Striking the right balance: health workforce retention in remote and rural areas

Lincoln C Chen[a]

Ensuring universal access to skilled, motivated and supported health workers, especially in remote and rural communities, is a necessary condition for realizing the human right to health, a matter of social justice. It is also at the core of each and every global health goal – the United Nations' Millennium Development Goals, primary health care, immunization, and control of HIV/AIDS, malaria and tuberculosis. For none of these goals is attainable if significant population groups are denied access to health workers.

Despite recent increased rhetoric, human resources remain a sorely neglected and grossly under-financed engine for health improvement. That is why 1500 global health leaders issued the Kampala Declaration in 2008: "to assure adequate incentives and an enabling and safe environment for effective retention and equitable distribution of the health workforce".[1]

Maldistribution is arguably the most critical workforce challenge, not only for achieving universal coverage but also for addressing inextricably linked workforce problems such as shortages and skill imbalances.[2,3] In many countries, overall shortages are exacerbated, indeed even caused, by severe maldistribution.

This is both a symptom as well as a driver of skill–mix imbalances. Often the problem may not be the absolute number of workers but the type of workers trained and their job location. National shortages often may be juxtaposed with rural vacancies and urban unemployment. Moreover, severe maldistribution in some circumstances may harm not only the disadvantaged, but also high-income populations. On the other side of the coin, excessive concentration of overly specialized professionals can cause unnecessary tests and procedures, over-prescription of drugs, iatrogenic diseases and wasted higher costs – plaguing the poor and rich alike.

Maldistribution is a commonly shared problem in all countries, as all market-based economies have labour markets where professionals exercise occupational mobility. Only one or two authoritarian regimes currently dictate exactly where each worker must live and work. And most professionals, it must be acknowledged, seek urban-based, middle-class professional work and personal lives. There is nothing wrong with this. It is the biased institutions, inequitable policies and perverse public subsidies that need fixing because they produce a workforce misaligned with equitable national health development.

Some problems of maldistribution are rooted in deep historical processes, like left-over colonial structures. In many countries, ethnic and cultural minorities have been forced into remote mountains, arid lands and recently into urban slums – that are further handicapped by weak economies and infrastructure. In communities that never had trained health workers, the challenge may be less retention and more the training of workers indigenous to the local communities or incentivizing urban workers for rural service.

Distribution within countries is mirrored by disparities between countries. Whereas high-income countries have more than 10 doctors/nurses per 1000, some of the poorest countries with higher burdens of disease may not have even 1 doctor-nurse per 1000.[2,3] Global inequity is magnified by the migration of skilled personnel from poorer to richer regions. Indeed, maldistribution within and across countries is an inter-linked continuum. As highly skilled professionals depart from poorer countries, a vacuum is created which further draws trained workers from poorer regions within the country. Some argue that similar shifts are taking place from poorer-paid public-sector jobs to the more lucrative private sector. Ironically, the importation of foreign workers into some high-income countries like the United States of America may be to cover its own disadvantaged populations – fixing one problem to create another or the international transmission of workforce deficiencies!

Abundant experience and sufficient evidence exist to solve this problem.[4] The challenge is implementing effective strategies in specific contexts. A recent World Health Organization expert group on "increasing access to health workers in remote and rural areas through improved retention" developed four categories of strategies: education, regulation, financial incentives, and management and social systems support.[5]

A country may select suitable actions from these strategies but there are at least three reasons why practical solutions are so difficult to achieve. The first is the engagement of multiple actors who have a stake – training institutions and universities, health and educational ministries, civil service, professional associations, nongovernmental organizations and others. The second is harmonizing multiple interests. While achieving good health may be one objective of workforce development, there are other purposes that must be served – employers offering jobs for public service or private profit, professionals seeking competitive compensation, good working conditions and career development, governments advancing national health goals, accreditation and certification functions of professional bodies. Third is multiple time-lines. Development of the health workforce takes time, at least a decade and often a generation. This requires sustained investment and capacity building, beyond electoral cycles and immediate political gains. The recent rush of "crash programmes" to train large numbers of community health workers has rightly attempted to address long-standing deficiencies but these emergency actions cannot be seen as a sustainable solution.

Ultimately, interventions must "move upstream" to supply the pipeline with an appropriate and sufficient workforce and to create attractive jobs in a sound national health-care system. There are no short-cuts; both supply and demand must be harmonized. The educational system must be adequately financed to produce the type of worker that comes from, is trained to serve, and wants to work in remote and rural areas. The national health system has to create jobs in remote and rural areas as part of an equitable sustainable system. ■

References

Available at: http://www.who.int/bulletin/volumes/88/5/10-078477

[a] China Medical Board, 2 Arrow Street, Cambridge, MA, 02138, United States of America.
Correspondence to Lincoln C Chen (e-mail: lchen@cmbfound.org).

References

1. *Kampala Declaration on fair and sustainable health financing.* Kampala: World Health Organization Country Office in Uganda; 2005. Available from: http://www.who.int/health_financing/documents/cov-kampala/en/index.html [accessed 8 April 2010].
2. Joint Learning Initiative. *Human resources for health: overcoming the crisis.* Cambridge: Harvard University Press; 2004.
3. *The world health report 2006: working together for health.* Geneva: World Health Organization; 2006.
4. Lehmann U, Dieleman M, Martineau T. Staffing remote rural areas in middle- and low-income countries: a literature review of attraction and retention. *BMC Health Serv Res* 2008;8:19. doi:10.1186/1472-6963-8-19 PMID:18215313
5. *Increasing access to health workers in remote and rural areas through improved retention* [Internet site]. Geneva: World Health Organization; 2009. Available from: http://www.who.int/hrh/events/2009/expert_meeting/en/index.html [accessed 8 April 2010].

Bull World Health Organ 2010;88:323 | doi:10.2471/BLT.10.078477