Healthcare workforce caring for older adults across the world: an overview

Healthcare workforce caring for older adults across the world: An overview

Professor Hafiz T.A. Khan, Professor of Public Health, The Graduate School, University of West London, St Mary's Road, London W5 5RF, United Kingdom, Email: hafiz.khan@uwl.ac.uk
&
Dr Saidu Ahmed, Assistant Director and National Project Coordinator, HEPIQ-C Project, Federal Ministry of Health, Nigeria, Email: saidu.ahmed@fedcs.gov.ng

Abstract:

This talk evaluates the demand and supply side of healthcare for older adults in a global context and presents a plausible scenario, with examples taken from a number of selected countries, of the current position of the healthcare workforce caring for older adults. This talk will also explore the gap between the current healthcare situation and the actual support and care that are needed to help and ensure a healthy ageing population. While acknowledging that there are a good number of healthcare workers in some countries, it's also true that they do not receive adequate training or possess the necessary skills to deliver appropriate support and care to elderly people. Findings from a recent survey on the Nigerian care workforce are shared here. The survey highlights the lack of appropriate knowledge, attitudes and practices (KAP) among this workforce that lead to real barriers for providing services to elderly people within the community. The findings will be of help to other regions of the world when redesigning their health care systems.

Introduction:

There is a growing global trend of people living for longer with the proportion of people aged 65 years and over gradually increasing (Higo & Khan, 2015; Powell & Khan, 2014; Khan et al., 2017). This large number of older people needing appropriate support and care is not always seen on the ground. Some countries have claimed that they have a good healthcare workforce but are still unable to deliver effective care services. There may be a number of reasons for this situation, one of them being a ruin public health system although a big divide exists in healthcare services between the developed and developing worlds (Higo & Khan, 2015). A huge variation can even be seen between different countries in the developing world. The numbers employed in a healthcare workforce are usually based on a country's demand as well as on its economic ability i.e., GDP. Having said this, the recruitment of healthcare workers may not be based on a country's future needs such as providing care for increasing numbers of older people. In addition to general population ageing, the exiting healthcare workforces are also ageing due to demographic transition. Research is being conducted in developed countries to look at the ageing healthcare workforces in order to keep the healthcare systems functioning appropriately. One reason for this is a desire to be less dependent on migrant healthcare workers. Questions remain however such as, just how capable are these existing healthcare workforces and can they actually provide appropriate healthcare to the older adults of their respective countries?

The aim of this study is to investigate the demand and supply side of the healthcare workforce to meet the requirements of ageing populations. The paper is structured in three parts: First, we highlight the demand and supply analysis for healthcare need across the world and identify a gap to meet the challenges of an ageing society. Secondly, an overview is provided on the exiting healthcare workforce and the production side and how ready it is to deliver the support and care needs of older adults. Thirdly, we identify the lack of KAP among healthcare workforces that would enable them to deliver such services to their countries. A recent study on the Nigerian care workforce is used as an example for others.

The world is experiencing a period of increasing longevity among its populations that is leading to increases in demand in many countries for long-term care services. This demand has increased because of socio-economic improvements at individual and at household levels (Raeside & Khan, 2008; Khan & Leeson, 2006). There has always been a question about who bears the costs of care although it varies across geographical regions (Khan et al., 2013). One certain thing however, is that both formal and informal care services need to expand to cope with the need. Unfortunately, informal care in some countries is gradually weakening because of modernisation and changes in

family type (Khan et al., 2017; Khan, 2014). In modern societies, family members can no longer be regarded as a reliable source for providing support and care. In this scenario, people in many countries are then forced to rely on the formal care sector.

Today healthcare has become big business in many countries as multi-morbidity is prevalent among older adults. Therefore, to provide appropriate care services for elderly each country needs to develop a skilled workforce. Healthcare comprises an extremely diverse range of goods and services, including surgical procedures, screening programmes, pharmaceuticals and counselling services (Morris et al., 2012). There are different types of healthcare providers such as hospitals, GP practices, pharmaceutical companies and ambulance services. We refer to these as "firms" and their job is to provide goods and services. The role of labour in the production of healthcare is important. There are many different types of healthcare workers (HCW). These include doctors, dentists, nurses and midwives, as well as a host of allied health professionals including pharmacists, radiographers, dieticians, occupational therapists, physiotherapists, paramedics, and speech, language, drama and music therapists. Within these roles, the HCWs may be specialized in different therapeutic areas. For example, doctors work in such diverse specialties as anesthesia, intensive care medicine, emergency medicine, general practice, medicine, obstetrics and gynaecology, occupational medicine, ophthalmology, paediatrices, pathology, psychiatry, public health, radiology, and imaging and surgery. There are many other workers that directly or indirectly contribute to healthcare services including those in the pharmaceutical and medical devices industries, as well as those providing medical supplies and IT services. The whole HCW team are engaged directly and indirectly to provide services for older adults.

When reaching old age, people are likely to need special types of care such as palliative care that families cannot always provide. Moreover, a service such as palliative care is generally only seen in developed rather than in developing countries. This is due partly to a lack of understanding about ageing and its consequences among policy makers. The good news is that research has started to address the healthcare needs of older people and how best governments can provide appropriate help and support such as through public and private partnership initiatives. When analysing the current global healthcare workforce we found that the proportional allocation of workers involved in caring for older adults is tiny. Table 1 shows the variation of healthcare across regions and indicates how some countries are better prepared than others. There was no data found on future targets for healthcare expansion to use as a comparison. This means there is a big gap between the demand and supply sides for meeting the needs of an ageing society. Statistics on the healthcare workforce providing care to older adults is not readily available in most countries and therefore it is difficult to figure out the actual supply side of a health system. Evidence shows that there is a shortage of supply compared with demand. Therefore, governments need to focus on this and invest the necessary resources in order to redress the balance between the demand and supply sides.

The UK is concerned about the potential shortage of healthcare workers after it has separated from the European Union, but there is a policy in place to train more NHS doctors and nurses in order to meet future challenges. It is clear that the demands made on healthcare workers are likely to increase in the future due to rising incomes, continual technological change and ageing populations. Evidence from the WHO shows that the distribution of healthcare workforces varies according to their place of residence, gender, age, type of work, and type of providers. Table 2 (below) uses China as an example.

Table 1: Comparison of health indicators in some selected countries with OECD countries, 2010

Countries/Region	Practicing physicians (per 1000 population)	Nurses (per 1000 population)
OECD	3.1	8.7
Japan	2.2	10.1
China	1.4	1.4
Viet Nam	0.7	0.9

Note: OECD Health Data 2012 (WHO, 2017).
http://www.wpro.who.int/hrh/documents/publications/hrh_buffet_country_profiles/en/

Even if there are healthcare workers allocated to older adults, they may not have adequate knowledge and training in geriatric care and support. A recent survey on Nigeria reveals that a lack of appropriate knowledge, attitudes and practices among healthcare workers are hindrances to the effective delivery of their daily care services to older people. More details about experiences in Nigeria are provided next in order to help with understanding the real situation on the ground.

Table2: Public and private sector distribution by health worker category, 2013

Category	Public Sector		Private Sector	
	N	%	N	%
Health workers	8 041 374	82.22	1 739 109	17.78
Health professionals	6 060 885	84.17	1 139 693	15.83
Physicians	2 265 642	81.07	529 112	18.93
Nurses	2 382 003	85.59	401 118	14.41
Pharmacists	339 531	85.83	56 047	14.17
Laboratory workers	340 840	87.75	47 581	12.25
Other health professionals	732 869	87.38	105 835	12.62
Village doctors and assistants	702 737	65.00	378 326	35.00
Other health workers	316 948	88.09	42 871	11.91
Health management workers	357 141	84.84	63 830	15.16
Supportive service workers	603 663	84.07	114 389	15.93

Source: China Public Health Statistical Yearbook and family-planning statistics (WHO, 2017).
http://www.wpro.who.int/hrh/documents/publications/hrh_buffet_country_profiles/en/

Nigerian Experience:

The number of older people in Nigeria is growing at a fast rate and therefore more people will be in need of healthcare. It was observed that a high proportion of older adults aged over 60 lived in the Sub-Saharan region (Ukiri Mudiare, 2013). Despite Nigeria having a huge healthcare workforce, the study revealed that there were very few if any health specialists concerned with care of older people and also detected poor attitudes generally towards care of the elderly. We did not discover any studies conducted in Nigeria on knowledge, attitudes and practices on healthy ageing prior to 2017. The problems would be better understood if such assessments were carried out scientifically. However, a study conducted in Abuja, the Federal Capital Territory (FCT) Administrative town of Nigeria showed that General Practitioners (GPs) had inadequate knowledge around ageing and their awareness of social and mental health facts of ageing was low in relation to the physical facts (Yang et al., 2015).

The study of KAP on health in Nigeria shows more than half of the HCW are midwives/nurses and the majority of respondents were found to be under 50 years of age. Three out of four HCW were aware of healthy ageing and less than a third were aware of health policy. The majority of respondents agreed attitudinally that it is a serious challenge as is access to health care for older people. It was observed that over half of the respondents had adequate knowledge (57%), positive attitudes (52.1%), and adequate practice of (56.2%) healthy ageing. This KAP study found out that I85 (55.4%) of the HCWs had adequate knowledge about healthy ageing but had not received or attended any form of formal training on healthy ageing.

It is of concern that those who had attended formal training or specialist training on healthy ageing were insignificant in proportion with 14/349, even though 93.3% of them had adequate knowledge on healthy ageing. Around 334 (95.7%) of the HCW had not attended formal training on healthy ageing and so highlighting that such training is grossly inadequate. This kind of scenario could be replicated in other countries in the world.

Analysis showed that FCT might face serious consequences in the future due to grossly inadequate training for HCWs on healthy ageing and wellbeing. Training was observed to be very significant in enhancing the knowledge and practice of healthcare workers that led to more effective delivery of health services. This in turn led to more positive experiences for older people receiving care from those health workers that had received training.

The introduction of training plans for HCWs by governments and other relevant stakeholders at primary, secondary, and tertiary health facilities is key at this particular time. Priority should be given to the cohorts who have inadequate or no knowledge. The practice strategy for training should also be detailed enough to improve the skills of the HCWs. Formal training of all HCWs in the FCT on healthy ageing and wellbeing would see a behavioral change of HCWs through communication and good governance that would serve to improve attitudes towards ensuring healthy ageing. There needs to be development of a health policy framework on healthy ageing and wellbeing in the FCT in collaboration with relevant stakeholders. This would provide an effective platform to address the problem of training at all levels involving both the public and private sectors.

Acknowledgement:

Paper prepared for oral presentation at the 2nd Congresso Brasileiro de Gerontecnologia, organized by Faculdade de Medicina de Ribeirão Preto, Universidade de São Paulo, Brazil, 16-18 November 2017. The official website is: http://www.cbgerontec.com.br/palestrantes. Professor Hafiz T.A. Khan is also an associate research fellow at the Oxford Institute of Population Ageing, University of Oxford, UK, email: hafiz.khan@ageing.ox.ac.uk. Authors would like to thank the Federal Ministry of Health, Nigeria for allowing us to use important findings of the HEPIQ-C Project.

References:

Higo, M. and Khan, H.T.A. (2015). Global Population Aging: Unequal Distribution of Risks in Later Life between Developed and Developing Countries. *Global Social Policy* 15(2):146-166.

Khan, H.T.A., Hossein, S. and Deane, J. (2017). Nexus between demographic change and elderly care need in Gulf Cooperation Council (GCC) Countries: Some policy implications, *Ageing International*, open access, August.

Khan, H.T.A. (2014). Factors associated with intergenerational social support across the world, *Ageing International* **39**(4): 289-326.

Khan, H.T.A., Leeson, G. W. and Findlay, H. (2013). Attitudes Towards Bearing the Cost of Care in Later Life Across the World. *Illness, Crisis and Loss* **21**(1):49-69.

Khan, H.T.A. & Leeson, G.W. (2006). The Demography of Ageing in Bangladesh: *A Scenario Analysis of Consequence*, *Hallym International Journal of Ageing* **8**(1):1-21.

Morris,S., Devlin, N., Parkin, D., & Spencer, A. (2012). Economic Analysis in Health Care. Second Edition, Wiley.

Powell, J.L. and Khan, H.T.A. (2014). Ageing in Post-Industrial Society: Trends and Trajectories. *Journal of Globalization Studies* 5(2): 143-151.

Raeside, R. & Khan, H.T.A. (2008). The Ageing Scottish Population: Trends, Consequences and Responses, *Canadian Studies in Population* **35**(2):291-310.

Ukiri Mudiare.,P (2013). 'Abuse of the Aged in Nigeria: Elders Also Cry'. *American International Journal of Contemporary Research*.vol.3 No 9; pp-79-87.

WHO (2017). OECD Health Data 2012, http://www.wpro.who.int/hrh/documents/publications/hrh_buffet_country_profiles/en/

Yang, Y., Xiao, L.D., Ullah, S. & Deng, L. (2015). "General practitioners' knowledge of ageing and attitudes towards older people in China", *Australasian journal on ageing,* vol. 34, no. 2, pp. 82.