Editorial

The health workforce in times of Covid-19

There will be a "before" and an "after" Covid-19 for the health workforce. The sanitary crisis exposed the fragility of health care systems and their lack of preparedness to cope with such a shock. It made visible the critical role of health workers in addressing such a challenge.

Before the epidemics came, in most countries, rich and poor, there were deficiencies in the health labour market, such as worker shortages -in some cases due to losses to emigration-, occupational-mix imbalances, geographical inequitable distribution, education programs not well aligned with the needs of services, and weak governance, regulation and management. At least since 2004, there have been alerts to the existence of a human resources for health crisis[*], and yet, decision-makers generally gave it little attention, even though their country had formally committed to universal health coverage. The 2020 pandemic has been a wake-up call and ensured that now no one ignores that the capacity and performance of healthcare systems depend primarily on their workforce.

Since the beginning of the crisis, health workers, everywhere, showed an exceptional dedication and capacity of adaptation to the unprecedented context. Those on the front line in intensive care units were more in view, but those who provide less spectacular, but essential, services, such as maintaining the care environment free of pathogens or simply transporting patients, also responded admirably. Many paid a heavy price, putting their health and, in some cases, their life at risk. The population and political authorities applauded, virtually and literally. It is a much deserved and appreciated form of recognition, but what workers really need is action to address issues of heavy workloads, low remuneration, poor career prospects, and of difficult working conditions.

There are already signs that the post-Covid health workforce will be different. For example, remote consultations increased noticeably as the crisis evolved, and practitioners and patients adapted well to this new way of interacting. It is conceivable that teleconsulting, ehealth and mhealth will become standard for the provision of services such as follow-up consultations, alerts to patients for therapeutic guidance, or monitoring medication adherence. This implies that the need for training current and future health care providers to use these tools competently. New roles are likely to appear to assume related functions still not yet known. Another change may result from the preference of older persons to avoid nursing homes, which were the epicenter of the epidemics almost everywhere. Demand for domiciliary care will therefore augment and, so will demand for workers specifically trained to provide these services. The crisis also showed that rigid definitions of roles were not appropriate in a crisis context. Flexibility and the use of the full potential of all categories of workers are required. There is already pressure to revise the regulation of scopes of practice and to allow for the expansion of the functions of nurses, pharmacists and others, as has already occurred in a number of countries[†]. In consequence, the division of tasks between the various health occupations may significantly change in the near future.

Policy-makers and planners face the challenge to decide now how to ensure that their country's health workforce aligns with the future service needs of the population. To that end, they must have a clear vision of the desired future health care system and of the founding values that will guide its organization and functioning. For instance, the pursuit of universal health coverage implies the strengthening of equity of access and financial risk protection, to tackle the

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[*] Chen, L. Evans, T. , et al., Human resources for health: overcoming the crisis, The Lancet ; 2004 Nov 27-Dec 3;364(9449):1984-90. doi: 10.1016/S0140-6736 (04)17482-5.; WHO, The World Health Report 2006: Working together for Health, Geneva, World Health Organization, 2006

[†] Maier C., Nurse prescribing of medicines in 13 European countries, Human Resources for Health (2019) 17:95 https://doi.org/10.1186/s12960-019-0429-6

sysable inequities that the crisis has revealed. There is equity when all members of a population have access to health workers, irrespective of capacity to pay and without any form of discrimination (social status, ethnic origins, religion, sexual orientation, etc.). Equity also means access to health workers modulated in function of the importance of the need, e.g. urgency of the need or the gravity of the health problem and to the same quality of service for the same type of need. Strong and accessible primary care services, and the right kind of workforce to provide them are the surest path to universal coverage[±].

More generally, the education and the work conditions of the health workforce of the future need to change, in response to demographic, epidemiological and technological change, and to the expectations and demand of populations for better access to quality services. In addition, planners need to understand and take into account how new workers will behave in terms of choice of area of work, of practice location, of workload they are prepared to accept, in an increasingly global health labour market.

In the Americas, many countries have started moving in the right direction in reaction to the Covid-19 epidemics, for instance by improving remuneration, working conditions, including safety and protection and access to additional training, and by facilitating the integration of new workers in the labour market, notably at primary care level[§]. Similar initiatives have taken place in the rest of the world. While this should be commended, governments must continue to progress in that direction. Their task is to work towards building a more efficient composition of the workforce, namely by balancing the proportion of nurses to physicians and fostering collaboration between workers at different levels of care. It is to ensure the quality of education and practice, through mechanism like independent accreditation and organizations like effective professional councils. To do so, they must strengthen their capacity to regulate, plan and manage the health workforce, with a view to ensure it provides the services that meet the needs and expectations of the population. The probability of succeeding will augment if planners have access to reliable information databases, such as National Health Workforce Accounts[**], if there is support from the main stakeholders, and if there are sufficient resources available, all of which require string political commitment at the whole government level. In recent years, there has been advocacy in favor of spending more on the health workforce, by arguing that if is done wisely, it is not a mere cost, but a sound investment[††]. Now that the Covid-19 crisis, amplified by the health workforce deficiencies, has generated a global economic crisis, decision-makers may be more likely to listen to this message.

Gilles Dussault
Global Health and Tropical Medicine
Instituto de Higiene e Medicina Tropical
Universidade Nova de Lisboa

Versión original

[±] Dussault G, Kawar R, Castro Lopes S, Campbell J. Building the primary health care workforce of the 21st century - Background paper to the Global Conference on Primary Health Care: From Alma-Ata Towards Universal Health Coverage and the Sustainable Development Goals. Geneva, World Health Organization 2018; https://www.who.int/docs/default-source/primary-health-care-conference/workforce.pdf?sfvrsn=487cec19_2

[§] Experiencias para destacar en gestión de Recursos Humanos para la Salud en países de América del Sur en el contexto de COVID-19 ; https://www.paho.org/es/noticias/27-5-2020-experiencias-para-destacar-gestion-recursos-humanos-para-salud-paises-america

** WHO "National health workforce accounts: implementation guide"- World Health Organization, 2018; https://apps.who.int/iris/handle/10665/275473

[††] WHO 2016. Report of the UN High Level Commission on Health Employment and Economic Growth. https://www.who.int/hrh/com-heeg/en/ Accessed 28 May 2019