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IFMSA Policy Proposal Global Health Workforce

Proposed by the Team of Officials

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Policy Commission

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Policy Statement

Introduction

The health workforce is essential to provide the highest attainable standard of health and to achieve universal health coverage (UHC). The final report of the United Nations High-Level Commission on Health Employment and Economic Growth projected a global shortage of 18 million health workers by 2030, primarily in low- and lower-middle-income countries (LMIC). This shortage has been underlined and augmented by the COVID-19 pandemic. Moreover, health workers globally continue to suffer from violence, harassment, and discrimination. Underlining the importance of the health workforce, 2021 has been designated as the International Year of Health and Care Workers. To provide access to high-quality healthcare to everyone, with nobody left behind, and to build resilient communities and health systems, it is essential that we act now and invest in the global health workforce.

IFMSA Position

The International Federation of Medical Students' Associations (IFMSA), comprising over 1.3 million future health professionals, affirms that the global health workforce is an essential part of healthcare provision and the resilience of a healthcare system. To achieve equity in access to quality healthcare and to leave nobody behind, greater financial and political commitment to the health workforce is required. Health workers should have high quality, continuous education; good, supportive, and safe working conditions; and adequate compensation and benefits. To achieve this, policies need to be developed, implemented, and evaluated together with the current and future health workforce.

Call to Action:

IFMSA calls for:

Governments to:

- Engage fully and meaningfully with local, national and international representatives of health professionals and future health professionals to work towards tackling the health workforce issues;
- Provide financial and political commitment to the health workforce by implementing policies to solve shortages, improve working conditions, and stimulate inclusion in decision-making;
- Implement wage and employment policies to tackle the gender pay gap;
- Implement and strengthen the institution of parental leave and other means to equally distribute parental duties within families;
- Fund and engage in bilateral and/or multilateral partnerships through global health programs and health policy and systems research that work towards a sustainable and adequately distributed health workforce;
- Facilitate continuous dialogue with employers, health workers and students, and other relevant stakeholders in the health sector;
- Support institutions in implementing global health workforce programs and research;
- Implement the World Health Organization global code of practice on international recruitment of health personnel, and facilitate information exchange on health personnel migration.

The United Nations, World Health Organization, International Labour Organization, Organisation for Economic Co-operation, and Development to:

- Engage fully with global representatives of current and future health professionals to work towards tackling health workforce issues, including providing transparency, meaningful engagement, and financial opportunities;
- Foster a collaborative environment and promote unity in achieving a sustainable and adequately-distributed health workforce;
- Encourage Member States to engage in bilateral and/or multilateral partnerships through global health workforce programs and research;
- Employ respectful language that does not alienate nor patronize any Member State during international cooperation on global health workforce programs;



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- Monitor the situation in Member States for discrimination based on gender, sex, race, religion, nationality and other factors.

Non-Governmental Organizations (NGOs) to:

- Fund and engage in bilateral and/or multilateral partnerships through global health programs and research;
- Collaborate with governments and institutions to implement global health programs and research;
- Engage with governments to facilitate the establishment of effective national policies and frameworks on health workforce planning;
- To provide support and protection for the individuals affected by workplace discrimination or gender-based violence.

Healthcare facilities and healthcare professionals to:

- Provide good working conditions to all health workers including students through adequate reimbursement, ethical working hours, safety, reporting mechanisms, mental support, and meaningful and equitable engagement in decision-making;
- Unite on the local, national, and international levels and shape strong stances towards the improvement of the global health workforce;
- Establish guidelines for students' participation within the healthcare system;
- Report on workplace discrimination, harassment and sexual violence, and foster an environment in which such acts can be safely and discreetly reported;
- Implement employment policies that provide equal opportunities for people regardless of gender including accessible childcare services and support for workers with children.

Universities, education providers, and academic/research institutions to:

- Invest in technology to provide continuous education for health professionals;
- Collaborate with other institutions to implement health workforce programs and research;
- Promote social justice and cultural sensitivity, when engaging with other contexts in global health workforce programs and research partnerships;
- Include health emergency content in the curriculum for undergraduate medical students.

IFMSA National Member Organizations (NMOs) and medical students to:

- Advocate for the health workforce while underlining the important role that health students play in health delivery;
- Build students' capacity to become health leaders that adequately understand the need to work towards improvements within the health workforce;
- Identify local demands through meaningful involvement with communities, and provide context-specific solutions accordingly;
- Collaborate on this with other NMOs whilst promoting social justice and cultural sensitivity;
- Raise awareness of the issues related to the health workforce crisis amongst civil society, promoting understanding on the issues of shortages, maldistribution and poor healthcare delivery conditions.



Position Paper

Background information:

The World Health Organization (WHO) defines health workers as “people engaged in actions whose primary intent is to enhance health.” (1) The health workforce consists of health service providers within and outside of the health sector, whose work is complemented by health management and support workers. Health service providers include professionals such as doctors and nurses, associates such as laboratory technicians, and other community health workers such as traditional practitioners. Health management and support workers include professionals such as hospital accountants, associates such as hospital administrators, support staff such as clerical workers and drivers, and even craft and trade workers such as painters of hospitals (2). Together, the health workforce, which is composed of both health and non-health occupations, share in the main function of healthcare delivery. The competency of such dictates the extent to which health needs can be addressed with health services (3). Therefore, the global health workforce plays an invaluable role in Universal Health Coverage (UHC), and a shortage of health workers may be detrimental to the attainment of UHC, which necessitates sufficient investment to improve health outcomes and, in turn, reduce the financial burden of preventable diseases (4,5).

The United Nations High-Level Commission on Health Employment and Economic Growth projected a shortage of 18 million health workers by 2030, primarily in low- and lower-middle-income countries, despite the projected 40 million new health sector jobs, that on the contrary, will manifest mostly in middle- and high-income countries. This mismatch that poses a great threat to global health security is expected to be further aggravated by health worker migration, especially from countries with weaker health systems (4). To address the vast inequality of health workforce distribution, the WHO Global Code of Practice on the International Recruitment of Health Personnel states that Member States should create a “sustainable health workforce and work towards establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel.” (6) Health system strengthening on the national level must be complemented by an equitable international collaboration with regards to ethical recruitment and data gathering through research (1). Special consideration must be made to underserved areas that more heavily bear the brunt of geographical maldistribution of health workers (6).

Beyond just responding to the shortage of health workers, health workforce investment must be coupled with protection of workers' rights, creation of a safe and decent work environment, and freedom from gender-based violence, discrimination, and harassment (1). This is because many health workers operate in high-stress and high-demand environments in which they are vulnerable to physical and psychological violence, and even biological hazards (7). In such an environment, women, who comprise 70% of workers in the health and social sectors, are especially vulnerable (7,8). This persists amidst a ubiquitous context in which women are subjected to higher illiteracy levels, harassment in the workplace, traditional customs and antiquated gender roles, and limited provisions on paternity and maternity leaves. Therefore, societal barriers that confine women to the lower tiers of the health workforce or that prevent them from being employed, to begin with, must be eliminated (1).

This position paper aims to further elucidate the rationale behind IFMSA's position on the Global Health Workforce. The following themes have been deemed pertinent points for discussion on the subject:

1. Access and Quality of Care
2. Rights and Safety of Health Workers
3. Gender-based Violence, Discrimination and Harassment
4. Ethical Recruitment
5. The Role of Students in Healthcare Delivery
6. Innovation and Education
7. International Collaboration



Discussion:

Access and Quality of Care

Ever since the propagation of the concept across different countries, there have been significant struggles in achieving the global goal of UHC that was laid out by the WHO and the United Nations (UN). UHC calls for better access to key healthcare services across the globe without financial burden on the beneficiaries. However, making healthcare easily accessible has proven to be a difficult task for many countries. The Consultative Group on Equity and UHC of the WHO recommends several ways to make the path towards UHC easier in both developing and developed countries. One of the most complex challenges is ensuring that populations living in rural and remote locations have access to trained health workers. (9)

The WHO suggests an improvement in this area through better attraction, recruitment, and retention of the health workforce in rural settings (10). However, every country has a different set of struggles in this regard. What is specifically alarming is the fact that contexts with the greatest health needs also have the lowest coverage of healthcare delivery. This manifests as discrepancies in live birth rates and maternal mortality among various countries (9). In its global policy recommendations for increasing access to health workers in remote and rural areas, the WHO further recommends national strategic efforts for nations having difficulty with health delivery (10).

The availability of health services across various health systems may not be accounting for adequate care provided to the patient (i.e. quality of care). This is yet again another huge barrier in the attainment of UHC. Experts suggest that the aims of patient care include safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness. These six parameters have to be strategically incorporated into the system to eliminate healthcare inequalities towards any particular group such as discrimination on the basis of culture, disease, caste, creed, race, or color. Healthcare workers, in this regard, share a specific responsibility towards ensuring the least neglect in the provision of care to any patient irrespective of their socio-cultural backgrounds, attitudes, and behaviors. This can arguably be countered to an extent via professional training and increased awareness across the health workforce (11,12).

Research indicates that patient or people-centered care improves patients' experiences and increases their trust in health services. Partnerships across healthcare workers, administrators, providers, patients, and families have proven to be beneficial to the quality and safety of healthcare; the cost of healthcare decreases, and there appears to be greater satisfaction among patients (12). Evidentially, it is rather impossible to achieve ideal care in healthcare, however, "equitable best care" as suggested in the Baylor Healthcare System, is fairly achievable with adequate organizational and institutional commitment towards the cause (11).

Analyzing the current situation of the global health workforce from a broader perspective, it is significant to understand how political and financial commitment reinforces improvement within this domain. Research suggests that investment in the health workforce and related policy developments rely heavily on political leadership, strong governmental strategies, the capacity of institutions, and intersectoral governance mechanisms. These are the same reasons why some countries lag behind others when it comes to health systems. A survey published in the BMJ that assessed human resources for health implications across various countries found that the majority of countries struggle to implement the best healthcare methods and policies in their regions. Hence, to overcome these flaws, national governments should continue to share responsibilities and cooperate with all relevant stakeholders in a coordinated manner (13,14).



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A recent positive development in this regard lies in the Recife Political Declaration on Human Resources for Health (HRH) in which 93 nationalities have committed to sustainably harnessing political leadership on human resources for health. The declaration emphasizes HRH information systems, adopting innovative solutions, and investing in research to strengthen the global health workforce. Countries in this regard will have to take appropriate measures according to their respective situations (14).

Rights and Safety of Health Workers

A significant aspect of empowering and improving the global health workforce is adhering to the rights of health professionals. Among the most prominent human rights of health workers include:

1. Basic individual rights, including civil, constitutional, and statutory rights;
2. Right to considerate and respectful behavior from their interactions with patients, superiors, or juniors free from harassment, abuse (both mental and physical), and attacks;
3. Right to protect themselves and their families in case of any violence or attack towards them
4. Right to good working conditions and appropriate work ergonomics;
5. Right to personal time during work shifts for food and fluids. (15)

In the context of work ergonomics for health workers, the emphasis was laid on decent working conditions during the UN General Assembly in 2015 as an integral part of 16 of 17 goals of the 2030 Agenda for Sustainable Development (16). However, on ground realities differ from country to country in this regard as the healthcare workforce faces multiple challenges. The work environment is one of the major factors towards better performance of healthcare workers and is also known to affect the quality of care provided. As a result of poor working conditions health professionals often encounter burnout, stress, negligence, and errors in practice. To counter this, comprehensive workplace policies need to be set in place to effectively address the mental and physical needs of health workers. (17)

The job-quality model suggested by Muñoz de Bustillo et al. emphasizes that the employment quality of health workers depends on six major elements: adequate pay, appropriate working hours, professional training, social benefits, participation, and type of job contracts. Parallel to this, they suggest that work quality would eventually depend on work autonomy, organization of work including staffing and dividing, organizational culture and trust, safety and health, pace of work, and social work environment. It is thus recommended that in order to increase the productivity of health workers and to maintain their physical and mental health, these parameters need to be catered to in every healthcare setting. (17)

For the safety of healthcare workers, their protection against any form of harassment and violence is imperative. Even though the primary responsibility of a health professional is to cater to the needs of an ailing body, they are entitled to their right to protection in the same way as an ordinary person. Any situation of this magnitude directly affects healthcare delivery to patients, the health facility, and the health system. Therefore, violence against health workers has serious humanitarian implications leading to a compromise on international human rights, humanitarian law, and codes of medical ethics (18). In line with the increasing violence in the health sector, various international organizations explicitly work and advocate for the reduction of violence towards health workers. Examples include the World Medical Association (WMA) in their declaration for the protection of health workers in cases of violence, the Safeguarding of Health in Conflict coalition in their report on violence against health workers, the WHO in their case study on workplace violence, and the Lancet in their world report on tackling violence against health care workers. (18–21).

In the light of the COVID-19 pandemic, there has been an even larger surge in the violation of the rights of healthcare workers around the globe. Insecurity Insight identified 823 incidents of such violence in 66 countries which directly affected healthcare delivery between January and August 2020, most of which were classified as related to COVID-19. The reasons identified for this violence range from psychological conditions of patients to their mistrust in health workers with regards to their management of the coronavirus (22). Furthermore, the psychological needs of health professionals have largely been



compromised. This has been reported in a recent meta-analysis which concluded a high prevalence of mental disorders among health workers amidst the pandemic. The study showed a high prevalence of anxiety and depression among health workers with insomnia as a major risk factor (23). Despite various efforts of public awareness and global cooperation, health systems all around the world have been struggling to address this problem; this necessitates better interventions that would, in turn, increase the productivity of the healthcare professionals (22).

Gender-based violence, discrimination, and harassment

Workplace gender, racial, and otherwise motivated discrimination is a well-documented phenomenon in the health workforce. Many biases and discriminatory patterns present in society, as well as government policies that promote inequality and discriminatory behavior towards vulnerable groups, have been indicated to affect the amount and form of workplace discrimination faced by healthcare workers (24–26). Discrimination against health workers presents a two-fold problem to health systems and UHC, with its obvious effects on the health workers themselves (27,28). However, patients are also indirectly affected as evidence links job-dissatisfaction, negative workplace relations, on-workplace bullying, and other negative effects of discrimination to poor job performance, decreased willingness to learn and improve job skills, and overall decreased quality of healthcare (29–32). An important factor specific to healthcare settings is the composition of the workforce, as many vulnerable groups, such as women or immigrant workers, feature prominently in the health workforce (33–35).

Women represent 70% of workers in healthcare and social sectors, yet at the same time are quantitatively most affected by workplace discrimination. According to the findings of the WHO, women represent the majority of nursing jobs, while men dominate physician jobs in most of the regions (with the exception of the European region). This trend is expected to change, however, as there has been a steady increase in female representation in higher-wage health professions, such as physicians, dentists, and pharmacists, as the majority of such workers aged 40 and less are women. (8)

Women suffer from a significant pay gap in the health sector. Across the health workforce, women earn, on average, 28% less than men. Among physicians, women earn, on average, 13% less per hour than men, and 12% less in nursing professions (8). Men typically occupy high-income brackets, while women are overrepresented in low-income wage categories (24,36). Women also tend to work fewer paid hours than men and are less likely to be employed full-time (8). In the academic sphere, female physicians are less likely to become full professors and tend to receive smaller research budgets (37–39). Some of these issues are attributed to perceived gender roles in family life and child care, as female physicians often spend a greater portion of time on domestic labor, and are more likely than male physicians to have a spouse that is employed full-time (40–42).

The prevalence of sexual harassment and sexual violence in the workplace appears to vary among countries and regions. While some studies place the prevalence of sexual harassment from 5 to 7%, other studies and polls suggest that as much as 60-80% of health workers have experienced some sort of sexual harassment (43–46). It is also implied that many cases of sexual violence or harassment remain unreported (particularly by male health workers), which is a trend consistent with this issue in the general population. Therefore, the true scope of this problem will likely remain unclear until more accurate data is collected. (47–49)

Ethical Recruitment of the Health Workforce

Migration of health workforce and health outcomes

Recently, the migration of health workers, which entails the transference of skills from more fragile health systems, has significantly increased. Health systems in some of the world's poorest countries are plagued with insufficient resources and serious health workers shortages; they are failing to meet even the most basic health needs of their populations. These circumstances cause health workers to migrate, even if the loss of their valuable skills greatly threatens the health, human rights, and development goals of the populations they leave behind. (50)



There is an acknowledgment of the correlation between the availability of the health workforce and health outcomes. Studies found that the lack of skilled health workers constitutes a major barrier to the implementation of health interventions that aim to improve maternal and child health and address HIV/acquired immunodeficiency syndrome (AIDS), malaria, and tuberculosis. This is further expounded by a quote from an article by Kollar et al. in 2013: “Critical health worker shortages strongly affect the operation of public health systems and overburden existing staff, which in turn raises error rates in diagnosis and interventions. Critical shortage may also undermine a country’s capacity to absorb external funds and implement international programs of health assistance (51).”

Health workers’ migration consequently affects the sustainability of health systems as facilities become understaffed; the quality of care decreases, and the morale among the remaining staff deteriorates (52). Therefore, it is imperative that the issue of migration of health professionals remains on the international agenda (53).

Global Code of Practice on the International Recruitment of Health Personnel

In 2010, during the WHO’s 63rd World Health Assembly, a framework for addressing the health workforce crisis at a global scale was formulated—the Global Code of Practice on the International Recruitment of Health Personnel. It established a framework for the ethical recruitment of health personnel and guides Member States in the development of national frameworks for ethical recruitment. The Code of Practice proposes that conditions for the recruitment of health personnel should be set out in bilateral agreements between source and destination countries, thereby creating win-win situations in the context of health workforce migration. (6)

The Code stresses that it respects the rights of individual health workers to migrate, and therefore asks source countries to address the factors that drive the health workers’ emigration. However, the individual right of a migrant to seek opportunities elsewhere can conflict with the country’s goals to secure the provision of health services for its people. (6)

Improving health worker retention, while at the same time respecting their individual rights can be achieved by improving working conditions in the donor country itself. In return, the destination countries are particularly asked by the Code to ensure adequate and context-specific long-term health workforce planning, focusing on capacity building of local professionals in order to decrease the pressure to ‘import’ health workers from elsewhere. Furthermore, destination countries are asked to support sending countries technically and financially to mitigate the current effects of migration of health personnel. Such solutions to the workforce crisis have been widely discussed and considered effective in tackling the shortage of health workers. (52)

To fulfill people’s right to health, the code calls out for: “Member States to strive to meet their health personnel requirements with their own human resources for health.” It encourages countries to implement measures to retain health workers, with the quality and quantity that corresponds with the country’s population’s health needs. To ensure monitoring and implementation of the code, it requires member states to periodically report measures taken, results achieved, difficulties encountered, and lessons learned. (6,54)

The Code raises that better information will assist the development of more effective policies, thus the recent spate of studies will prove to be a valuable contribution. Better human resource planning and management strategies will improve attraction to and retention in poorer countries. (53)

The Role of Students in Health Care Delivery

The responses to the COVID-19 pandemic caused a wide range of reactions in health systems and clinical environments (55). Consequently, medical students and residency applicants are being affected in various ways. The withdrawal of medical students from clinical encounters leads medical students to seek ways to participate in the spirit of volunteerism, to replace some of their lost clinical experiences (56).



One paper by Miller et al. from 2020 showed that the benefits of allowing students to perform clinical tasks, in specific instances, outweigh the risks associated with their involvement. The authors believe that medical students are clinicians who have responsibilities to patients and should be allowed to fulfill their duties as such. Adding up to the benefits to patients and the health care system, student participation reinforces important values, such as altruism, service in times of crisis, and solidarity with the profession. They state: "Students are willing and able to fight in this historic pandemic and should be given the opportunity to do so." (57)

Student participation in clinical care has varied across institutions. Some schools forbid any patient interaction, whereas others have recruited students for hospital-based roles or even graduated medical students early so that they can serve as frontline clinicians. Potential clinical roles for medical students amidst COVID-19 have been discussed widely. As medical schools decide on how to proceed, below is a list of suggested roles that students can perform :

- Medical students can assist with routine outpatient clinical care. Medical students can boost the efficiency of lightly staffed clinics by taking histories, calling patients with laboratory test results, providing patient education, documenting visits, and fielding questions about COVID-19. Even in a pandemic, patients with chronic conditions need ongoing care. Pregnant women need routine check-ins, and discharged patients require follow-up. Many of these tasks can be performed via telemedicine, so there would be no risk for infectious transmission.
- Students can provide care on inpatient services that do not have patients with COVID-19, under the supervision of senior residents or attending physicians.
- Medical students can remotely assist in the care of patients with COVID-19. They can monitor patients with mild COVID-19 symptoms who are not admitted; expedite care for admitted patients by reviewing charts, drafting notes, and ensuring tests are performed; and follow-up with patients after discharge. Although all of the roles we have discussed would require physician supervision, they would reduce the overall burden on clinical teams. This would, on balance, improve patient care;
- Medical students can be valuable in fields of research on COVID-19.
- Medical students can volunteer, use social media to educate the masses about social distancing and the SOP (Standard Operating Procedure) that need to be followed.
- And finally, medical students have joined frontline workers where a large number of frontline health care workers were urgently needed. (56,57)

There's an assumption that students are an available resource in terms of volunteerism during a crisis. However, engaging students in such work requires sufficient preparation (58). An article by Klasen et al. published in 2020, states that: "our role as educators is to create opportunities that will engage medical students in the learning they require to ensure that the strength of their contributions continues to grow (55)."

The involvement of medical students as frontline workers with inadequate clinical training, highlights the need for the inclusion of pandemic/crisis-specific content in the current curriculum, especially for medical students in the final years of their program as they offer a vast wealth of potential (56,57). The insistent need for competency-based medical education, even before the emergence of COVID-19, was prompting medical schools to move towards active self- and team-directed, case-based learning (55).

Innovation and Education

Problems related to the global health workforce are structural problems—one of which includes insufficient educational bases that mainly concern LMICs. The large number of medical schools with market-oriented and non-socially accountable profiles leads to a deficit in the quality of healthcare and to the centralization of the workforce in urban centers. This centralization is also a result of the unequal distribution of health resources and the poor health management planning in many regions. (59,60)

Furthermore, evidence-based management planning must be implemented. In the context of global health, research with a local approach is extremely important. When geopolitical and cultural aspects



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are accounted for, this approach has been proven to project a more realistic picture of the situation, which helps in structuring possible solutions (61). Addressing the global health workforce issue, identifying the number of professionals, and their capacity building in healthcare becomes the focus of the discussion, along with maldistribution, skill imbalances, low productivity, low salaries, and poor work environments. (60–62).

Therefore, offering continued education, through socially responsible policies, to regions that need more access to specific health services is essential in preventing the need for those living in non-urban areas to leave their hometowns in search of doctors, nurses, dentists, and other health professionals based in cities. African and Asian countries have the greatest disparity in terms of health workforce distribution - with a critical HRH shortage (<2.28 doctors, nurses, and midwives / 1000 inhabitants) in many countries. (62)

Access barriers due to geographical reasons have also proven to be a huge problem, thus e-learning can come as complementary training for health workers to acquire pertinent skills in healthcare delivery, as it allows for quick interaction without heavy travel costs (63). Despite the limitations, it may address the lack of certain skills among specialized health professionals, as well as provide more knowledge to general professionals, who constitute the majority of those working in low-income and difficult-to-access areas (60). Aside from e-learning, soft technology and protocols are other innovations that help mitigate the lack of access to quality healthcare in geographically isolated and disadvantaged areas (61).

During the COVID-19 pandemic, there have been many changes in medical and health education as new innovations and solutions arose. The pandemic highlighted the importance of developing good research methodologies to promote advances in healthcare and to ensure a safe working environment for health workers. Moreover, in line with the shift to online learning that medical schools have undergone, technology and education have never been more inextricably linked. In conclusion, incentivizing research is essential to understanding the situation of a region, and it creates solid bases for advocating for the allocation of resources in favor of education and technology that would, in turn, reduce disparities in the global health workforce. (64,65)

International Collaboration

Inequalities in mortality rates pervade economies and expose the flaws of health systems across the world. Societies characterized by such necessitate greater attention from global health efforts as they are less likely to achieve the WHO's recommendations on the global health workforce, detailed by "Working for Health": A Five-Year Action Plan for Health Employment and Inclusive Economic Growth (66,67). This underlies the WHO's commitment to achieving UHC, which calls for a multidimensional approach that engages a diverse set of contexts while fostering a collaborative environment. At a time of great uncertainty, it is crucial for Member States to engage with one another in bilateral and multilateral partnerships through global health programs and health policy and systems research (HPSR) that work towards creating conditions for a sustainable and adequately distributed health workforce (68). In addition, Member States must actively gather national and international data and participate in knowledge sharing of information on the international recruitment of health workers (6). Examples of these include the Triple Win Program, a bilateral agreement between Germany and the Philippines that is centered on the sustainable recruitment of nurses, and Japan's Asia Health and Human Well-Being Initiative that aims to promote regional cooperation in response to rapid aging within the region (6, 69). However, despite their capacity to narrow down mortality rates and improve health outcomes, it is important to note that focusing solely on the outcomes of such programs provides a simplistic view of global health (70,71). This perspective fails to underscore the need for partnerships to be implemented in an equitable manner, given that social justice must always be at the core of international collaboration (71).

International research cooperation plays an indomitable role in promoting advances in medicine and public health (72). It equips institutions of LMICs with financial and infrastructural resources to strengthen their research capacity. International studies have proven to be a valuable avenue for testing hypotheses in different contexts and developing new technologies—creating mutual benefits to all



stakeholders involved (72, 73). In light of global health threats such as climate change, antimicrobial resistance, and non-communicable diseases, exchanging knowledge and unifying efforts against such issues have become a necessity (74). In the context of the global health workforce, HPSR must be augmented to support the already emerging evidence on the socio-economic benefits of health workforce investment and to optimize the ways in which health workforce reform should be conducted (75). However, despite the undeniable benefits of international cooperation, there are ethical considerations that stakeholders must always comply with, amidst a much larger movement towards decolonizing global health. (76)

The origin of global health lies in “tropical medicine,” a field that emerged from the need to protect colonial rulers from tropical diseases. Despite the multiple paradigm shifts in the past few centuries that led to the modern definition of global health, remnants of its colonial history remain and should be given careful consideration (77). In terms of international cooperation, collaborators must always be clear with the benefits that their partnership will bring to their respective contexts through specific provisions that aim to maximize mutuality of benefit (78). Partnerships must have a proper balance of influence, in which the developing country actively provides contextual knowledge and is proactive in decision-making processes (74,78). These efforts should address the issue of potentially exploiting populations through research. To aid with building consensus and in the long-run, intersectoral commitment, programs must facilitate continuous social dialogue between governments, employers, and workers (67). Concurrently, stakeholders must employ reflexivity to prevent sully projects with neocolonial influences. (79)

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