Moving from advocacy to activism? The fourth WHO global forum on human resources for health (HRH) and implications for dentistry

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Abstract

As we debate shaping the future oral health workforce within the UK, to meet the needs of current and future populations, it is helpful to take an international perspective on this very important issue. Globally, there is a strong recognition that human resources for health (HRH) are fundamentally important to deliver effective care, accessible to all people. This paper reviews the outcome of the fourth global forum held by the World Health Organization (WHO) in Dublin which highlighted the urgency for action. The main objectives of the forum were to advance the implementation of (i) the WHO Global Strategy on HRH for Health 2030 and (ii) the United Nations High-Level Commission's Health Employment and Economic Growth recommendations. From an oral health perspective, the global burden of oral disease remains huge with untreated dental caries, periodontal disease and tooth loss ranking among the most prevalent conditions worldwide. Major considerations are how dental education, practice delivery and/or oral health systems as a whole could and should innovate to accommodate the growing needs of the population. As dental professionals, it also becomes necessary for us to engage and play a proactive role in this change process. Due to growing differences between population needs and available services, it is necessary for oral health personnel to work more closely with the broader health workforce so as to identify solutions that are in the best interests of the patients and populations at large.

Keywords: health workforce; integrated solutions; WHO

In Brief:

- Investment in oral health workforce is crucial towards strengthening the global agenda on SDGs and UHC.
- There is an increasing need for oral health personnel to work more closely with the broader health personnel (doctors, nurses, pharmacists, allied health personnel, health workers and others).
- Dentistry needs to play a more visible role in the mainstream global health workforce agenda.

Introduction

"There is no health without health workforce"

Today, Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC) are two major global issues. The SDGs adopted by the UN General Assembly in September 2015 are a set of 17 development goals aimed to end poverty, protect the planet and ensure that all people enjoy peace and prosperity.[1] SDGs build on the success of the Millenium Development Goals (MDGs),[2] and sets the global direction for the next 15 years. By substantially broadening the development agenda with an emphasis on country-level ownership and multisectoral partnership, these new global goals call for action by all countries (both rich and poor).[3] While all SDGs are interconnected, SDG 3 specifically focuses on Health. There is considerable emphasis on the proposition that an adequate, well-distributed, motivated and supported health workforce is fundamental towards meeting these health targets, and in achieving UHC. [4]

In light of the various health workforce challenges and recognising the centrality of the health workforce towards achieving UHC and SDGs, the Fourth Global Forum on Human Resources for Health (the Forum) was organised by the WHO in November 2017 at Dublin [5]. The main objectives of the Forum were to advance the implementation of (i) the WHO Global Strategy for HRH for Health 2030 and (ii) the UN High-Level Commission's Health Employment and Economic Growth recommendations. The Forum was rather 'extraordinary' and seemed to propel a bold vision of "advocacy to activism" in investing in the health workforce. In this paper, we examine the main themes arising from the Forum, and offer our observations on the dialogue and outcomes of the Forum to the future of oral health workforce in the UK and dentistry at large.

Main themes arising from the Forum

Adopted by the 69th World Health Assembly in 2016, the WHO Global Strategy on HRH 2030[6] set up for the first time a global vision and framework to lead the health workforce agenda.[4] The global HRH strategy 2030 sees the availability, accessibility, acceptability and quality of health workers as vital towards obtaining the required health coverage to all people.[6,7] Adequate investments to health workforce, and implementation of effective policies at all levels (national, regional and global) are considered essential to ensure healthy lives and to promote equitable socioeconomic development through decent employment opportunities.[6] The United Nations High-Level Commission's report on Health Employment and Economic Growth launched in September 2016, brings a joint effort from International Labour Organization, Organisation for Economic Cooperation and Development and the WHO.[8] The core message is an irrefutable case for investment in health workforce can accelerate progress across many SDGs.[4,9] Both the WHO global HRH Strategy 2030 and the UN High-Level Commission's recommendations, present overarching global frameworks to enable good governance and stable progression towards achieving UHC and SDGs.

The Dublin Declaration on HRH,[10] was announced at the Forum, which brought together the joint efforts of the WHO, member states and partners. Figure 1 presents an illustration of the main themes we consider arising from the Forum and its relation to the broader health system and global goals. The following description provides a short note on these themes.

Data and evidence generation

An integrated approach for the collection and reporting of health workforce surveillance data has been argued to dramatically improve information architecture across countries and globally. It is expected that the proposed National Health Workforce Accounts,[4] will streamline the collection and reporting of data, and capable of seamless linking with existing global data structures such as the WHO Global Health Observatory. A special hub in the WHO has been

designed specifically for this purpose. The activities of this hub are to be streamlined with the Health Data Collaborative,[11] which is a partnership of international agencies, governments, philanthropists, donors and academics with the common purpose of improving health data.

Aligning health workforce education to population needs

Owing to the mismatch between health personnel competencies with population, health system and health labour market needs, reorientation of the health workforce education agenda towards greater social accountability is necessary.[4,12] The evidence presented was systematic and consistent across countries. Areas of priority include a focus on interprofessional education, teamwork and collaborative practice with an aim to build lifelong learning models focussed towards delivering patient-centric integrated care.

Mobilization of funding to support health workforce initiatives

As workforce issues were considered central towards achieving UHC, adequate financial resources towards strengthening the technical and policy initiatives is essential. It is argued that countries recognise the need for investment in health workforce and play a proactive role in meeting targets in health education, service delivery and research.[4] Internationally, a Working for Health Multi-Partner Trust Fund (MPTF), was proposed at the Forum,[13] mainly to support countries to expand and transform their health workforce. It is expected that this MPTF will help partners and Member States to pool funding to provide the support needed to generate change at the country level.

International cooperation on mobility of health personnel

The first consultation on a mechanism for establishing an international platform on health workforce mobility was held at the Forum. Today, a greater commitment exists to support the platform to maximize mutual benefits and mitigate adverse effects from the increasing magnitude and complexity of health labour mobility.[4]

Capacity building for future leaders

Understanding the importance of building skills for HRH policy and planning, new education and training programs are required to equip health personnel with big picture perspective as well as health workforce policy and planning. The WHO is currently leading the development of such programs to foster capacity building in several countries/regions and have mapped a detailed plan for the instrumentation of these programs.[14]

In addition to these themes, the Global Health Workforce Network (GHWN) was central to the policy dialogue in the Forum and is expected to support the global mechanism for multisectoral collaboration and dialogue on health workforce policies. The GHWN will now continue with work of the Global Health Workforce Alliance, which completed its 10-year mandate.

Implications for dentistry and the oral health workforce

Dentistry in UK and in many parts of the world has remained historically 'distinct' from medicine and the broader health profession. In the light of better integration of oral health with general health, there is a need to consider some key aspects of the oral health workforce and how they align to main discussion arising in the Forum.

Globally, there seems very little agreement on what constitutes the oral health workforce, as many countries' register only dentists. Dental surgeons and dental specialists (together represented as dentists) contribute to at least three-quarters of the overall global oral health workforce.[15] Mid-level dental providers (including dental therapists, dental hygienists, dual-qualified oral health therapists) are reported in small numbers and under-reported. A sizeable proportion of ancillary support dental staff (dental nurses and dental assistants) are not reported as part of the oral health workforce. Owing to these differences in the surveillance and reporting of oral health workforce data across WHO Member countries,[7,16] developing meaningful and regular estimates across the various oral health workforce occupations, as a basis for understanding trends, practice patterns and policy options is essential. Further, differences also exist in registration requirements, occupational roles and in recognition of mid-level dental providers.[17] A global agreement on these issues, as well as developing international standards that accommodate various educational competencies and skill sets of oral health personnel is necessary.

Disaggregated estimates on oral health workforce, where available, in the WHO global health observatory do not provide the level of stratification (on various oral health workforce groups) to cater to the intricate needs of oral health workforce policy and planning in several countries. While in UK, with joint regulation and good availability of workforce data, there is still a need to improve granularity of available data.

Investment in the oral health workforce is critical. The global burden of oral disease remains huge. Untreated dental caries, periodontal disease and tooth loss rank among the most

prevalent conditions in the global burden of disease study [18]. Oral diseases are also linked with several systematic conditions, and it is estimated that the direct treatment costs alone for oral disease account to about US298 billion globally, corresponding to an average of 4.7% of the global health expenditure [19]. Therefore, it is only logical to invest in the oral health workforce (and by extension the health workforce in general), and thereby all faculties that contribute towards oral health workforce including education, research, policy, and planning.

International migration of dental personnel is a growing issue[15,20] ; it is exacerbated by the growth in the number of private dental colleges in developing countries. Like medical personnel, dentists represent a global elite professional group, which is highly sought after. Whilst migration brings benefits, there are also ethical issues such as loss of investment by source countries, integration of migrant personnel in host countries and a growing need to better understand migration patterns and migrant challenges across the globe.

While the proportion and mix of the 'dental team' varies across countries, the potential to widen the skill mix of the dental team with enhanced roles for mid-level providers is debated among dental academics and policy makers researchers, together with developing models of care that refocus the dental team more towards the delivery of primary care and prevention [21,22]. Two parallel agendas also exist which call for integration with healthcare in general. First an argument for broader roles of other health practitioners (such as general practitioners, nurses, allied health practitioners and community health workers) in relation to oral health, and an opposing argument for oral health professionals to perform some medical assessments (such as screening for diabetes, hypertension and delivering lifestyle interventions). Much of this diffusion of roles and expanding the skill mix, though must pass through necessary regulatory bodies and professional associations and is dependent upon the education sector for development of the necessary skills and experience.

Finally, much of dentistry and dental care provision is organised in private clinics. This fundamental difference in the organisation of the dental system limits the definition of UHC

(at no out of pocket expenditure) in many countries to services provided by an already overburdened dental public sector. Across the UK, dentists as independent contractors are able to treat public patients under an NHS contract which differs across the four nations. Several considerations have been raised on the limitation of such contracts to enable oral health personnel to provide more comprehensive care. In general, questions exist on how access could be improved, how various types of dental funding models can work with a private dental sector, number of dental practitioners required, types of services oral health personnel provide in public and private facilities, improving teamwork and collaboration within the dental team, how dentists can engage with the broader health professions and develop various interdisciplinary collaborative approaches as well as integrated care models across healthcare and within dentistry.

On Reflection

By raising the urgency for investing in HRH, and the call for action, undoubtedly the WHO and partners have made a grand commitment. First, investment in oral health workforce is crucial towards strengthening the global agenda of SDGs and UHC. Secondly, we recognise the need for oral health personnel (including clinicians, policymakers, professionals, academics and researchers) to work more closely with the broader health personnel (doctors, nurses, pharmacists, allied health personnel, health workers and others). Thirdly, global dental organisations need to work more closely with the WHO on this important agenda in which the UK can lead the way. A continuous mechanism needs to be established that accommodates participation from key oral health organisations such as the International Association for Dental Research, FDI World Dental Federation, other global and regional oral health organisations and concerned research centres and academic institutions involved in oral health workforce issues to ensure the solutions are in line with the WHO Global Strategy for 2030 and the UN High-Level Commission's Health Employment and Economic Growth. Finally, as delegates of the Forum, we raise the importance of oral health/dentistry playing a more visible role in the mainstream global health workforce agenda, and the potential for more effective collaboration between the oral health workforce and broader health workforce, and between all health workforce groups with WHO and the newly-established Global Health Workforce Network.

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