Structures to support integrated working between public health and primary care

A global perspective on the education and training of primary care and public health professionals

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Key messages

The global shortage of health workers and the global epidemic of non-communicable diseases require shared solutions which will involve job and role redesign and fundamental changes in education and training.

Why this matters to me

After 20 years in the NHS – the last 6 years as Chief Executive of the service – I have spent 5 years

working in health in low- and middle-income countries in Africa and Asia with a particular emphasis on the preservice education and training of health workers. As a result, it has become clear to me that whilst there are many differences between these countries and the UK, there are also many similarities, and that new approaches to workforce design and education and training need to be adopted globally.

ABSTRACT

Background There is a critical shortage of health workers globally, which is not just a problem for low- and middle-income countries, but needs to be tackled through shared action. At the same time, public policy around the world is responding to changing health needs, social trends and technological possibilities by placing ever greater emphasis on primary care and public health, the interconnections between them and their relationships with other disciplines. All these themes mean that a new approach to the education and training of health workers is required.

Setting Global, but with relevance to the UK.

Question The education and training of professionals in public health and primary care need to adapt to the changing epidemiological, social, technological and policy environment, as well as to health worker shortages and resource constraints.

Methods This article brings together the results of reviews undertaken by the Global Health Workforce Alliance taskforce on scaling up the education and training of the health workforce and the Lancet Commission 'Health professionals for a new century – transforming education to strengthen health

systems in an interdependent world' (of both of which the author was a member) with the author's own experiences working in Africa, Asia and North America as well as in the UK.

Results There are obvious differences in the needs and capabilities of health systems in different countries, but whatever the context – and whether they are high-, low- or middle-income countries – there are many similarities in the approach that is needed to educate and train professional and non-professional health workers, and a great deal that all countries can learn from each other.

Conclusion/discussion As the NHS enters a new phase in the continuing development of general practitioners as commissioners and providers there is a need to look for insights from around the world and to develop a new approach to educating and training primary care and public health professionals which takes account of this global perspective and global learning.

Keywords: education and training, global health, health workforce crisis

The massive shortage of health workers globally is sometimes seen as being a problem only for low- and middle-income countries. This is understandable given that the estimated shortfall of 4.3 million workers in 2006 particularly affected these countries. Fifty-seven low- and middle-income countries were described by the World Health Organization (WHO) as being in crisis.¹ The migration of health workers from poorer countries to richer ones is a major part of this problem for all the countries that are worst affected and needs to be addressed.

The World Health Assembly agreed a Code of Practice in 2010 which balances the rights of migrants – who are sometimes abused in their new countries – with the rights of countries to secure an adequate workforce.² An underpinning tenet of this code is that major benefiting countries such as the UK should support the education and training of health workers in countries that lose out from migration.

England had already established its own ethical recruitment policy and code of practice and in 2006 made changes to immigration status that effectively ‘closed the door’ to most migrants. The numbers of migrant health workers registering in England each year have plummeted since 2006: with, for example, the number of South African nurses falling from a high of 2114 in 2002 to 39 in 2007.³ The UK has also made some investment in supporting health workers’ education in affected countries but, as I have recommended to the government, should go much further.⁴

Migration is not the only problem for these countries in crisis. Employment conditions and working environments are such that there are major ‘push factors’ which encourage health workers to move into other types of work locally, as well as to go abroad. Migration is not even the most important factor. The best estimates are that 135 000 health workers with any level of training have migrated from sub-Saharan Africa, but that 1.5 million health workers are needed there. Even if they are all returned to Africa it would barely make a dent in the problem.

The underlying issues are resources and a massive shortfall in educating and training health workers. Ethiopia has trained 3500 doctors in 35 years – 100 a year; the UK, with a smaller population trains around 8000 a year.⁵ This is not just a local problem, however, the UK is one of very few countries that now educate broadly enough people for their own needs. The USA, for example, has a population six times that of the UK but educates little more than twice our number of doctors each year.

We are all affected by these shortages of health workers and, confronted by rising demands for health-care – especially from the fast developing populations of India and China – can expect the crisis to deepen. We need shared solutions which will involve job and role redesigns and changes in education and training.⁶

What sort of health workers are needed for the future?

I do not need to spell out for readers of this Journal the way in which the needs of patients and the public have been changing over recent decades and that we are now confronted by a global epidemic of long-term conditions and non-communicable diseases. Nor do I need to describe how this re-emphasises the importance of public health and primary care in the prevention of disease and in supporting patients to look after themselves, to manage them through intermittent crises and to help them to live as independent and fulfilled a life as possible. I will concentrate instead on the issues of job and role redesign and education.

I start with low- and middle-income countries because the issues there are in many ways starker and clearer – and because we in richer countries have so much to learn. I was privileged to co-chair an International Task Force on the Scaling Up of Education and Training for Health Workers with Commissioner Bience Gawanas of the African Union, which was charged with developing a plan to increase the number of health workers rapidly in low- and middle-income countries.⁷ The Task Force recognised that the solutions did not lie in simply transferring curricula, regulations and practices from richer countries, but that there was already a great deal of innovative practice in countries around the world. People without our resources and, importantly, without our historical baggage and vested interests, were creating new and viable ways of addressing their problems.

A large part of many of these solutions is to train individuals to undertake specific tasks, which may range from surveillance to surgery and immunisation to public education about hygiene, health and family planning. Analysis of recent evaluations of Pakistan’s Lady Health Workers, India’s ASHAs and African community and mid-level health workers shows that some have failed at some tasks, but has also begun to reveal the factors that make for success. These, very broadly, are good task identification, appropriate initial training, adequate updating and retraining, and being part of a functioning health system with all that implies about being supervised and able to refer patients on to others who are more skilled.

A single example exemplifies this. In Mozambique the vast majority of caesareans are conducted by *tecnicos di cirurgia* – mostly nurses with additional training. More than 10 years of study by European researchers has shown that they perform as well as doctors, at much lower cost and do not migrate.⁸

The Task Force looked in some detail at 10 countries ranging from Iraq to Bangladesh, and Brazil to Malawi, and analysed many such examples of this ‘task

shifting' or 'task sharing', as well as other types of innovation. It identified 10 critical success factors for making successful changes in workforces and scaling up education and training. These range from having the political will and clarity of direction to appropriate education processes and methodologies.

The analysis and recommendations of the Task Force have obvious resonance in the UK. We have growing needs and shrinking resources and need to understand how and where less trained people can contribute within an overall system with high and improving standards. Examples like that of Mozambique challenge some of our basic assumptions. It is interesting to note, moreover, that whilst the NHS has done some 'task sharing' in recent years with examples such as nurse prescribing, general practitioners (GPs) have probably done most within their own practices where many new tasks have been taken on by nurses and others.

There is a great deal that we can learn from low- and middle-income countries as the excellent articles by Mathew Harris and Geoffrey Meads in this issue of the Journal show. It is a theme that I drew out in some detail in *Turning the World Upside Down*.⁶

Health professionals for a new century

These changes in job and role redesign are crucially dependent on the education and training of health workers. The Lancet Commission 'Health professionals for a new century',⁹ of which I was privileged to be a member, set out to address the issue of what sort of education is needed for the top groups of professionals in order for them to perform their practitioner and leadership roles in this changed environment.

It produced the first comprehensive survey of the education and training of public health workers, nurses, midwives and doctors, and revealed both the scale of the current activity – one million new professionals a year – and the range of different approaches that have been taken. It also showed what a comparatively small amount of health expenditure went on professional education.

The commissioners concentrated their focus on reviewing leading practice from around the world and consulted many groups. In setting out their findings they emphasised the interdependent nature of the world – reflecting the relationships not just between countries in health terms, but between patients and professionals and between health and wider social issues – and explicitly took a systems-based approach. They also placed as the ultimate goal, the training of health workers to achieve equity in health. Whilst this

is, of course, a value statement, it also reflects the goals of the approach of the vast majority of governments and health systems around the world which are explicitly working towards universal access to health and healthcare for their populations.

The Commission argued that we are now entering a third generation of educational reforms. The scientific reforms of a century ago were followed by problem-based learning and now are being succeeded by a systems-based approach. Health professionals in their practice and education need to understand and operate within systems in addition to their other skills.

The Commission also emphasised the connected roles of everyone working in health and healthcare, and argued that an interprofessional and transprofessional approach was therefore needed. Within this framework, the higher professionals have a particular transformative leadership role – as the people who lead and enable change – which needs to be reflected in their education.

Against this background, the Commission made 10 recommendations, some of which were to do with instructional issues and some institutional. Many – such as the need to adopt a competency-based framework – will appear familiar as they derive from existing best practice. Together, however, they represent a fundamental change in professional education.

Instructional reforms

- Adopt a competency-based framework.
- Promote interprofessional and transprofessional education.
- Exploit the power of IT for learning.
- Harness global resources and adapt locally.
- Strengthen educational resources.
- Promote new professionalism.
- Establish joint planning mechanisms.

Institutional reforms

- Expand from academic centres to academic systems.
- Link through networks, alliances and consortia.
- Nurture a culture of critical inquiry.

The emerging direction

I cannot do justice to the work of the Commission or the earlier Task Force in this short article and, in particular, cannot draw out the richness of the examples from around the world which they both considered. Nevertheless, I have attempted both to identify the compelling need for change and to sketch

out the overall direction. Both the Commission and the Task Force based their conclusions on what was happening in the real world of practice and education. There are very powerful patterns emerging around the world which need to influence in the UK and will help us to influence others.

As the Commission has shown, there is a wonderful opportunity here. One million new health professionals graduate every year. Their education and their mindset will shape the health of the world for years to come.

In England, there are lessons to be learned from the reforms following the NHS Plan of 2000. They brought many improvements in services and service redesign with the result that public satisfaction with the NHS almost doubled in a decade.¹⁰ However, the reforms themselves were too focused on economic incentives and hospital services. GP commissioning needs to learn the lessons from this period and play its part in helping develop an NHS workforce for the future.¹¹

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ETHICAL APPROVAL

Not needed.

CONFLICTS OF INTEREST

None.

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