularly when their domestic efforts have not established a sufficient domestic supply of health workers that is distributed to meet the needs of their citizens. In such instances, it is often more cost-effective for them to recruit from developing countries to solve their domestic problems.(11)

As noted above, the migration of nurses and other types of health workers has significant impacts. It exacerbates the ethical, economic and social inequalities between source and destination countries, and can destabilize health systems in source countries. Therefore, continued unrestricted international recruitment of nurses and other types of health workers has become a global threat.(11)

The WHO Code of Practice was adopted in 2010 to move forward with solutions to manage these threats.(12) It establishes the ethical principles that should underpin the international recruitment of health personnel, with an emphasis on ensuring recruitment strengthens (or at least does not directly weaken) the health systems of low- and middle-income countries.(13) The WHO Code of Practice continues to serve as an important guiding framework that is invoked in nearly all global discussions about HHR. Unfortunately, there are few (if any) levers available to enforce the WHO Code of Practice, which has led to continued challenges in protecting the world's most vulnerable health systems.(14) It is also worth noting that the dynamics between source and destination countries are evolving, with jurisdictions like the Philippines transitioning away from a universal openness to sending

domestically educated health workers (particularly nurses) abroad, as they grapple with the many health-system challenges created or made worse by the COVID-19 pandemic.(15)

Despite a growing body of evidence about how to make workplaces excellent and the importance of collecting, sharing and using HHR data, relatively little attention has been paid to implementing such initiatives in meaningful and systemic ways

As noted above, the HHR crisis is characterized in part by high rates of burnout, attrition and turnover among nurses and many other types of health workers.(1-2) While these issues have historically been a challenge for health-system leaders, they have been made worse by the COVID-19 pandemic.

We have amassed decades of rigorous evidence about what works to foster healthy workplaces and about adequate nurse staffing for providing a safe care environment (for example, the work on 'magnet' environments for nursing practice started more than 40 years ago). However, very few efforts within countries have focused explicitly on improving workplaces for nurses and other health workers with the aim of improving well-being specifically (see Appendix 2). For example, in responding to the HHR crisis, Canadian provincial and territorial governments recently focused on recruitment and retention (often with financial incentives underpinning these efforts) and investing in the supply of health workers by increasing 'seats' in professional education programs, without targeted efforts to improve workplaces for nurses and other health workers.(16) Indeed, there is a need to focus more on fostering workplaces where health workers can experience joy and have a sense of accomplishment and meaning in their contributions, while mitigating levels of stress and burnout.(17)

In addition, there is a need to align accreditation standards to considerations related to making workplace excellent. In some countries like Canada, it has been a longstanding concern that healthcare settings like hospitals are able to achieve a gold standard of accreditation while being somewhere between challenging and terrible places to work. If any hospital is to achieve top level accreditation for care, some argue that it must be mandated to achieve the same for the people working there.

Lastly, little attention has been paid to strengthening data infrastructure, and capacity to collect, share and use HHR data in ways that can directly inform decision-making and planning.(4) As shown in Appendix 2, while many strategies exist across jurisdictions that focus on digital health and data strategies, few focus on HHR data specifically, and even fewer appear to have led to concrete actions. Ideally, accurate, comprehensive and comparable HHR data should be made available to inform decision-making within and across jurisdictions, although achieving this requires extensive collaboration among key stakeholders (e.g., government policymakers, regulatory bodies, professional associations and educational institutions), which can be difficult domestically, let alone internationally.(2; 4)

Elements of a potentially comprehensive approach for addressing the problem

Many approaches could be selected as a starting point for deliberations about addressing the global HHR crisis. To promote discussion about the pros and cons of potential approaches, we have selected three elements of a larger, more comprehensive approach to address the global HHR crisis. The three elements were developed and refined through consultation with the steering committee and key informants who we interviewed during the development of this evidence brief. We present below the three elements and look at what we know so far about them based on the best evidence we found. We also explore how these elements are being rolled out in a purposively selected sample of countries.

Recruit ethically

Element 1 focuses on ensuring that, when international recruitment of nurses and other types of health workers from other countries is necessary, steps are taken to ensure the approach abides by the WHO Code of Practice and the WHO Health Workforce Support and Safeguards List.(10; 12) Drawing on these frameworks, this approach would ideally include the following components:

- ensuring approaches to recruitment are transparent, fair and don't undermine the sustainability of source provincial/territorial/national health systems (hereafter source health systems)
- ensuring approaches to recruitment are not in conflict with or do not contravene the legal responsibilities of nurses and other types of health workers within their 'home' health system (e.g., return-to-service agreements)
- facilitating circular migration of nurses and other types of health workers so that both source provinces/territories/countries and destination provinces/territories/countries (hereafter source and destination jurisdictions) benefit from their skills and knowledge
- ensuring the recruitment, employment and treatment of migrant nurses and other types of health workers is in accordance with the laws of both source and destination jurisdictions
- ensuring that terms of employment are based on objective criteria (e.g., levels of qualification and years of experience)
- ensuring the equal treatment of internationally and domestically educated nurses and other types of health workers, as well as those recruited to work on a temporary basis and those recruited to work on a permanent basis
- taking measures to ensure that migrant nurses and other types of health workers have opportunities to strengthen their education (including orientation about the health system to which they are recruited) and qualifications while progressing in their careers
- committing to engaging in HHR planning efforts that reduce the need for recruitment from source health systems (including educating and ensuring the 'pipeline' is sufficient to meet domestic needs)
- supporting other jurisdictions (including other countries) technically and financially in their HHR development efforts when they require assistance
- sharing recruitment-related data nationally and internationally (*also relevant to element 3*)
- adhering to the above principles when entering into bilateral and/or regional and/or multilateral arrangements related to the recruitment of nurses and other types of health workers
- establishing a body to monitor whether recruitment is ethical and does not bring internationally educated nurses into toxic work environments (*also relevant to element 2*).

We identified 13 evidence syntheses relevant to element 1 (see Appendix 3). Most syntheses focused on recruitment and retention of health workers in rural and remote areas. They revealed that rural clinical rotations, recruiting providers from rural areas, and retention schemes that provide financial incentives and personal supports are potentially effective ways to increase the recruitment and retention of health workers in rural and remote areas. However, it is worth noting that a range of policy and social factors can impede this retention and recruitment. As documented in Appendix 2, our jurisdictional scan identified many initiatives at the global, regional and national level focused on recruitment, and many of these often emphasize one or more of the components outlined above.

Make workplaces 'excellent' for nurses and other health workers, and hold employers accountable

Element 2 focuses on establishing workplaces that value quality and respect for nurses and other health workers, and that strive to create excellent working environments. These efforts would form the backbone of any approach to addressing HHR challenges, and need to be approached with flexibility to meet the evolving needs of the diverse workforces that exist within and across countries. In addition, this element emphasizes the need to hold employers accountable to achieve this. At the country and province/territory level, this element could include:

- working with health authorities and organizations providing strategic direction for and oversight of care delivery to establish provider experiences as an explicit focus of performance measurement and management (ideally, alongside the other components of equity-driven 'quadruple aim' metrics, such as health outcomes and care experiences, and keeping per-capita costs manageable)
- working with those overseeing health workplaces and practice environments (e.g., regulators, accreditation bodies, hospital associations, labour unions and professional associations) to establish and enforce standards for ensuring the establishment of excellent workplaces, including through the adoption of 'magnet hospital' principles (i.e., a healthcare facility considered to be the gold standard for nursing practice and innovation) to drive improvements to provider experiences
- working with system leaders in health workplaces and practice environments to implement approaches that are known to make workplaces 'excellent' for nurses and other health workers.

At the international level, this element could include efforts to ensure existing strategic frameworks and established principles (including the WHO Code of Practice) are clear about the need to focus on establishing excellent workplaces, and developing global guidance that can be locally contextualized.

We found 16 evidence syntheses relevant to element 2 (see Appendix 4). The health and well-being of the health workforce is a commonly studied issue, and the identified syntheses suggest that support systems (e.g., peer support, professional-development opportunities, meditation, mindfulness strategies and wellness programs) can help to address many mental-health challenges experienced by health professionals (e.g., anxiety, stress, burnout and depression). The syntheses also indicate that facilitators of improved staff satisfaction, retention, productivity and workplace environment include relational leadership styles, performance appraisal, reward systems, career planning, organization-directed interventions, and internship and residency programs that feature teaching or mentorship components. One synthesis also revealed that magnet hospitals have better nursing work environments and are associated with better outcomes for nurses, patients, and organizations than non-magnet hospitals. As noted above and documented in Appendix 2, our jurisdictional scan found that very few efforts within countries have focused explicitly on improving workplaces for nurses and other health workers.

Share more and better HHR data, and use it in robust HHR planning processes

Element 3 focuses on mandating the contribution of data to a country-wide HHR database by everyone who is able, the compilation of these databases into a common database, and the use of these databases in robust HHR planning processes. This may include:

- promoting the use of the WHO handbook on Strengthening the Collection, Analysis and Use of Health Workforce Data and Information (18)
- accelerating the implementation of the WHO National Health Workforce Accounts (NHWA)(which feed the NHWA data portal, World Health Assembly reporting, UN SDG 3.c.1 reporting, Global Health Observatory

reporting and other global and regional thematic reports), a system by which countries progressively improve the availability, quality and use of data on health workforce through monitoring of a set of indicators to support achievement of UHC, the SDGs and other health objectives.(19)

We found five evidence syntheses relevant to element 3 (see Appendix 5). These syntheses revealed that HHR planning models often utilize stock-flow estimates and a demand component based on population needs. In addition, 'big data' can help to advance and improve medical education policies, and measures for evaluating interprofessional collaboration generally focused on assessing collaboration, communication, teamwork and supportive factors among health workers (e.g., nurses and physicians). As noted above and documented in Appendix 2, despite the global efforts noted above there has been a lack of process at the country level to advance aspects of this element.

Implementation considerations

Below we identify some barriers that may make it difficult to proceed with the elements, as well as facilitators that could create a window of opportunity for advancing them.

References – see Appendix

Gauvin FP, Moat KA, Ali A, Lavis JN. Evidence brief: Addressing the global health human resources crisis. Hamilton: McMaster Health Forum, 6 July 2023.

This stakeholder dialogue is being organized in collaboration with the Canadian Medical Association, the Canadian Nurses Association, and the International Council of Nurses. The evidence brief and the dialogue it was prepared to inform were funded by the Canadian Medical Association. The McMaster Health Forum receives both financial and in-kind support from McMaster University. The views expressed in the evidence brief are the views of the authors and should not be taken to represent the views of the funder and organizing partners.

ISSN 1925-2250 (online)