

Editorial

Two decades of health workforce development planning: What do we learn/miss

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Ethiopia has made significant strides in expanding its Primary Health Care Units (PHCUs) by upgrading existing facilities and constructing new ones. While there has been progress in increasing access to healthcare services in the decade leading up to 2015, several health indicators remain suboptimal, highlighting the need for both improved coverage and service quality [1].

At the heart of these healthcare challenges lies the issue of human resources for health (HRH). The provision of accessible, affordable, effective, safe, and patient-centered quality health services depends on having a sufficient, motivated, and appropriately skilled healthcare workforce working within service delivery models that enhance their performance [2]. Globally, one of the main barriers to healthcare service access is the shortage of properly trained healthcare workers [3]. During the Millennium Development Goals era, the country had one physician to a population of 42,000 and one midwife to 57,000 and an overall ratio of 0.3 health workforce (HWF) for 1,000 people. The figures were indications that Ethiopia was in the worst crises even compare to the average for sub-Saharan African countries [4].

Recognizing the need to improve public sector services and utilize resources optimally, the Federal Ministry of Health (FMoH) introduced Business Process Reengineering (BPR) as a tool for streamlining work processes and systems [5]. The health sector's Human Resource Development Framework (2006-2010) and subsequent HRH Strategic Plans (2010-2015 and 2016-2025) were developed to address the identified challenges in HRH, respond to reform agendas, and improve health outcomes in alignment with national and global priorities [6,7].

In the HSDP IV (2010/11 – 2014/15), improving human capacity and governance was one of the key strategic objectives. The plan aimed to achieve a positive balance between the production and loss of health staff to attain the right numbers and skills mix of health workers. Efforts were made to improve the availability of key HRH categories, focusing on scaling up pre-service training for professionals in scarce supply, including medical doctors, Integrated Emergency Surgical Officers (IESOs), anaesthesia providers, and midwives. Initiatives such as the accelerated midwifery program and the expansion of medical education programs were undertaken [9].

By 2015 those human resource development initiatives resulted in improvement of HWF density from 0.3 to 0.7 per thousand population. However, this significant expansion in specific categories of health professionals came at the cost of closing some programs and a significant decrease in enrolment numbers, especially for pharmacy, laboratory, environmental health, and health education. A trend analysis report depicted in the table below from the Human Resource Development and Administration Directorate at the FMoH in 2015 revealed the number of graduates (BSc) of health professionals from public institutions for five consecutive years.

Table 1: Trend of number of health professionals graduated from public universities from 2020/11-2014/15.

Professional category	2010/11	2011/12	2012/13	2013/14	2014/15	Total
Health officers	850	890	1234	1492	1439	5905
Physicians	345	447	481	833	1316	3481
Nurses	1020	911	1100	1043	1375	5449
Midwife	320	321	347	397	548	1933
Pharmacist	451	420	415	400	377	2063
Medical Lab Technologist	160	152	141	145	143	741

The analysis also predicted that if the preservice education continues with the same output, the country will face a critical deficit of over 11,291 pharmacists and laboratory technologists by 2020 to meet the minimum standard of existing healthcare service demand, plus the saturation of civil service hiring capacity for medical doctors in less than 3 years. In 2015, the regional health bureaus have already stopped hiring health officers deployed from the center. Hence, the FMOH presented the findings of the analysis to the Ministry of Education, recommending an improvement in the enrolment of laboratory technologists and pharmacists while reducing the enrolment of medical doctors by half and focusing on improvement of quality of medical education.

Since 2014, regional health bureaus have expressed deep concerns about the critical shortage of allied health workers, particularly laboratory professionals and pharmacists. For example, in the 2016/2017 graduation year, the Ministry has deployed 2170 medical doctors, 1199 health officers, 1087 nurses, 1091 midwives, but only 450 pharmacist, 165 laboratory technologist and 96 anesthesia.

Fast forward in 2022, the country reported 14,587 physicians in the public sector, 70,246 nurses and 21,993 midwives, reaching the WHO minimum standards for both medical doctor and nurses. Despite these the HWF density is only 2.2 per 1,000 population (below the WHO set target) and Ethiopia still has the lowest HWF density compared to the African region [11].

The paradox is that, with the existing Ethiopian health facility human resource staffing standard, the civil service sector has saturated its capacity to hire health professionals. And in the last 5 years the failure to deploy health professionals centrally has resulted in uncertainty for employment of graduates, dissatisfaction with the regional hiring procedures, exposing the HRH to injustice, unemployment, and ethnic politics.

In conclusion, despite significant expansion in the development of the health workforce, particularly since 2009 and the introduction of licencing examination as quality control, there is a growing concern of the imbalance on skill mix and employability of essential health professionals. The consequences of this oversight are already being felt, with a critical shortage of certain allied health professionals, graduate unemployment, and exposure of graduates to regional politics and abuse. The healthcare system appears to be leaning heavily toward an oversupply of physicians compared to the available civil service positions, further compounding the skill mix imbalance. Addressing these issues will be crucial for sustaining and improving Ethiopia's healthcare services.

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