A call for action

While there is no panacea which will solve the health manpower problems of all countries, some very concrete recommendations can be made for actions to correct the imbalances. But there will be resistance to such steps!

by John H. Bryant and Alfred Gellhorn

Health manpower out of balance? The very thought is revolutionary. Health manpower and womanpower have for the past half century been above criticism because they have been assumed to be motivated and devoted only for the good of mankind. Has anything changed? Apparently a striking change in the image of health workers, and particularly physicians, has occurred. Patients, the public and public officials have all become sceptical about the health care system, and even on occasion doubt physicians’ motives and their commitment to the health needs of all.

In the past 50 years, there have been greater scientific discoveries regarding the causes and treatment of disease than in previous recorded history. But access to this knowledge has been patchy, and the health care systems and the personnel in those systems have failed to address the inequities and the needs of large segments of the population all over the world. And at the heart of the problem has been, and is, the cost of health care.

“There are more doctors than we can afford and the doctors we have are badly distributed, or of poor quality, or both, so that large numbers of our citizens are not medically cared for.” This was the consensus view of the participants from 40 countries at last year’s conference in Acapulco on health manpower.

After World War II most parts of the world had economic growth, optimism, and social concern for improving the quality of life for everybody. Stimulated by the great advances in medical knowledge, high priority and high hopes were pinned on the health area. Production of physicians increased, thanks to larger medical school classes, more medical schools, and generous support of medical research, particularly in the industrialised nations.

But the outcome failed to meet the high expectations. In some countries, medical education was of poor quality and post-graduate training opportunities did not keep pace with the increased output. Many young doctors were poorly prepared, while others sought opportunities for further training and ultimately for permanent relocation in countries other than their own. Many Third World nations exported doctors to affluent countries such as the United States and Canada, a form of foreign aid which developing countries could ill afford. Advances in biomedical knowledge resulted in a proliferation of medical specialties at the expense of primary care physicians and ever-growing emphasis on high technology. This, in turn, led to a concentration of doctors in wealthy urban neighbourhoods while the countryside and city slums lagged desperately behind in making preventive as well as curative measures available. Even when individual doctors were interested in serving deprived communities, the health care systems themselves were seldom in place, so that those willing to serve were frustrated.

Then in the late 1960s and early 1970s came the economic crisis caused by the profligate expenditure of energy resources and the unprecedented dependence on small number of oil-producing countries. Mounting international debts of the developing countries and widespread unemployment in the industrialised nations compounded health problems and the quantitative, qualitative and distributional health manpower imbalance which already existed, not only among physicians but also among nurses and other key auxiliary personnel.

Recommendations

The conference in Acapulco did not long wallow in doom and gloom. Recognising that there are many well-entrenched vested interests—social, economic and political—which resist change with glacial tenacity, the participants took a strongly activist stance and made a series of recommendations which stressed the urgency of taking steps to remedy the imbalance.

While there is no panacea which will solve the problems of all countries, the following proposals are calls to action on the part of international organizations, national governments, medical educational institutions and health personnel individually and collectively.

– Firstly, honour the internationally agreed-upon Health for all concept through massive emphasis on primary health care.

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Photo WHO/M Jacot
Next, each country (or group of countries) should develop health manpower data banks to avoid the current over-production of physicians to the detriment of other more relevant health personnel.

Health care and health manpower planning must be realistically based on a country's health budget. Affluent countries must be educated to understand that health is a universal good, while ill-health is a threat to the healthy as well as the ill.

Changes in curriculum content are needed for all health personnel schools in order to provide greater insight and knowledge of the pressing health problems of the region served.

Production of certain categories of health manpower should be reduced by limiting the intake into training schools or restricting the numbers who graduate, and surplus manpower should be retrained so as to meet needs more appropriately.

Incentives and disincentives should be introduced to bring about a better redistribution of health manpower.

Some countries may have to postpone opening new medical schools or even consider closing existing ones.

Finally, some countries might find it necessary to impose a compulsory retirement age for their physicians.