

A new model of health workforce training

by Joel Negin

29 July 2015



A new model of health workforce training has the potential to be an innovative, cost-effective, catalytic initiative that can build national health systems, empower women and make itself obsolete in a decade.

Such an endeavour would align perfectly with the Australian government's [2014 development strategy](#), which highlights performance, innovation, empowering women, value-for-money and extending Australia's influence. Additionally, it responds to the emphasis in the government's [recent health strategy](#) on building strong national health systems in the region, including through investments in health workforce training.

Many of the countries in the Indo-Pacific region have [dramatic shortages of health workers](#) (doctors, nurses and midwives) – below the 23 per 10,000 ratio regarded by the World Health Organization as the minimum needed to provide essential primary health care services (see note below). This means that these countries are less able to provide for the health of their people, leading to lower productivity, [higher rates of preventable morbidity and mortality](#) [pdf], higher risks of emergent infections, and less social stability. As noted in the new health strategy, “a region will only be as strong as its weakest link.”

Health worker ratios in the Indo-Pacific region

Country	Year (latest data)	Doctors per 10,000 population	Nurses and midwives per 10,000 population
Australia	2010	39	106
Southeast Asia			
Cambodia	2012	2	8
Indonesia	2012	2	14
Laos	2012	2	9
Myanmar	2012	6	10
Thailand	2010	4	21
Timor-Leste	2011	1	11
Viet Nam	2013	12	12
Pacific			
Cook Islands	2009	13	64
Fiji	2009	4	22
Kiribati	2010	4	37
Marshall Islands	2010	4	17
Micronesia (Federated States of)	2009	2	33
Nauru	2010	7	49
Palau	2010	14	57
Papua New Guinea	2010	1	6
Samoa	2008	5	19
Solomon Islands	2009	2	21
Tonga	2010	6	39
Tuvalu	2008	9	58
Vanuatu	2008	1	17
Other			
Maldives	2010	14	50
Mozambique	2012	0	4
Sri Lanka	2010	7	16

Source: *WHO Global Health Workforce Statistics*

As noted in an earlier [post](#), the West African Ebola crisis highlighted the great weakness of health systems in developing countries: insufficient numbers of quality health workers where people live. Amidst [low numbers of people being trained](#) as doctors and nurses, and [high numbers of trained health workers migrating](#) to rich countries, the West African health workforce was dramatically depleted – thus opening a door for the epidemic and [eroding gains in maternal and child health outcomes](#) due to the loss or displacement of skilled health workers. Looking at the numbers in the table above, would countries in our region be able to respond to health challenges rapidly and securely without compromising their progress towards improved maternal and child health?

Over the past decades, one of the models of scholarship training preferred by the Australian government and universities (and those in many other countries including

developing countries themselves) was bringing bright young students to Australia to study. Doctors, public health officers and other health workers spent time in Australian universities getting their degrees or further (non-degree) training in the form of short courses. Indeed, public health has been one of the more common degrees sought by [Australia Awards](#) recipients. (*Conflict of interest declaration: I have taught a large number of Australia Awards recipients in the Masters of International Public Health program at the University of Sydney*).

According to the [Performance of Australian Aid 2013–14](#) report released earlier this year, there were around 6,000 Australia Awards awardees in Australia in that financial year and the program spent \$362.5m in that time: more than \$60,000 per student per year.

While my [own research](#) has noted some commendable positives of the scholarship program, value-for-money remains a key question mark hanging over the program (especially given the capture of much of the scholarship funding by Australian universities). This existing model is not sufficient given the challenges ahead. Could a different model reach more students, have greater impact, and be more cost-effective while maintaining an Australian identity?

The option of committing ourselves to building the capacity of training institutions in our region is one whose time has come. Stronger universities in Indonesia, PNG, Myanmar and elsewhere, buttressed by Australian technical and education expertise, would mean the production of a greater number of more competent health workers and would build goodwill for Australia.

The initiative could and should be modelled on that being implemented through the US government's [Medical Education Partnership Initiative](#) (MEPI). MEPI aims to assist with increasing the number of new health care workers in Africa by 140,000 by strengthening medical education systems and building capacity of African institutions. The program brings together 13 African universities with more than 20 US collaborators. For example, the Kilimanjaro Christian Medical Centre has [partnered](#) with Duke University's Global Health Institute and School of Medicine, and Stanford University is [collaborating](#) with the University of Zimbabwe's Faculty of Health Sciences. The aims are to train a new generation of physicians largely by transforming the academic environment in the host country, thereby improving retention of staff and improving quality. The nuts and bolts include long and short-term staff exchanges, joint research, and educational innovation.

At the University of Nairobi, the [MEPI partnership has supported](#) more than 300 medical, nursing, dental, and pharmacy students to complete elective rotations and 180 staff members have received training in clinical teaching. Those involved in the

initiative highlight not only these outcomes but the many intangible benefits: realising that their skills are comparable to that of American counterparts; fuelling optimism and confidence; and countering the isolation that many health workers feel.

MEPI is a joint effort of the Office of the US Global AIDS Coordinator, the Centers for Disease Control and Prevention, the Department of Defense and the National Institutes of Health, and benefits from funding of US\$130m over five years. A similar model for **nursing schools** has been launched in five African countries. The governance model is well developed with two transnational coordinating centres (one in the US and one in Africa) and separate governance bodies, advisory groups, or academic consortia within each host country, which work to align priorities and agree on implementation strategies.

In my **next post**, I will outline how such an approach could be developed by Australia in the Indo-Pacific region.

Joel Negin is Associate Professor of International Health and Deputy Head of School at the School of Public Health at the University of Sydney. This post is the first in a two-part series about a new model of health workforce training; the second post can be found [here](#).

Note: WHO regards a health worker-to-population density of 23 doctors, nurses and midwives per 10,000 population as the minimum needed to provide 80% coverage of basic essential services, for example, skilled birth attendance and childhood immunisation. Countries below this threshold, including several in the Indo-Pacific region, are considered to have a critical health worker shortage.

Author/s:

Joel Negin

Joel Negin is Head of School and Professor of Global Health at the University of Sydney School of Public Health. He focuses on health and development in sub-Saharan Africa and the Pacific.

Link: <https://devpolicy.org/a-new-model-of-health-workforce-training-20150729/>