Human Resources for Health

EDITORIAL

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Global Strategy on Human Resources for Health: Workforce 2030—A Five-Year Check-In

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In May 2016, the Sixty-Ninth World Health Assembly adopted the Global Strategy on Human Resources for Health: Workforce 2030. The Strategy set forth an ambitious policy agenda aiming to accelerate progress towards Universal Health Coverage (UHC) and related Sustainable Development Goals (SDGs) by increasing access to health workers and strengthening health systems. The strategy highlighted shortages of health workers, along with skill-mix imbalances, maldistribution, barriers to inter-professional collaboration, inefficient use of resources, poor working conditions, and gender inequalities among health and care workers and outlined policy options and recommendations to address these issues. The Strategy outlined the need to adequately finance health systems and boost political will to mobilise resources needed to redress workforce gaps.

The Global Strategy on Human Resources for Health: Workforce 2030 called for a greater focus on the preparation of the entire health workforce for emergencies, such as their involvement in preparedness and response, training, and planning for staffing requirements and surge capacity. However, many countries were unprepared for the COVID-19 pandemic. Pressure on health workers—as individuals and as a core component of the health system response and the spotlight as the impact of insufficient human resources for health was felt globally and acutely. It is clear that COVID-19 has had an impact on health and care workers, with many reporting burnout [1].

The Special Series *Global Strategy on Human Resources for Health: Workforce 2030—A Five-Year Check-In* [2] comes at a time of crises and change [3]. A time when the assessment of the progress on milestones identified by the Global Strategy on Human Resources for Health: Workforce 2030 [4] has taken on greater urgency in the drive to accelerate progress towards the global sustainable development goals. Although it is clear we need to do much more to achieve UHC, we can see that some progress has been made. An increase in the global workforce stock has meant that the shortfall, projected at the time of the Strategy to be 18 million by 2030 has been revised to 10 million [5]. The long-term impact of COVID-19 on these trends are yet to be fully understood. Yet, it is clear that the response to COVID 19 must pivot societies towards investing in what matters most to people and economies: health.

The papers in this Special Series are both a testament to advances made since 2016 and a warning of how much further we still need to progress in order to attain universal accessibility, acceptability, coverage and quality health workforce within strengthened health systems. This can only be achieved through adequate investments and the implementation of effective policies at national, regional and global levels.

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Foremost, we have seen progress on the foundations for sound policy making: data collection and information exchange. The paper by *McQuide* et al. on health information systems speaks to both the great importance of data as a public good and the progress made over the past two decades [6]. Several papers in this series highlight the use of this enhanced capacity and improved evidence to inform policy. *Garg* et al. show the importance of evidence to filling thousands of additional full-time jobs in areas where needs were previously unmet [7]. Yet, it is not just about collecting more data, but also using better data, and *Newman* et al. underscore the importance (and feasibility) of collecting gender data to counteract systemic structural gender discrimination and inequality in the health and care workforce [8].

The papers in this series also highlight progress on the capacity, coordination and governance structures that are so essential to the achievement of UHC. *Martineau* et al. highlight the examples of Malawi, Nepal and Sudan where HRH units and intersectoral coordination mechanisms have been instrumental in advancing the health workforce policy and investment agenda [9]. *Kolie* et al. outline the coordination needed for more equitable distribution of health workers in Sub-Saharan Africa [10].

Taken together, we are optimistic that progress is being made towards UHC through effective implementation of evidence based HRH policies. However, in the context of system damage and policy upheaval caused by the COVID-19 pandemic, and discussed in the paper by *Bustamante Izquierdo* et al., we are concerned that there is a patchiness to this progress [11]. The paper by *Dedeilia* et al. discusses how the COVID-19 pandemic has severely disrupted health worker education [12]. *Enabulele* et al. reflect on lessons and the enabling factors for improved course completion rates in Commonwealth countries [13]. Both papers offer considerations for countries looking to scale up health workforce production. This is also reflected in the use of health workforce assessment tools and mechanisms by bilateral and multilateral partners in the paper by *Nove* et al. [14]

Beyond what the papers in the series tell us, there are also some critical gaps in the narrative of progress. As suggested by *van de Pas* et al., there has been limited progress in generating fiscal space for health, the development of health workforce partnerships and its global agenda or the governance of international health workforce migration [15]. The paper by *Nurruzzaman* et al. highlights that in Bangladesh, the public sector comprises only an estimated 18% of the total health workforce [16]. The private sector is a large employer of health workers in many countries, yet dialogue on partnerships for public purpose or oversight of the private sector is limited. The paper by *Leslie* et al. provides further insights on regulation that can be used by policymakers, governments, and regulators to inform regulatory design and practice in line with the Global Strategy [17].

While the overall health workforce shortage in relation to at least 80% of population accessing UHC is shrinking, inequality appears to be increasing [5]. This includes distributional inequality, but also inequalities among workers, such as the inequalities faced by foreign-trained health workers outlined by *Harun and Walton-Roberts* [18] and those faced by women as *Newman* et al. [8] outline. The many more jobs being created in the health and care economy are important, but with growth skewed to high- and middle-income countries, there is concern about who is being left behind.

Micah et al. show that the majority of developmental assistance to human resources for health is being directed towards in-service training. [19]*Toure* et al. find that health worker remuneration accounted for a quarter of country health expenditure in low-income countries and a third in middle-income countries [20]. It is perhaps not surprising then, that most multilateral and bilateral agencies that provide financial and technical assistance to countries for human resources for health since 2016 do not identify it as a key focus; few have published a specific policy or strategy to guide health workforce investments [14]. With the increasingly connected and global nature of health labour markets, coordinated global action is needed to drive investment, not just in education, but also towards employment and decent work in countries struggling to do this with domestic resources alone.

The value of this Special Series lies not only in its rich and varied content which shows the breadth and scope of the Global Strategy on Human Resources for Health, but also its influence on policy *fora*. Articles in this series resonated across sessions at the 5th Global Forum on Human Resources for Health held in April 2023. The data and evidence from these papers informed the dialogue at the Forum and resulted in a clear action agenda [21]. Urgent action to prioritise and scale investments to address the global health and care workforce shortage, on three critical aspects:

Protect We must protect the existing workforce and reduce attrition with decent work and improved working conditions.

Invest We must position and prioritise investments and action on tackling the health and care workforce shortage at the top of the agenda.

Together We must act in solidarity, and with all sectors and partners.

Translating this into the action necessary in each and every country is needed. Research, particularly research

on implementation, will continue to play a central role in this era of action.

Author contributions
All the authors contributed in writing the manuscript, and all the authors read and approved the final manuscript.

Funding
Not applicable.

Availability of data and materials
Not applicable.

Declarations

Ethics approval and consent to participate
Not applicable.

Consent for publication
Not applicable.

Competing interests
Michelle McIsaac is on the Editorial Board for Human Resources for Health. James Buchan is an Editor Emeritus for Human Resources for Health. James Campbell is on the Senior Advisory Group and Editorial Board for Human Resources for Health. Ayat Abu-Agla and Rania Kawar declare that they have no competing interests.

Published online: 03 October 2024

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