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Health Workforce in the Sultanate of Oman: Improving performance and the Health System

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Abstract

This Analytical narrative review will shade a light on the Sultanate of Oman, which is the second largest country of the Arabian Peninsula. The health system for Oman was non existence before 1970 as no hospital or local health centers exists. However, forty years ago the establishment of health system started and major transformation from negligence took place in a progressive positive manner over years of steady build up. Nowadays, Oman is of high middle income countries in the region but with round two thirds of its current inhabitant are citizens and around one third are foreigner workers. This analytical narrative review bring to light an era that hardly been looked at previously of health system in Middle East region at such details.

Keywords: Health care; Health workforce; Oman; Human rights

Introduction

After decades of insufficient investment, poor management, inadequate attention, and ill-advised policies, many organisations attention is now focused on the health workforce. By some estimates, US$46 billion per year is required to scale up health services in low-income countries [1]. The majority of these funds would be used to expand the capacity of human resources in health, as this is a prerequisite for increasing the access to essential health services and for bringing down the disease burden to the level of the Millennium Development Goals (MDGs) [1,2]. The MDGs are a set of 8 goals, 18 targets and 48 performance indicators relating to poverty reduction by 2015. Of these goals, four are directly related to better health outcomes: two-third reduction of infant and under five mortality, three-fourth reduction of maternal mortality, halt and reverse HIV/AIDS, tuberculosis, and malaria epidemics, and halve the proportion of people suffering from hunger [2]. Without skilled, motivated, and well-equipped workforce accessible to everyone, MDGs, especially health goals will go unrealized and the human right to the highest attainable standard of health unfulfilled [3,4]. Indeed, the health workforce, improved health outcomes, and human rights are inextricably linked. Not only is a strong health workforce needed for improved health and fulfilling human rights, but human rights are needed to develop the workforce that can lead to overall better health [3,5].

The health workforce shortage reflects and amplifies patterns of global inequity. The developed world, despite a lower burden of disease, claims the majority of the world's health workers [3,6]. United States and Canada possesses 37% of the world's health workforce, despite only suffering 10% of global health disease burden and accounts for at least 50% of global health expenditures [7]. The health discrepancy in coverage is reflected in health outcomes, such as markedly high maternal mortality in developing countries, which is strongly associated with lack of access to qualified health workers [7].

This analytical narrative review will discuss the global shortages of the health workforce. It shall discuss Oman as a case study and its effort to maintain the national nurses' workforce. This will be followed by recommendations to address the problems in general and especially to Oman and finish with a conclusion

Global Health workforce issues and challenges

Human resources are central to health care systems and essential for the delivery of services to patients. In sub-Saharan Africa (SSA), especially, failure to invest adequately in health systems and professional health education, the rising death toll from HIV/AIDS and international migration of health professionals are all major factors contributing to the ongoing health workforce crisis [8,9]. Accelerated recruitment from developed countries, where populations are aging, expectations of health care increasing, recruitment of health workers (especially nurses) is poor and attrition considerable, has intensified this crisis, raising complex ethical, financial and health questions [7,10]. In a context of widespread existing health staff shortages in Africa, migration has further weakened fragile health systems [7,10]. Moreover, the costs of training health care workers in developing countries are considerable, hence migration has been perceived as a subsidy from the poor to the rich [11].

Indian subcontinent provide the largest absolute number of physicians to the recipient nations, but the relative draw on nations, as measured by the emigration factor, is actually greater for sub-Saharan Africa and is very pronounced for Caribbean countries [7,8,10,12]. The United Kingdom, Canada, and Australia draw

substantially from South Africa, and the United States draws very heavily from the Philippines [7,10,12]. Former colonial ties and the English language are strongly associated with many of the avenues of heavy migration [7,10,12].

Although there are undoubtedly benefits that accrue to source countries whose physicians move to high-income English-speaking nations, there can be little question that the emigration of these physicians is also a loss to the health systems of the source countries [13,14]. The effect of the emigration of physicians, many of whom come from poor countries, varies from nation to nation, but there are always costs to the source country in terms of financial resources (investment in education) and human capital (gifted, ambitious people) [13,14]. It is well recognised that while there is a right to health for everyone, there are also health-workers' rights to consider. Health workers should have freedom of movement and choice of where they live and work, just as any workers should [15,16]. To encourage the retention of health workers, governments and policy makers need to use incentives and to address the reasons for migration: low salaries, inadequate resources, long hours and heavy workloads, a threat of infections and violence, and lack of career development [17,18].

Active recruitment of health workers from African countries is a systematic and widespread problem throughout Africa and a cause of social alarm: the practice may, therefore, be viewed as an international crime [18,19]. Recruitment of health workers from Africa is a structured initiative led by recruitment organisations, but clearly sanctioned by countries that then accept these placements, such as Australia, Canada, Gulf Countries, the UK, and the USA [17,18,20]. Active recruitment is considered unethical under many national policies, leads to negative health outcomes [21,22] and undermines the right to health as asserted in the Universal Declaration of Human Rights [23], various International Covenants and numerous declarations and legally binding treaties including the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women [11].

The reliance of the United States, the United Kingdom, the Gulf countries, Canada, and Australia on physicians from other nations does not preclude them from drawing on each other. Physicians from the United Kingdom constitute the largest group of international medical graduates in Canada and Australia, and physicians from Canada are the fifth largest group of international medical graduates in the United States [15,17,24,25]. The patterns of emigration and immigration of physicians among these countries constitute a form of workforce "cycling" [15]. Within OECD countries, the net beneficiaries of this cycling are the United States and Australia, with net gains of 12,902 and 2539 physicians, respectively, whereas the net donors are the United Kingdom and Canada, with net losses of 9837 and 5604 physicians, respectively. Canada actually enjoys a net positive position with regard to the United Kingdom and Australia but has lost 8990 physicians to the United States while gaining 519 [15].

The government of the United Kingdom is committed to achieving a rapid increase of 9500 physicians by a combination of new medical schools and increased recruitment abroad [15-17,26]. Canada is adding residency positions to accommodate more international medical graduates and is streamlining immigration and training requirements to facilitate the direct entry of international medical graduates into practice [27]. Australia plans to increase the numbers of Overseas Trained Doctors and Temporary Resident Doctors in practice, in addition to increasing the number of medical school positions [28,29]. In the United States, a number of professional organizations and academic leaders have called for measures to augment the numbers of physicians in practice [30]. These developments suggest that the demand for international medical graduates in the United States, the United Kingdom, Gulf countries, Canada, and Australia is likely to grow in the near future, thus exacerbating current trends. It is important that developing countries implement various evidence-based strategies to increase and retain their health workforce in this trend of global crisis if to achieve the health related MDGs and the right to health for their people. Oman, as one of these developing nation needs to examine its situation very carefully.

Oman: Political system and social strata

Oman is an autocracy in which the Sultan retains the ultimate authority on all important foreign and domestic issues [31,32]. The country has small immature ill-formed democratic political institutions, and its citizens do not have the ability peacefully to change their leaders or the political system. The Government prohibits the establishment of independent human-rights groups [31,32]. The existing restrictions on the freedom of speech and association do not permit any activity or speech critical of the Government [33]. In addition, some aspects of Islamic-law (Shari'a) and tradition as interpreted in the country also discriminate against women. In the realm of employment, female participation remains relatively low; with only 19% of women economically active though recently has increased with a better involvement and participation within government agencies. In the government sector, 36% of Omani employees are female, but in private sector that number falls to 17% [33-36]. Local nurses are still facing certain cultural dilemma and face a lot of challenges in the country [32,34]. Yet, female nurses are highly sought after in Oman and other Gulf countries, because of the cultural and religious barriers in managing female patients.

Workforce Self-reliance

Before 1970, there were no medical or nursing institutes nor were there any Omani nurses [31]. Nowadays, Oman is steadily marching towards reasonable level of self-reliance in human resources [37]. In 2007, Omani health sector as a whole has reached over 58% Omanization of the workforce [37,38]. The MoH has reached overall Omanization level in 2007 of about 68% and other government entities about 55% [37]. However, the private sector has achieved only an overall Omanization level of under 5%

Although the stock of Omani workforce increased, the MoH still had to import non-Omani manpower during 2000-2007 in a few categories; in order to meet the additional manpower needs resulting from continued expansion or up-gradation of the healthcare infrastructure [32,41]. However, expatriate workforce faces major problems in Oman [42-44]. Upon arrival in the country, these nurses are sent to the most rural places without proper preparation for the challenges they may face including language barrier and cultural shock [44]. In addition, the environment in these rural areas is very harsh and coping with the daily hassles are very strenuous [42-44]. Also, these workers' human rights are not well respected [33,45].

The number of non-Omani nurses started declining since1996-2000. The % reduction in the number of non-Omani nurses during 2001-2006 has been almost eight times that in the previous period[38-40]. The percentage decline in 2006-2010 is about 3%, perhaps signaling the need to scale down the production of Omani nurses so as to allow them to gather much-needed experience and help achieve total self-reliance in the nursing profession [38-40]. Thus the number(s) of expatriate staff have risen significantly in some categories in order to accommodate the needs implied by continued expansion and up-gradation of the healthcare infrastructure. While the number of expatriate staff in MoH fell by 9% during 2001-2005, it actually rose by 4.4% during the 2006-2010 [38-40]. This implies that the health system infrastructure of the MoH is still developing, and there is still scope of scaling up the production of Omani personnel in some categories.

Omanization Prospects

Despite substantial expansion in health facilities and the consequent need for additional manpower, the increases in the stocks of Omani manpower have helped in raising Omanization levels in several categories [46]. The availability of local manpower production facility in case of nurses helped in improving the Omanization levels in these professions during 2000-2007 [46].

After basic education reached a reasonably satisfactory status, MoH initiated post-basic education in selected nursing specialties [47-51]. In 2007, MoH has as many as 3,164 nurses working in specialized areas comprising about 36% of all nurses. MoH has set up an Institute of Specialized Nursing in Muscat to serve as the focal centre for nursing specialty education. The Ministry has also initiated specialized training in midwifery in a few of its regional capitals. As a consequence of these initiatives, 56% of the specialized nurses are Omani. The local nursing level in neighboring countries is only about 3.5% [47-51].

According to the Ministry's latest projection exercise undertaken for 2006-2010, the MoH is expected to further consolidate its gains in human resources development during this plan [48]. Nurse Omanization level will increase to over 80% by the end of 2010, with several regions touching 100% [48]. However, WHO have advised Oman to invest more in achieving professionalism and continuous medical education among these young and enthusiastic workforce that lack experience [37].

Achieving Professionalism

Accreditation agencies assess and evaluate education and training courses and institutions to ensure consistency and quality of course standards. Completion of accredited program is a cornerstone of professional registration. The Oman Accreditation Council is the body responsible for accreditation of institutions and programs including those under MoH [52]. It has developed an institutional framework applicable to all types of institutions [52]. The Nursing and Midwifery Council was established in 2001, with a view to promoting professionalism in the nursing services, nursing education and practice [53]. This Council has undertaken several initiatives including the preparation of a manual of professional ethics, development of a career structure for nurses and midwives, setting standards of nursing education; nursing and midwifery practice, and issuing guidelines for registration and licensing [53].

Recommendations

The shortage of health workers in Oman and elsewhere, combined with greatly increased national and international attention to the health workforce over the past few years, creates a unique opportunity to re-envision and develop that workforce. If Oman government is genuinely committed to achieving the MDGs and other health goals, significant investment in the health workforce are required, as are national health workforce strategies. This health workforce should not simply be an expanded version of the present workforce. Rather, Oman have the opportunity- and obligation-to create a new type of health workforce, where health workers are trained in human rights, including the right to health; a health workforce that is equitably distributed; and a health workforce that has the tools required to provide their populations with the highest attainable standards of health.

Health workforce plans should offer an opportunity to formally integrate human rights, particularly the right to health, into education, curricula and training for health workers at all levels, from the undergraduate level to specialist and continuing education programs. This is critically important not only to create future advocates, but also to better ensure that ethical and human rights standards guide conditions of practice. Oman political system and lack of unions that support the disadvantage people, especially expatriate workers, makes its human development less credible.

The first challenge is to strengthen the health system (HS), despite Oman achievement of 8th place of the overall health achievement and ranked first in terms of health efficiency by WHO report 2000 [54]. Without more efficient and equitable HS, Oman will not be able to scale up the disease prevention and control programmes required to meet the specific health goals [40].

The second challenge is to ensure that health workforce is prioritized within the overall development and economic policies. Oman should look beyond the HS and to address the broad determinants of workforce availability including low level of education, unequal

gender relations and women right, and unhealthy environment-as well as raising the profile of health within national strategies and government reform processes [55].

The third is to mobilize more resources for health, as Oman spends only 3.5% of its GDP on health [39,40]. Therefore, there is a need to look closely at how much it would cost to achieve and maintain the MDGs and to examine how health services could be delivered more efficiently and equitably. Finally, various departments of the government make polices and decisions that inevitably have an impact on health workforce and, ultimately, on the health of the nation. However, collaboration and joint planning among government sections are still rudimentary and need to be strengthened through development of a national planning framework [40].

The fifth challenge is the necessity to improve the quality of health data. Measuring Oman progress towards the MDGs is a key responsibility of the government, and global monitoring is one of the most important functions performed by the UN system [56]. Such monitoring is instrumental in informing global and national policy-making. At the global level, demonstrating progress can help to generate further resources and sustain political momentum. At country level, reliable information can help to ensure that policies are correctly oriented and targeted at workforce areas most in need.

Possibly the most challenging imperative to expand the health workforce is the need for "task shifting", the process of delegation in which tasks are moved, where appropriate, from more to less specialized health workers [57]. Reorganizing the demographic characteristics of the health workforce in this way allows more efficient use of available human resources and quickly expands the overall human resources pool [57].

Conclusion

Oman should implement human resources development and improved quality of health workforce [48]– by applying the following guidelines: sustained effort, continued financial backing, galvanized inter-sectoral cooperation, innovative approaches to combat unexpected obstacles, de-centralized institutionalization of major functions and continuous activities, strengthening of focused research capacity, promotion of data-based decision-making and innovative search for new partners, and further encouragement of the private sector's involvement in social development and MDGs implementation [58].

In order to compact gender-based discrimination and ensure that women are able to enjoy right to health on an equal basis with men, Oman is obligated to integrate a gender perspective in their health-related policies, planning, programs and research in order to promote better health for both women and men. A gender-based approach recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women. Such a perspective is all the more critical given women's extraordinarily important role in providing health care services in both formal and informal settings worldwide, accounting for up to 80% of the health workforce in some countries [37].

Financial crisis and economic recession and oil prices fluctuation could hamper Oman's development and maintenance of its achievement and should invest more on other resources and improve human development [39].

References

1.Sachs J. World Health Organization. Commission on Macroeconomics and Health, investing in health for economic development: report of the Commission on Macroeconomics and Health. 2001:202 p. Available from: https://apps.who.int/iris/handle/10665/42463

2.UN. United Nations Millennium Decleration. New York, United Nation, 2000 9A/RES/55/2. http://www.un.org/millennium/declaration/ares552e.htm

3.Houweling TA, Kunst AE, Mackenbach JP. World Health Report 2000: inequality index and Socioeconomic inequalities in mortality. Lancet. 2001;357(9269):1671-2.

4.Lerberghe Wv. World Health Organization. Make every mother and child count. Geneva: World Health Organization 2005.

5.London OD. Some countries will not achieve millennium development goals for health by 2015, WHO says. BMJ 2005;330.

6.People's Health Movement., Med act., Global Equity Gauge Alliance. Global healths watch 2: an alternative world health report. 2nd ed 2008.

7.WHO (2006a) WHO, World health report: Working together for health, WHO, Geneva (2006). Available from: https://www.who.int/whr/2006/en/

8.Hagopian A, Thompson MJ, Fordyce M, Johnson KE, Hart LG. The migration of physicians from sub-Saharan Africa to the United States of America: measures of the African brain drain. Human Resources for Health. 2004;2:17.

9.Cole F. U.S. national debate topic 2007-2008: healthcare in Sub-Saharan Africa. Bronx, N.Y.: H. W. Wilson 2007.

10.WHO (2006b) WHO, Taking stock: Health worker shortages and the response to AIDS, WHO, Geneva (2006).

11.Save the Children (2005) Save the Children, Whose charity? Africa's aid to the NHS, Save the Children, London (2005).

12.Ferrinho P, Poz MRD. Towards a global health workforce strategy. Antwerp, Belgium: ITG Press 2003.

13.Patel V. Recruiting doctors from poor countries: the great brain robbery? BMJ. 2003;327:926-8.

14.Stilwell B, Diallo K, Zurn P, Vujicic M, Adams O, Dal Poz M. Migration of health-care workers from developing countries: strategic approaches to its management. Bull World Health Organ 2004;82:595-600.

15.Simoens S, Hurst J. Ensuring an adequate supply of physicians' services in OECD countries. Paris: OECD Health Working Papers Organisation for Economic Co-operation and Development 2006.

16.Smith RD, Chanda R, Tangcharoensathien V. Trade in health-related services. The Lancet. 373(9663):593-601.

17.Buchan J, Dovlo D. International recruitment of health workers to the UK: a report for DFID. London: DFID Health Systems Resource Centre.

18.Mullan F. The metrics of the physician brain drain. New England Journal of Medicine. 2005;353(17):1810- 8.

19.Mills EJ, Schabas WA, Volmink J, Walker R, Ford N, Katabira E, et al. Should active recruitment of health workers from sub-Saharan Africa be viewed as a crime? The Lancet. 371(9613):685-8. doi: 10.1016/S0140-6736(08)60308-6.

20.Labonte R, Packer C, Klassen N. Managing health professional migration from sub-Saharan Africa to Canada: a stakeholder inquiry into policy options. Human Resources for Health. 2006;4(1):22.

21.WHO. World Health Organization, Human Resources for Health.

22.MSF. Help wanted: health worker shortages limits access to HIV/AIDS treatment in southern Africa: MSF press release.

23.UN. Universal declaration of human rights.

24.Blumenthal D. New steam from an old cauldron - the physician-supply debate. New England Journal of Medicine. 2004;350(17):1780-7.

25.Bourassa Forcier M, Simoens S, Giuffrida A. Impact, regulation and health policy implications of physician migration in OECD countries. Human Resources for Health. 2004;2:12.

26.The NHS plan: a plan for investment; a plan for reform. Norwich, United Kingdom: The National Health Service, July 2000:50-5.

27.Ehman A, Sullivan P. South Africa appeals to Canada to stop recruiting its MDs. CMAJ (Ottawa). 2001;164:387-8.

28.Birrell B, Hawthorne L. Medicare plus and overseas-trained medical doctors. People Place. 2004;12:83-99.

29.Australian Medical Workforce Advisory Committee annual report, 2003-04.

30.Cooper R. Weighing the evidence for expanding physician supply. Ann Intern Med 2004;141:705-14.

31.Allen CH, Rigsbee WL. Oman under Qaboos : from coup to constitution 1970-1996. London ; Portland, OR: Frank Cass 2000.

32.US. US State Department. Oman 2003.

33.Oman. World Fact Book. Washington DC: Office of Public Affairs, Central Intelligence Agency, 2002. 2002.

34.Al Riyami A, Afifi M, Mabry RM. Women's autonomy, education and employment in Oman and their influence on contraceptive use. Reprod Health Matters. 2004;12(23):144-54.

35.Bank W. World Bank Development Indicators. Washington DC: World Bank. 2002.

36.UN. Arab Human Development Report. New York: United Nations Development Programme, 2002.

37.WHO. 'Country Cooperation Strategy for WHO and Oman 2005-2009' (EM/ARD/007/E/R), World Health Organization, Regional Office for the Eastern Mediterranian, Cairo (2006). 2006.

38.Curtiss R. Oman: A Model for All Developing Nations; 1995.

39.World Bank. 'Sultanate of Oman: Cost Effectiveness Review of the Health Sector'. The World Bank (March 2001). 2001.

40.World Bank. 'Sultanate of Oman' Enhancing Revenues for Health Services: Issues and Options', The World Bank. 2006.

41.Globalis. Oman: urban population. Arendal (NO): Norwegian Ministry of Foreign Affairs, Norwegian Agency for Development Cooperation; 2007.

42.Al Dhawi AA, West DJ Jr, Spinelli RJ, Gompf TA. The challenge of sustaining health care in Oman. Health Care Manag (Frederick). 2007;26(1):19-30.

43.Al-Kharusi W. Update on road traffic crashes: progress in the Middle East. Clin Orthop Relat Res. 2008;466(10):2457-64.

44.Al-Riyami A, Afifi M, Al-Kharusi H, Morsi M. National Health Survey, study of lifestyle risk factors. Muscat (OM): Ministry of Health, Research Department; 2000.

45.Human Rights Watch. UAE: Meeting Should Address Migrant Workers' Right.

46.Lakshmi A. New challenges to the healthcare system in Oman.

47.MOH. Annual Health Report, Ministry of Health (2005), Oman (http://www.omanet.com/). 2005.

48.MOH. 'The Human Resurces Development Plan (7th Five Year Health Development Plan 2006-2010)', Ministry of Health, Oman. 2005.

49.MOH. Annual health report. Muscat (OM): Directorate General of Planning; 2005. https://www.moh.gov.om/ar/1 . Accessed April 28, 2009 2005.

50.MOH. MOH Web site. Statistics. Available at: https://www.moh.gov.om/en/home. Accessed on [April 2009].

51.Moosa H, Mazzoni-Maddigan J. Health care in the Sultanate of Oman from a graduate internship experience perspective. Health Care Manag (Frederick). 2004;23(1):40-5.

52.MOH. Accreditation: Guidlines for Programs in Continuing Professional Education, Ministry of Health, May 2007.

53.MOH. Guidlines for Registration and Licensing, Oman Nursing & Midwifery Council, June 2004.

54.WHO. World Health Organisation 2000, The World Health Report: Health Systems: Improving Performance, World Health Organisation: Geneva, Switzerland.

55.Samarakkody DMP, Jayawardana P, Abeysena C. Obstacles to health in the Arab world. BMJ. 2006;333.

56.UNDP. United Nations Development Programme: Human Development Report 2005. New York. 2005.

57.Young C. Task substitution: the view of Australian Medical Association. Med J Aust. 206;185:27-8.

58.'Country Cooperation Strategy for WHO and Oman 2005-2009' (EM/ARD/007/E/R), World Health Organization, Regional Office for the Eastern Mediterranean, Cairo (2006).

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