Global Health Workforce and Physician Assistants

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Prepared as part of an education project of the Global Health Education Consortium and collaborating partners
Learning objectives:
By the end of this module - participant will:

1. Understand the disparities in global health and in the healthcare workforce
2. Be informed about the Physician Assistants (PA) profession as one approach to addressing access in global health
3. Recognize practitioners similar to PAs globally
4. Discuss how PA programs that originated in the US have expanded globally
5. Consider the future challenges and opportunities with global use of a “PA” model of health care delivery.

The PA profession is a young profession that is quickly moving into global health in response to the overwhelming needs in the health care workforce created by multiple issues affecting health and health disparity. Many other non-physician providers are also emerging in response to the same global health care crises. The purpose of this module is to define the issues related to both the need for and the complexities of the non-physician provider role in the realm of global health. We use the physician assistant model as the backbone of this discussion.

For the purposes of this module the definition of a PA is a “health professional authorized to work under doctor supervision who provides medical care in a delegated role.” This is not framed necessarily in American terms.
1. Disparities in global health and in the healthcare workforce

- Global health disparities
- Issues impacting disparity
- Workforce distribution
The Task Ahead

“One overall challenge for public health and medicine in the future is to allocate available resources effectively to reduce major causes of disease burden globally and to decrease health disparities between poor and affluent populations.”

Catherine M. Michaud, MD, PhD; Christopher J. L. Murray, MD, DPhil; Barry R. Bloom, PhD
Issues Impacting Global Health & Workforce Needs

- Major health issues
- Changing demographics
- Health care disparity
- Health workforce distribution
- “Brain drain”
### Major Health Issues: Impact of Income

#### Top 10 causes of morbidity and mortality

<table>
<thead>
<tr>
<th>High-Income Countries</th>
<th>Global</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic heart disease</td>
<td>Lower respiratory infections</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>HIV/AIDS</td>
</tr>
<tr>
<td>Trachea, bronchus, and lung cancers</td>
<td>Prenatal conditions</td>
</tr>
<tr>
<td>Lower respiratory infections</td>
<td>Diarrheal diseases</td>
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<tr>
<td>COPD</td>
<td>Unipolar major depression</td>
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<tr>
<td>Colon and rectal cancers</td>
<td>Ischemic heart disease</td>
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<tr>
<td>Alzheimer’s and other dementias</td>
<td>Vaccine-preventable diseases</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>Cerebrovascular diseases</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>Malaria</td>
</tr>
<tr>
<td>Stomach cancer</td>
<td>Nutritional deficiencies</td>
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</table>

Major causes of morbidity and mortality are related to many factors, but perhaps the most influential factor is poverty. Poverty affects nutritional status, work environment, living conditions, access to health care and health education, and even availability of health care providers. People in poor countries are more likely to die from an infectious cause than as a consequence of a chronic illness. They often do not live long enough to develop the chronic illnesses that are major contributors to morbidity and mortality in more affluent countries. Other health indicators that are adversely affected by poverty are infant mortality rates and rates of mortality in children under the age of five.
Life Expectancy as a Measure of the Effectiveness of the Healthcare System

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<table>
<thead>
<tr>
<th>Country</th>
<th>Life Expectancy Rating</th>
<th>Probability of Dying (per 1000)</th>
<th>Life Expectancy (Years) at Birth</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Age &lt; 5 y</td>
<td>Between Ages 15-59 y</td>
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<tr>
<td></td>
<td></td>
<td>Boys</td>
<td>Girls</td>
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<tr>
<td>Japan</td>
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<td>5</td>
</tr>
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<td>Niger</td>
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</tr>
<tr>
<td>Sierra Leone</td>
<td>191</td>
<td>326</td>
<td>298</td>
</tr>
</tbody>
</table>

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Notes: Life Expectancy as a Measure of the Effectiveness of the Healthcare System

While poverty has a huge effect on life expectancy it is not the only factor to consider. According to the World Health Organization, a shortage of human resources has replaced financial issues as the most serious obstacle to implementing national treatment plans. In order to expand the health care workforce, three factors must be in place: political leadership, adequate financing, and a comprehensive plan. Lack of these three factors can adversely affect the healthcare system in even the most affluent countries. The United States is a prime example. Despite being one of the richest countries in the world, the U.S. rates 24th in life expectancy. Countries with fewer resources coupled with a lack of leadership and planning fare far worse. Life expectancy in Sierra Leone, the lowest ranked country, is less than 26 years. Lessening of health care disparity on a global level will require a concentrated and cooperative effort that includes well planned workforce expansion.
Changing Demographics

• Urbanization
• Aging populations
• Migrating populations
• Increasing economic disparity
• Global interconnectedness
Changing Demographics: Urbanization

- By 2025, 61% of humanity will live in large cities (UN 1999)
- 80% of urbanites will live in developing countries
- Cities have a disproportionate burden of poor and vulnerable populations
- Cities developing more rapidly than infrastructures are unable to keep up
- Cities need to be prepared for terrorist attacks and divert funds for this purpose

Health problems related to urbanization are many. Most occur among the poor who often live in unsanitary, unsafe, and overcrowded environments. Preventable infectious diseases are the biggest problem. Respiratory infections result from overcrowded living conditions. Gastroenteric problems result from poor sanitation and hygiene. In many areas diseases such as tuberculosis and cholera run rampant. Homelessness, lack of employment, and loss of social structure and culture increase hopelessness, psychiatric problems, substance abuse and domestic violence.

The health care system has difficulty keeping up with the increased demand for services and is faced with an increasing number of poor clients who cannot pay for services. With a projection of 61% of humanity living in large cities by 2025, the urban health care crises will only worsen if creative solutions are not found soon.
Changing Demographics: Aging Populations

- More chronic disease
- Drain on the healthcare dollar
- Many healthcare providers retiring

Industrialized nations tend to have higher percentages of elderly persons, 59% of the world’s elderly now live in developing countries (US Dept. of Commerce). This means that poor countries also are facing a huge burden of health care costs related to care of chronic conditions as well health workforce issues related to retirement of providers. In addition, industrialization has resulted in an increase in a number of chronic conditions such as diabetes and heart disease in developing countries. With health care budgets already strained, nations are being faced with hard decisions regarding where to place the health care dollar. The United States spends a large portion of its health care budget on end-of-life care. Many other countries do not have that luxury.
Changing Demographics: Migrating Populations

Migrating populations:
- Diverse cultural and linguistic needs
- Changing patterns of disease
- Refugee mental health

Increasing economic disparity
- Public health needs
- Migration of populations
- Brain drain in healthcare

Global interconnectedness:
- Infectious diseases no longer isolated
- Ripple effect of economic and political issues
- Increasing obesity and related morbidity
Notes: Changing Demographics: Migrating Populations

Natural disasters, wars, internal conflicts, and deforestation have caused an unprecedented amount of migration since the early 1990. Immigrants, refugees, and internally displaced persons face increased health risks related to poverty, personal danger, and mental health issues. Crude mortality rates among refugees and internally displaced population between 1990 and 1996 ranged from 1.2 to 31.3 deaths per 10,000 per day (Humanitarian Crises 1999). Providing health care for these at-risk populations is difficult and costly. A new paradigm in management of humanitarian crises is emerging.

With greater migration comes a change in the skills needed by health care providers. There is a greater emphasis on infectious disease, tropical medicine, cultural sensitivity, as well as global health in medical education. Not only are providers more likely to work in distant areas, but patient populations throughout the world are also becoming more diverse as are the medical conditions with which they present.
Healthcare Workforce is a Major Resource
International action needed to increase health workforce

“The simple fact is that the world needs many more health workers. The world faces global as well as local threats to health. Infectious diseases have staged a dramatic comeback, and chronic diseases are on the rise. We cannot improve people’s health without the staff to deliver health care.”

Dr. Margaret Chan, Director-General of the WHO in her welcoming address to a new international Task Force to address the global shortage of health workers. March 13, 2007; Geneva, Switzerland
With the changing demographics and disease burdens, the health workforce must adjust to meet the needs. This means medical education institutions need to make the necessary changes to produce the numbers and types of providers needed. Institutions have to assess the needs, recruit eligible students, and train them appropriately within the constraints of their own financial and manpower resources.
# Health Workforce Distribution

*(Physicians - Nurses and Midwives)*

<table>
<thead>
<tr>
<th>WHO Region</th>
<th># countries</th>
<th># w/ shortage</th>
<th>% needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>46</td>
<td>36</td>
<td>139</td>
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<tr>
<td>SE Asia</td>
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</tr>
<tr>
<td>Europe</td>
<td>52</td>
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<td>NA</td>
</tr>
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<td>E. Mediterranean</td>
<td>21</td>
<td>7</td>
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<td>W. Pacific</td>
<td>27</td>
<td>3</td>
<td>119</td>
</tr>
<tr>
<td>World</td>
<td>102</td>
<td>57</td>
<td>70</td>
</tr>
</tbody>
</table>
Notes: Health Workforce Distribution

The distribution of health care providers depends on a number of factors:

• Available training institutions
• Finances for training
• Adequate eligible pool of applicants
• Lifestyle and income available to trained providers
• Job and personal security

Poorer countries and regions of countries typically have fewer resources available to train adequate medical workforces as well as less ability to retain the individuals they have trained. Often well educated individuals can find more attractive opportunities in more affluent locations, resulting in “brain drain” from the areas that need them the most.
2. The PA profession as one approach to addressing access in global health

- Quality
- Cost effectiveness
- Culturally competency
- Successes
- Challenges
- Barriers
The PA Profession

As a means of addressing health workforce needs in the U.S. and globally

– What is a PA?
– History of the PA profession
– Physician assistant: team member

Physician assistants are health care professionals licensed to practice medicine with physician supervision and educated in the medical model designed to complement physician training.

Within the physician-PA relationship, physician assistants exercise autonomy in medical decision-making and provide a broad range of diagnostic and therapeutic services. Physician assistants are also involved in education, research, and administrative services.

Graduation from a PA program accredited by the ARC-PA and passage of the National Commission on Certification of Physician Assistants (NCCPA) examination are required for state licensure.

The PA profession is one of the ten fastest growing occupations in the United States. There are more than 63,600 practicing PAs.
History of the PA profession in the US

**Start** - Formally established in the United States in the late 1960s

**Why** - Response to shortage and maldistribution of physicians

**Market** - To improve access to health care and enhance existing health care delivery system

**Resource** - Returning Vietnam era military corpsmen

In the 1960s there was a shortage of primary care physicians in the United States, particularly in rural and other underserved areas. At the same time there were military corpsmen returning from the war in Vietnam who had acquired medical skill, but had nowhere to use them. Duke University was the first to put the two together in the form of the Physician Assistant. Since that time, the profession has grown to improve access to health care in all 50 states. PAs work throughout the United States and in many other countries, providing care in both primary and specialty areas.
Physician Assistants

PAs are educated in the medical model and work as members of physician-directed teams. PA scope of practice is determined by:

1. Education and experience
2. State law
3. Facility policy
4. Delegatory decisions made by the supervising physician

One important aspect of the physician assistant model is the team approach to medicine. PAs are trained according to the medical model used in physician training programs, but practice with the physician as part of a team. The scope of practice of the PA is dependent on a number of factors including their education and experience, state laws, and the rules in their facility of employment as well as the decisions made by their supervising physician regarding delegation of duties. The same PA may have a very different scope of practice from one practice setting to another depending on these factors.
Cultural competence

- Accredited PA programs must prepare students to provide medical care to patients from diverse populations
“PA-like” model is

• **Cost effective**
  • *Efficient*
  • *Flexible*
• **Accepted**
  • adaptable
The PA concept as a type of global health manpower

• “Health workers are all people primarily engaged in activities with the primary intent of enhancing health” (WHO Report 2006)

• PA concept adaptable to the specific health needs of other nations

• Category of “physician assistant” globally lacks standardization and has differing academic competencies, skills, and functions.

(Global applicability Physician Assistant Education Association International Affairs Committee)
Notes: The PA concept as a type of global health manpower

The PA profession is a relatively new profession even in the United States. As the profession expands into the arena of global health, there are challenges as well as exciting opportunities. While the profession has the flexibility and the cost effectiveness to be a good fit for many global health situations, there is confusion surrounding its role. There are many non-physician providers throughout the world. Some have roles equal to or very similar to that of the physician assistant. Others have more differences than similarities. The many names and many roles for non-physician providers can be confusing. There is discussion about standardization of core requirements, but even that is difficult when the needs and resources of countries vary so tremendously. This is an area that needs study and careful planning.
Global Developments

- The United States 1960s
- Canada - military 1984; legislation in place for civilian PAs 2001
- Netherlands - 2002
- Haiti - 2002-2003; program not sustained
- Taiwan - approximately 2003, became a nursing program 2005
- Germany 2005 (limited information)
- Scotland - pilot 2006
- The Ministry of Health of Australia - 2008

In discussion - Rwanda, Thailand, Puerto Rico, South Africa, Ghana, China, Ireland, Japan, others

Over the past several decades a number of countries have started programs based on the PA model. Some have succeeded and some have not. Others are in the planning stages. AAPA committee on international affairs reports that 83 countries have expressed interest in the PA model. P. 285. Ref: Hooker R., Cawley J. Future Directions. Physician Assistants in American Medicine. Second edition. Churchill Livingstone. 2003. Pp. 273-287
The Global Development of Physician Assistants
(PAEA International Affairs Committee)

Canada
United Kingdom
Netherlands
China
Taiwan
Australia
South Africa
Thailand
Republic of Ireland
Ghana
• **What is a PA?**
  – Do we have anything like it in countries outside the US?
  – How did the PA profession come about?
  – What are the barriers and challenges to starting?
  – What resources are there to assist us?
  – How do we implement a new profession?
  – What shall we call it?
  – Is there international recognition?

When a country is considering the PA concept, these questions often come up about starting a similar profession.
What is a PA?

A Provider who:

• Provides a broad range of medical care with physician supervision
• Has autonomy in medical decision making
• Graduated from an accredited PA program and is nationally certified
How Did the PA Profession Come About?

**Need:**
- There was a shortage of physicians in the 1960s
- Access to healthcare was limited in many areas
- Healthcare disparities resulted from access and financial barriers

**Opportunity:**
- Medics returning from the Vietnam war had skills, but no job opportunities to use them

**Vision:**
- Duke University had a vision to expand upon those skills to meet the need

*Need + Opportunity + Vision = Birth of the PA Profession*
Do we have anything like it outside the US?

• Many health workers analogous to PAs have differing competencies in response to their country’s needs
What are the barriers and challenges to starting?

- Developing educational model
- What substrate to use (registered nurse, allied health worker, international medical graduate, community health worker, post secondary school graduate, among others)
- Length of program
- Cost
- Marketing to appropriate target audience
- Accreditation
- Certification
Notes: What are the barriers and challenges to starting?

A new profession has to be carefully researched to make sure that it will meet the needs of populations. The World Health Organization encourages certain guidelines:

- Accreditation to promote competence and trust
- Admission policies to reflect diversities
- Programs that retain students through graduation
- Quality and responsive curricula
- Recruit a competent workforce of teachers
- Focusing on practice-based teaching, problem-based learning, and patient-focused practice
- Encourage and support teaching excellence
- Promote faculty development programs
- Ensure continued financing
What resources are there to assist us?

Organizations:
- Physician Assistant Education Association (PAEA)
- American Academy of Physician Assistants (AAPA)
- Physician Assistants for Global Health (PAGH)
- National Commission on Certification of Physician Assistants (NCCPA)
- Accreditation Review Commission on Education for the Physician Assistant (ARC-PA)

Other resources:
- PAEA International program development guide
- Global Health Education Consortium (GHEC)
- Websites of country specific programs; workforce and competencies evaluation materials
How do we implement a new profession?

• Determine the type of health professional needed to provide care for the underserved communities
• Identify stakeholders: key individuals from the medical community, government, ministry of health, and interested parties
• Review health professional training programs from other countries, such as the PA model, to determine suitability
Notes: How do we implement a new profession?

The AAPA’s “Physician Assistant Programs: A Guide for International Development” recommends the following steps:

- A needs assessment to identify unmet workforce needs. Because the PA can be trained more quickly and efficiently than the physician, several PA programs outside the United States have been developed. More are scheduled to begin.
- Educate and garner support of key players in proposed PA program development
- Generate helpful suggestions pertaining to development plans and identify important questions that need to be addressed
- Program planning should begin only after it has been determined that a PA program is a viable solution to meeting the identified need
- Appointing an advisory committee for facilitation and thorough planning of the PA program
- The program should be guided by a carefully developed mission statement
What should we Call it? What have other countries done?

Roles based on a PA-like model have been developed in many countries who may struggle with a name.

- **UK**
  - Medical Care Practitioner

- **Canada**
  - Clinical Assistant

- **US**
  - Medex
  - Physician Extender

*All eventually renamed physician assistants or physicians assistant*

**Historical examples:**
- Feldshers: Russia & Eastern Europe (1600-present)
- Officier de santé: France (1803-1892)
- Barefoot doctor: China (1966-present)
- Community Health Technician: Columbia, Mexico, Peru, Guyana (1970s)
- Clinical officer: Kenya (1960s-present)
- Nurse Practitioner: US, Canada, Great Britain (1966-present)
- Medical Assistant: Ghana (1969-present)
- Technicos de Medicina: Mozambique (1961 to present)
- South Africa: Clinical Associate (2007)
There are a number of issues related to collaboration between PA or PA “like” programs. At present there is no standardization of programs. This raises barriers to collaboration such as student and faculty exchanges.

There are no set standards of education, licensing, credentialing or reciprocity for PAs to work in other countries.
Can we join the US PA organizations?

Representatives of interested programs from various nations have attended US PA Organization meetings

- AAPA: non PA membership is available
- PAEA: individual colleague or non-voting institutional membership is available
3. Practitioners similar to PAs

- Limitations of information available on professional titles
- Scope of practice
- Training
- Similarities and differences to US PAs
- Participation by PAs in global health
Name and role confusion

- As more non-physician providers emerge throughout the world it is difficult to know who does what
- Many have similar roles but different names
- Training programs vary
- Scope of practice varies, and is often expanding
- The title “Physician Assistant” translates imperfectly
- Determining an equivalent name for the “PA” role globally has been difficult
- “Physician/doctor have different meanings globally and varying roles and titles depending on the country
Physicians

• Physician education completed in 6-13 years after secondary school depending on the requirements of the individual country

• Training varies from one part of the world to another

This is not necessarily the case in all countries. For example: in Nicaragua all college students take the same courses their first year. At the beginning of their second year they begin their professional training (medical school), which, for doctors lasts another 4-5 years. That time includes a mandatory rural internship. Doctors going into specialties will complete a residency program in their specialty area following medical school.
Registered Clinical Officers - Clinical Officers - Medicos de Technicos - and other Non-Physician Clinicians (Africa)

- Trained beyond the secondary school level
- Have fewer clinical skills than physicians but different than nurses
- Trained to deliver a range of personal clinical health services
Notes: Registered Clinical Officers - Clinical Officers - Medicos de Technicos - and other Non-Physician Clinicians (Africa)

In nine countries in sub-Saharan Africa, numbers of non-physician clinicians (NPC) equaled or exceeded numbers of physicians.

“In countries such as Kenya, clinical officers have become the backbone of the health system, and run most health centers; in Malawi, clinical officers provide medical care, do surgical procedures, and give anesthetics”  Lancet 2007

Training and scope of practice are not standardized across the sub-Saharan Africa. All NCPs do basic diagnosis and medical treatment, with some trained in specialty areas or for specific procedures within a specialty. Examples include caesarean sections, orthopedics, ophthalmology, anesthesia, and hospice care.

The role of the NPC is not necessarily based on a US or European health practitioner. The most common titles used for African NPCs are clinical officer and health officer. NCPs are trained in less time and with less cost than physicians. Many are recruited from rural and poor areas and tend to work in those same areas. They are less likely to move within the country or overseas than physicians and nurses.
Health Extension Workers (Papua New Guinea)

• Started in the 1960s, the position of health extension officer (HEO, formerly medical assistant) was designed to address the workforce needs in rural areas
• Trained 3 years beyond secondary education
Medical Assistants (Ghana)

• Previously, experienced nurses with a year of advanced training and 6 months of internship to enable them to function independently
• Currently, secondary school graduates with 3 years of didactic training followed by a year of internship
Medical Care Practitioner (UK)

- Created in response to a looming crisis in clinical care
- Based on the PAs in the US
- Initial trial of using US PAs in the UK prior to developing their program

Medical care crisis came about because of changing demographics of aging, increasing demands for clinical services, and a severe shortage of doctors in the rural areas. US trained PAs were employed in the UK on a trial basis. Evaluation of their applicability led to the creation of the Medical Care Practitioner. Duties include:

* Obtain medical histories and perform physical examination
* Diagnose, manage (including prescribing) and treat illness within their competence;
* Request diagnostic tests and interpret the results;
* Provide patient education and preventative healthcare advice regarding medication, common problems and disease management issues;
* Decide on appropriate referral to, and liaison with, other professionals.
Nurse Practitioners

- Licensed independent practitioners
- Practice autonomously and in collaboration with health care professionals
- Education at the master’s, post master’s, or doctoral level
- Training includes didactic and clinical courses
- Registered nurses and licensed practical nurses may function as “nurse practitioner” in various countries

Nurse practitioners practice in ambulatory, acute and long term care as primary and/or specialty care providers. They may also work as health care researchers, interdisciplinary consultants, and patient advocates. A major part of their practice is involved with teaching and counseling of individuals, families and groups with a strong focus on health promotion. The autonomous nature of their practice requires accountability for health care outcomes. Requirements include certification, periodic peer review, clinical outcome evaluations, and a code of ethical practice, continuing professional development and maintenance of clinical skills. The role of the nurse practitioner continues to evolve, combining the roles of provider, mentor, educator, researcher, and administrator.
Nurse Midwives

• Legally licensed and/or registered to practice the full scope of nursing and midwifery in his/her country
• Nursing profession responsible for establishing scope of practice, educational standards, and credentialing
• Training programs of sufficient length and academic and clinical content to facilitate safe and autonomous practice
Notes: Nurse Midwives

Nearly half of all births in developing countries occur without the assistance of a trained health care provider. Maternal mortality is the health indicator for which the differential between developing and industrialized countries is greatest. The practice of midwifery is organized differently in different countries. In some countries the midwife is not required to be a nurse. For nurse midwives, the midwifery qualification may be acquired prior to or after the nursing qualification or through a combined nursing/midwifery program.

Nurse-midwives are qualified and credentialed to practice within the full range of nursing practice, but in addition they have particular expertise in and concerns for women during pregnancy, delivery and the post partum period and in the care of the neonate. (International Council of Nurses Position Statement)
Community Health Workers

- Perform basic curative services
- Monitor the community’s health/identify patients at risk
- Provide preventive medical services and longitudinal care
- Act as liaison between the community and the health system
Health Promoters

Health Promoters in El Chague, Nicaragua

- Lay Health Promoters have a long history in many different cultures and countries.
- Come from the community in which they work
- Well trained in health promotion, education and service delivery within a limited scope
- Promote health among disadvantaged groups
4. PA programs originating in the US have expanded globally

- PAs working in other countries
- PAs helping other countries develop their own PA type profession
The PA concept as a type of healthcare manpower

- The United States
- Canada
- The Ministry of Health of England
- The Ministry of Health of Australia
- Others
5. The future challenges and opportunities with global use of the “PA model” of health care delivery

• Future needs
• Consistency
• Challenges
• Future role
• Creative solutions
Notes: Challenges

- Aging of populations may impact prioritization of funding factors and educational priorities.
- Disparities in health care delivery will become an increasing factor, as homogenized solution and education may not adequately address varying population needs.
- Organization of health care service delivery may change based on current model that is plagued with fragmentation and inefficiency.
- Boundaries between medical professions will increasingly blur
- Collaboration among organizations will be necessary for effective planning to meet the health workforce shortages.
- Educational resources for global health education are finally being developed but are inadequate to meet program needs
Future needs

• Countries need to produce high performing workforce and promote good practice by health care workers
• Development of an “International Consortium” that deals with physician extenders globally or a forum for discussion

The health work force needs are great. In order to meet these needs, nations and health care professions need to unite with a common goal and a shared vision to work through the barriers and meet the challenges. The PA profession needs to be part of that discussion, and perhaps a leader in it.
Consistency

- Expanding training opportunities, as well as the need for health manpower, creates need for global standardization of these groups
- Assurance of educational quality and regulation
- Need for inclusive alliances and networks
- Idea of “global health care worker” being considered
- Innovative stewardship
Challenges

• Aging populations
• Disparities in health care delivery
• Organization of health care service delivery
• Boundaries between medical professions
• Collaboration among organizations of strategic importance
• Production of innovative resource materials for program and faculty development
Future Role

• Expand the PA profession in areas of clinical expertise and professional opportunity
• Prospectively address emerging global issues.
• Determine where PAs fit into the skill mix of the global workforce. A World Health Organization category would be helpful.
• The PA profession as a “global profession”
• Emphasize communication between the US PA organizations and other non-physician provider groups
• The ultimate goal of health workforce strategies is a delivery system that can guarantee universal access to health care and social protection to all citizens in every country.

• There is no global blueprint that describes how to get there - each nation must devise its own plan.

• Effective workforce strategies must be matched to a country’s unique situation and based on a social consensus.

Source: WHO 2006
Creative Solutions

• The workforce crises in global health is huge
• The PA profession offers an efficient and cost effective model that is being adopted and adapted world-wide
• Transformational vision
Summary

- Health workers in the world are distributed unequally between and within countries.
- The US based PA model is young, flexible, and continues to evolve.
- There has been interest in and development of PAs internationally similar to the US model.
- There are limitations to trying to compare existing practitioners worldwide.
- The PA model may be one approach to a more equalized distribution of health workers worldwide.
Credits

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