High-Level Commission on Health Employment and Economic Growth

Call for Commitments to Action and Consultation on the ILO OECD WHO Five-Year Action Plan on Health Employment and Economic Growth

Submissions Received: 15 December 2016 – 17 February 2017
Introduction

In response to the request of the High-Level Commission on Health Employment and Economic Growth, the International Labour Organization (ILO), Organisation for Economic Co-operation and Development (OECD), and World Health Organization (WHO) has taken immediate action to convene stakeholders to agree on a five-year action plan to support the implementation of the Commission’s ten recommendations. The High-Level Ministerial Meeting on Health Employment and Economic Growth was held in Geneva, Switzerland, on 14 and 15 December 2016. The meeting brought more than 200 representatives together, including Ministers of education, health, labour, and foreign affairs as well as representatives from international organizations, civil society, heath worker organizations and unions; the private sector, academia and others to garner commitment and momentum for health and social workforce investment and action.

A Five-Year Action Plan on Health Employment and Economic Growth was presented at the meeting, which sets out how the ILO, OECD and WHO, in partnership with their constituents and other multilateral organizations, can support country-driven implementation of the Commission’s recommendations. It embodies the type of integrated and innovative approaches that the 2030 Agenda for Sustainable Development and the achievement of the Sustainable Development Goals calls for.

Call for Contributions

Twenty-six statements of commitment were presented at the High-Level Ministerial Meeting. Building on this strong foundation, the ILO, OECD and WHO issued an online public call for contributions from member States and relevant stakeholders to review and submit further inputs for the finalization of the Five-Year Action Plan; and contribute statements of commitment to action on the Commission’s recommendations. Contributions were used to revise the five-year action plan for submission to the seventieth World Health Assembly as requested by the 140th WHO Executive Board.

Contributions were sought from all stakeholder groups and sectors, including health, social protection, education, economics, labour, gender, and human rights. There were 21 submissions (17 with publication permission) received in response to the call from 15 December 2016 – 17 February 2017. Contributors were not limited to any set of countries and their submissions could reflect a country-specific, regional, and/or international perspective. Submissions were a maximum of 1500 words and were received in English or French or Spanish.

This document presents the submissions as received, without editorial revisions, and is presented in the order in which they were received. It only includes contributors that provided permission to publish and lists all the contributing authors.

Disclaimer: Contributors who have submitted contributions via this call and are included in this compilation have given consent to the WHO to use and publish their submission; however, the WHO reserves the right not to publish comments that were deemed inappropriate due to offensive language, advertising or personal promotion. The WHO is also not responsible for the different view expressed.
Questions Asked

Q1. How will you take the Commission’s recommendations and immediate actions forward at local, national, regional and/or global levels over the next five years? Briefly describe the actions and investments you commit to implementing.

Q2. What is your feedback on the Five-Year Action Plan? Briefly summarize reflections and suggestions on the version for consultation.
Submission #1

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<tr>
<th>Name/Position</th>
<th>Dr. Viviana Martinez-Bianchi, WONCA-WHO Liaison</th>
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<tr>
<td>Organization</td>
<td>World Organization of Family Doctors (WONCA)</td>
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<td>Name/Position</td>
<td>Amanda Howe</td>
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**Question 1:**

The World Organization of Family Doctors (WONCA) is in agreement with the Commission’s recommendations as these recommendations are congruent with its mission. The Mission of WONCA is to improve the quality of life of the peoples of the world through defining and promoting its values, including respect for universal human rights and including gender equity, and by fostering high standards of care in general practice/family medicine by:

- promoting personal, comprehensive and continuing care for the individual and the family in the context of the community and society;
- promoting equity through the equitable treatment, inclusion and meaningful advancement of all groups of people, particularly women and girls, in the context of all health care and other societal initiatives;
- encouraging and supporting the development of academic organizations of general practitioners/family physicians;
- providing a forum for exchange of knowledge and information between Member Organizations and between general practitioners/family physicians; and representing the policies and the educational, research and service provision activities of general practitioners/family physicians to other world organizations and forums concerned with health and medical care. WONCA is led by an executive council, with seven regions, each of which has their own regional Council and run their own regional activities including conferences.

WONCA has a number of working parties and special interest groups and regional “Young Doctors’ movements” that work between world council meetings to progress specific areas of interest to WONCA and its members around the globe.
These groups comprise hundreds of family doctors who meet three yearly, sometimes more often, and in between work by correspondence.

The Commission’s recommendations will be shared with these groups, to work on aspects that are of particular interest for each group. Each region will continue to work with local governments, and private entities to support local action for improvement of its mission, which is congruent with the recommendations of the Commission. The list below are the working parties and Special interest groups that could participate and consult on particular recommendations, targets and deliverables.

Working Parties:
A. Education
B. Ethical Issues
C. eHealth
D. Indigenous & Minority Groups Health Issues
E. Mental Health
F. Quality & Safety
G. Research
H. Rural Practice
I. WICC (International Classification)
J. Women & Family Medicine

Special Interest Groups
• Complexities in Health
• Conflict & Catastrophe Medicine
• Elderly Care
• Emergency Medicine
• Family Violence
• Health Equity
• Migrant Care, International Health & Travel Medicine
• Non-communicable diseases
• Workers' Health

Question 2:

The World Organization of Family Doctors (WONCA) represents over half a million family doctors in over 140 countries and territories across the world. Its mission is to improve the quality of life of people through fostering high standards of care in general practice/family medicine. WONCA welcomes the Health Employment and Economic Growth: A Five-Year Action Plan (2017–21) dated 9 December 2016 developed by the International Labour Organization (ILO), Organisation for Economic Co-operation and Development (OECD), and the World Health Organization (WHO) WONCA welcomes the five-year action plan’s emphasis on transforming the health workforce through stimulating investment in the creation of appropriate health sector jobs, and strengthening the quality, depth and breadth of education; while at the same time securing equity in the training of women and young health professionals. The recommendations, if adopted, have the opportunity to strengthening primary health care in order to achieve universal health coverage and deliver excellent integrated people-centred health services. WONCA also welcomes the focus on prevention
and on the efficient provision of high-quality, affordable, integrated, community-based, people-centred primary and ambulatory care, with special attention to underserved areas.

Primary care teams which include family doctors, are essential for the delivery of good quality, cost-effective, comprehensive, coordinated, continuous, person-centred primary care in high, middle and low income countries alike. There are examples where primary care and family medicine has made notable improvements in recent years. In order to meet the growing needs in access to affordable and equitable primary healthcare services significant efforts are still needed in many countries to strengthen primary care service delivery, and within this family medicine. In particular long-term policies needs to focus on investing in and supporting an adequately trained primary care workforce to deliver preventive, promotive, acute, chronic, rehabilitative and palliative care in the community.

Whilst there is reference to Primary Care in the report, under “The workforce should be geared towards the social determinants of health, health promotion, disease prevention, primary care and people-centered, integrated, community- based services; including all types of health and social workers and support workers”, and also referenced in 4. “Reform service models concentrated on hospital care and focus instead on prevention and on the efficient provision of high-quality, affordable, integrated, community-based, people-centered primary and ambulatory care, paying special attention to underserved areas”; WONCA would like to urge the authors of the report that it is of the utmost importance that there is also a need for an explicit reference to the need to invest in developing and strengthening a workforce of family doctors.

We would like to see the ILO OECD WHO Five-year action plan emphasizing the role of primary health care and family medicine. Ensuring that the planned expansion of primary healthcare resources will lead to a cost-effective allocation of resources and specifically to prioritizing the deployment of multidisciplinary primary health care teams of diverse health workers with broad competencies, avoiding the pitfalls and escalating costs of excessive dependence on tertiary care. It proposes adopting a diverse and sustainable skills mix, enveloping both the breadth and depth of Family Medicine/General Practitioners training, with complexity of skills and competencies much needed for every region in the world. A primary care workforce with family doctors can deliver high quality and comprehensive care across the full spectrum of primary care in collaboration with other members of a multi-disciplinary team. They can provide training and supervision in primary care and act as gatekeepers through an appropriate referral system into the wider health system. The risk of not being explicit regarding the importance of investing in the development of a workforce of family doctors is that the full potential of primary care to address the challenge of a growing burden of acute and chronic conditions is not realised in many countries.
Question 1:

ICNs membership of over 130 National Nursing Associations covering 16m nurses worldwide ICN has, and can continue to, play a key role by:- communicating and raising awareness of the Commission’s recommendation amongst the global nursing community- identify the challenges, barriers and enablers at local, national and regional level to implementing the Commission’s recommendations- monitoring and reporting on progress in delivering the Commission’s recommendations- supporting nursing associations to collaborate with governments and other stakeholders to develop and implement an action plan ICN and its Nursing Associations are uniquely placed to provide feedback from both the front line of care delivery and also at the Country and Regional level that is critically to bridging the policy practice divide. In May this year in Barcelona ICN hosts the flagship International Nursing conference and the health workforce and Commissions report and action plan will be a major focus of debate and discussion with the thousands of nurses who attend. At the High Level Ministerial meeting in December ICN President and Commissioner Judith Shamian stated that ICN can be a conduit to harness expertise and experience of Nurses from around the world to provide specific advice in relation to;

- Empowering women through institutionalizing their leadership
- Scaling up transformative education for both new nurses and existing staff
- Identify opportunities through which advanced nursing roles can develop, widen and strengthen healthcare delivery and advice on the appropriate development of new cadres
- Advise on clinically effective technologies to improve both access to and the quality of health services
- Develop and promote the capabilities of nursing in humanitarian, conflict and disaster settings
- Support the development of workforce planning systems to ensure the right numbers of staff with the right skills in the right place at the right time
- Identify unsafe and unfair working conditions and practices, advocate for and negotiate improvements in working conditions and environments
- With Nursing Associations monitor and lobby for health spending and investment

**Question 2:**

It is critical that the current baseline and a clear set of agreed metrics for the Commission’s recommendations are established to ensure progress is monitored in a meaningful and comparable way. The action plan refers to developing tools/standards/plans etc but metrics are required to measure progress against these. There should be clear outcome as well as process metrics and these should be part of an overarching evaluation framework.

UN ComHEEG has successfully raised awareness of the 40m new health worker jobs expected to be created by 2030 and the potential 18m health worker shortfall. There should be at least annual reporting against these figures to highlight if job creation is at the rate expected and whether the size of the shortfall is being reduced.

The respective roles and responsibilities of WHO, ILO and OECD should be clearly set out so there is no ambiguity in terms of accountabilities and leadership.

There is a risk that Countries will look up to the global institutions to lead therefore actively engaging Governments and being clear on their role in taking forward the Commission’s recommendations is critical.

WHO should clearly map and articulate the alignment between the Commission’s recommendations, monitoring and reporting processes and those for the Strengthening Nursing and Midwifery strategy and the Global Strategy on Human Resources for Health: Workforce 2030. There is significant cross over and interdependencies between these strategies. It may be useful to establish a specific working group that is representative of the WHO regions and includes key nursing stakeholders to undertake this work.

WHO, ILO and OECD should agree and share the budget to support the work, highlight organizations or partners who are undertaking funded activity in relation to delivering the recommendations and those monies that are available for partner organizations to receive or bid for.

WHO, ILO and OECD should collate and compile evidence and case studies that demonstrate how the delivery of the recommendations improves and enhances patient and population health and outcomes. This evidence should be an integral element of regular public reporting against progress over the next 5 years.
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<th>Name/Position</th>
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<td>Name/Position</td>
<td>Frances Day Stirk</td>
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<td>Organization</td>
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**Question 1:**

"The International Confederation of Midwives (ICM) supports, represents and works to strengthen professional associations of midwives throughout the world. The recommendations and immediate actions of the High-Level Commission on Health Employment and Economic Growth are aligned with the vision of ICM, specifically, Recommendation 3, 4 and 9. Following the Action Plan, ICM commits to continue to promote and provide global evidence-based resources to assist policy, decision makers with areas such as midwifery education and midwifery regulation. ICM will rapidly take on helping those who have been tasked with immediate action of developing and improving their national midwifery services.

The ICM identified 4 main components of the action plan in 2016: firstly, to prioritize health workers with competencies in health promotion and disease prevention. Secondly, optimising scopes of practice of health workers at all levels so that they can use their skills fully (and neither unskilled nor over skilled) and develop multidisciplinary and complementary teams of health workers. Thirdly, building stronger links between health and social sectors to meet health and social care needs. Investing in the midwifery workforce can trigger health equity through intersectoral action especially around social determinants of health. And lastly, empowering people and communities to play a greater role in designing health systems to participate in their own health.

ICM created the Midwifery Framework (MSF), a tool and process to support the development and strengthening of midwifery services across all countries focusing on a quality midwifery workforce. The MSF is beneficial to this work as it addresses most of the WHO’s recommendations and aligns with the HEEC Action Plan by way of its inclusiveness of all stakeholders at country level. In this respect ICM is already taking some of the recommendations forward on an international level and will increase its work to align itself to the relevant
recommendations on a local, national and global basis, working in conjunction with global partners and ministries of health and education.

Specifically, on the point of Recommendation 3, ICM’s education standards and essential competencies for midwifery practice will provide guidance in achieving quality education of midwives, as it is essential for them to be appropriately educated and to have updated skills and training, in order for them to provide quality care. The standards will be disseminated widely along with additional tools developed by ICM to support the implementation of midwifery education. There will be close collaboration between the Ministries of Health and Education to ensure programmes are robust from an education quality perspective and also to meet the needs of the health system and/or maternity service. ICM education consultants will be placed to support this recommendation which will be our priority.

Globally, ICM has 121 Midwives Associations within the confederation from all the 4 regions of the globe, and well over 400,000 midwives. ICM is in the right position to take a leading role in Sexual, Reproductive, Maternal and Child Health and gender equity with its Member Associations. ICM also has a number of evidence-based core documents, on Education, Regulation and Midwifery Services Framework (MSF), which could be used and adopted by high, middle and low-income countries, according to their needs.

ICM is a non-government organization hence it cannot carry out its salient work without the support of its collaborators, sponsors and partners, e.g. WHO, UNFPA. Through its technical midwifery consultants, ICM will enter into collaborative projects concerning transformative education, implementing the MSF, supporting and strengthening the Midwives Associations (MA), including the setting up of regulation standards and mechanisms for Midwives. Collaboration through its MA’s can take place across the world.

With partners’ sponsorship and support, ICM can continue to develop our twinning programme, whereby MAs from high income countries support MAs from low income countries, to develop midwifery education and the practice of midwives of their country. They could also support in developing midwife educators and leaders.

Through collaborations with national partners, ICM will harness its technical education resources. It will build a blended approach to learning using elearning and mHealth, in addition to face-to-face opportunities, to reach learners living in remote and rural areas.

ICM strongly believes that through the Five Year Action Plan, it can work with global partners and local communities to increase the standard of midwifery internationally, nationally and locally; raise the respect of the profession; improve the treatment of healthcare workers, especially midwives; and these activities will in turn lead to healthier families and communities, globally. Over the next five years ICM’s core activities will be to continue to strengthen midwifery associations and midwives globally through capacity building, leadership training, midwifery services development, setting global standards and defining midwifery competencies. We will support the implementation of ICM’s global standards for education and regulation by training midwifery educators to raise the standard of teaching and thereby education. This work will include training midwifery educators and preceptors to use competency based education methodologies, the development and implementation of training for midwives in emergency skills related to post-partum haemorrhage and neonatal resuscitation. The outcome of these activities will be the mitigation of maternal and infant mortality.

Our work will be delivered globally, in priority need countries, to build capacity and competence in respective midwifery workforces. This will be achieved via the provision of quality
competency based education, midwifery-specific regulatory frameworks, strengthening midwifery associations, promoting best practice, advocating gender equity and human rights in childbirth and advocating for midwives as the most appropriate caregivers for childbearing women. ICM will also continue to advocate on global platforms that investment in midwifery is a vital solution to addressing sustainable development goals relating to maternal and newborn health.

We presently work with a variety of partners and stakeholders to deliver midwifery workforce development activities globally. These include UNFPA, Bill and Melinda Gates Foundation, Sanofi Espoir Foundation, Laerdal Global Health Foundation and Johnson and Johnson Corporate Citizen Trust and Johnson and Johnson Consumer Incorporated. We will continue to build on these relationships and seek to develop new alliances to enhance our impact and improve our reach.

In June ICM will identify their new strategic goals at the Annual Council meeting. Following this a time bound strategic activity plan will be developed for implementation over the next five years. In addition ICN and its National Nursing Associations can help bridge the practice policy divide and is committed to working with stakeholders at all levels, through for example conferences and events, to enable a dynamic process of communication, monitoring and implementation.

ICNM is the name of a strategic collaboration, including partners such as WHO and CGFNs that was established as a global resource for nurse migration. It includes global nursing experts, publishes newsletters and reports on evidence, trends and issues in relation to nursing migration and mobility. It is a body that could actively support the international platform recommended by the Commission.

**Question 2:**

The International Confederation of Midwives (ICM) strongly agrees with and supports the key strategic phases particularly 4, 6 and 9. ICM strongly supports the Commission’s findings that “health workforce investments coupled with the right policy action could unleash enormous socio-economic gains in quality education, decent work, inclusive economic growth and health”. The expected demand and doubling of need for health workers by 2030, means that there must be 40 million new health worker jobs created and there may be a potential 18 million short fall.

Given that ICM’s objectives are to optimise maternal, reproductive, sexual and child health care and to promote and strengthen midwives, midwifery education and regulation and midwives’ association, the proposed High level commission’s recommendations for immediate actions in the next 5 years are of critical importance for midwives of the world. Six of the ten main recommendations focus on what needs to be changed in health employment, health education and health service delivery to maximize future returns on investments, in a five-year action plan (2016-21). Thus, the action plan will be enthusiastically supported by ICM.

The suggestions which ICM has on the plan are that although, it is clear there is a focus on acute facility based health services changing to facilitate community and ambulatory services, there is no strategy to address it. This clarification would be greatly appreciated by the ICM.

ICM also believes that there needs to be a strategy which addresses the sociology of health issues in relation to the power imbalance and the inordinate influence medicine has on how health policy is developed and health services are planned and delivered.
Submission #4

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<td>Wanicha Chuenkongkaew, Professor of Ophthalmology, Coordinator of Asia-Pacific Network for Health Professional Education Reform</td>
<td>Thinakorn Noree</td>
<td>Department of Ophthalmology, Siriraj Hospital, Mahidol University</td>
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<tr>
<td>Nonthaburi, Vice Chair</td>
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<td>International Health Policy Program Foundation (IHPF) Health Intervention and Technology Assessment Foundation (HITAF)</td>
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Question(s) Addressed
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Contribution Applied at
Local, National, Regional and/or international levels

Five-Year Action Plan on Health Employment and Economic Growth: Movement in Thailand

Question 1:

At national level by enhancing the capacity and quality of HWF and networking locally, regionally and globally thru the establishment of HRH unit which is a joint force from Human Resource for Health Development commission (2017-2026) and Health Professional Education Reform commission (2014-2018) and inclusive institutional mechanisms to coordinate an intersectoral HWF agenda. These strategic plans will be used as the framework for propelling education reform for the health workforce in related organizations. The commission requests the local administrative organizations and relevant governmental organizations to apply the approach based on the power and function of the local administrative organizations or their affiliated units to implement the plans through participatory processes that involve social sectors’ networks and provision of financial support at the community level. and requests the Health Assembly networks, community organizations, social sectors’ network, and relevant private developmental organizations to participate in propulsion of education reform for the health workforce through the operational channel of each network or organization. At regional level. we work thru WHO regional network and
existing active regional network e.g., AAAH network. At global level, we work thru our international network related to different issues.

At national level
1. Annually update and report on National Health Workforce Accounts (eg. Type of health workforce, quantity, qualification, distribution, active, non-active, public or private services)
2. Scale-up of socially accountable and transformative health workforce education and training, institutional/instructional reforms and skilled HWF assessment including funding mechanism for sustainable financing for transforming health workforce education. Health workforce education and training in the country has diversity in the region based on their different context as an inter professional education (IPE) and inter professional practice (IPP), is more oriented to addressing community's need and gradual development of family care team. Community engagement health workforce education has become a fundamental element of the development of health workforce policies for better retention and appropriate distribution. Further more, our program that brings skilled health professionals to provide on-the-job-training to health workforce in the remote regions has enhanced the capacity and quality of family care team.
3. Reform health service model shifting from hospital based curative care to home based, community-oriented, people-centered, preventive, primary and ambulatory care by skill mix cadres.
4. Strengthen intersectoral collaboration and coordination for the implementation of national health workforce strategies,
5. Develop evidence-based policy and implementation of capacity to address gender biases and inequalities. Since women are significantly contributing to healthcare as health workforce or caregivers to communities but are unpaid, unrecognized or undervalued socially and politically.

At regional level
Implementation in the region is set for strengthening capacities to optimize HWF towards UHC, by forecasting and closing the gap between HWF needs and supply, building institutional capacity for effective governance and leadership, and consolidating a core set of HWF data.

Our objectives are
1. To assess country situations regarding the existing resources, mechanisms and/or potential to implement and achieve the prioritised milestones.
2. To promote and support the development of a country’s specific action plan related to the prioritised milestones taking subject to the availability of resources and the seriousness among country partners.
3. To coordinate, support, and facilitate capacity building and knowledge sharing across countries as well as development partner agencies in order to achieve the prioritised milestones.

A
1. To harmonize different recommendations for effective implementation at country level: a) the HEEG report, b) WHA resolutions on global health workforce strategies 2030, c) rural retention, d) transformative health professional education, e) WHO global Code of practice on international
2. Expected outcomes: Increase in health sector jobs
3. Core activities:
a. dialogue between related ministries and agencies  
b. outline the policy on health employment and economic growth including research and implementations  
c. conduct research and implement the policy  
d. evaluate the achievements  

B  
1. To increase the government fiscal space for health in the context of economic downturn in certain countries is equally challenging as intersectoral actions for health; recruitment of health personnel  
2. Expected outcomes: Increase in government fiscal space for health  
3. Core activities:  
a. dialogue between related countries  
b. map out the fiscal space for health in respective countries  
c. set out measure to increase fiscal space for health in respective countries  
d. evaluate the achievements  
4. Stakeholders: ILO, WHO, SEARO Member Countries and OECD

Question 2:  

As the ILO OECD WHO Five-Year Action Plan are proposed in the pursuit of the 2030 Agenda, unprecedentedly, it includes socio-economic domains, which require different set of information to be understood of all the big picture. It still has opportunities to provide baseline information for lead agencies to see what the baseline could possibly be, thus, they can compare with the improvements they contribute to after the completion of implementation of this Action Plan.  

Since the intersecteral strategy involves four key domains including finance, labor, education and health, it would require collective efforts from different ministries to work together on the very same issue for greater synergy between health employment and economic growth. The Action Plan should address the important of policy engagement beyond ministerial level. It should suggest on how the ministries can convince their governments to move the plan forward.  
The lead agencies on specific deliverables of the Action Plan and Immediate Actions should provide-specific guidance to all member countries on how to implement their plan in order to achieve the targets according to their own contexts. Developing countries and developed countries might need different guidance to achieve the same targets. Countries in Africa and Asia probably require different technical support from lead agencies.  

In many countries, accurate information of employment and gender equality in health sector is limitedly provided, the lead agencies should help member countries to study these issues for those countries to comprehend more about their circumstance before taking further action.  
The ten recommendations including six items of Transforming the Health Workforce and four items of Enabling Change stated in the Action Plan can be implemented considerably. Nevertheless, the Action Plan could be more relevant, if the recommendations are prioritized according to principles
that might be agreed among lead agencies and member countries. In that sense, the Five-Year Action Plan could be properly monitored and evaluated.

To implemented the Immediate Actions, it could possibly take member countries longer than the set timeframe of March 2018 as countries and regions will still be implementing the 2030 Agenda to reach the Global Milestone 2020. As the Immediate Actions is related to the 2030 Agenda. The timeframe should be also aligned.

The Action Plan and the Immediate Actions should address the good governance and accountability plan for all related agencies and member countries in order that all of them could justly benefit from the Action Plan and not being taken advantages. The lead agencies should provide platform for member countries to dialogue their stories, among themselves in order that they can learn from successful and thriving cases and how to improve their implementations and attain their targets.

It is also important for the Action Plan and the Immediate Actions to have mechanism for monitoring and evaluation to assess the achievements at appropriate time of the Action Plan and the Immediate Actions.
IntraHealth International—Commitment to Support High-level Commission on Health Employment and Economic Growth Action Plan

**Question 1:**

IntraHealth International commits to supporting the High-level Commitment on Health Employment and Economic Growth (Comm-HEEG) action plan and WHO Global Strategy on Human Resources for Health (HRH) to advance health workforce goals at global, national and regional levels. We will generate evidence and share knowledge through technical publications to inform best practices and highlight returns on investment from developing and supporting a needs-based, fit-for-purpose health and social workforce. IntraHealth will align research with global research priorities,
and contribute to standardized global indicators and metrics that enable comparison, tracking and advancing global knowledge.

We will leverage IntraHealth’s team of health workforce experts and country offices in Africa, Latin America and Asia and in-country networks and coalitions, building on HRH work in a variety of countries, including but not limited to the Dominican Republic, Guatemala, India, Kenya, Liberia, Mali, Namibia, Senegal, Tanzania and Uganda. IntraHealth will leverage its leadership secretariat role of the Frontline Health Workers Coalition, an alliance of U.S.-based organizations advocating for greater and more strategic U.S. government investment in frontline health workers.

**Digital health, data, and capacity building:** IntraHealth will help countries address workforce challenges through application of open source IntraHealth-developed data-driven tools such as the iHRIS suite health workforce information system and mHero, as well as such tools as WHO’s Workload Indicators of Staffing Need (WISN). IntraHealth will support countries in linking HRH information systems (such as iHRIS) to planning tools (such as WISN), and connecting them to HRH and volunteer registries, performance tracking systems and payroll systems. We will partner with WHO and AFRO to promote appropriate use of WISN and consolidate and disseminate lessons learned about WISN application. IntraHealth commits to supporting countries to perform automated routine reporting for National Health Workforce Accounts. We will help countries link information from HRH management to licensure tracking, to university student tracking, to registries of workers and volunteers, to payment systems, rather than creating parallel project-based systems. IntraHealth will provide technical assistance to countries on integrating health workforce data and information systems as part of national eHealth policies.

**Gender equality:** IntraHealth will contribute our gender analysis expertise as requested by countries and globally to maximize women’s economic participation and foster their empowerment through institutionalizing their leadership, addressing gender biases and inequities in education and the health labor market, and tackling gender concerns in health system reforms.

**Youth empowerment:** IntraHealth will help maximize opportunities to improve the quality of education, education opportunities, human capital, decent work and career pathways for youth as future health and social workers. Through partnerships with health and education institutions and other stakeholders, we will foster pathways for young people to enter the health and social service sectors. We will strengthen health services to ensure adolescents have timely access to sustainable, high-quality care and improve educational and training programs so health and social service workers are better prepared to meet youth needs, further encouraging youth to become health and social workers themselves.

**Needs-based, fit-for-purpose health and social workforce:** IntraHealth will advocate for and provide technical assistance for health and social workforce policies, investments and actions that support current and future needs of populations for universal health coverage and global health security. IntraHealth will help countries plan, budget and implement sustainable programs to capacitate and appropriately place health workers and to ensure workplace environments conducive to motivated providers and quality services. We will work with health professional training institutions to scale up transformative high-quality education and ongoing learning to support development of a needs-based, fit-for-purpose health and social workforce geared toward health promotion, disease prevention, primary health care and people-centered, integrated community-
based services. We will help health professional schools assess and address management issues, identify cost efficiencies, and monitor and sustain improvements, expanding performance-based learning connecting education and training to competencies and job responsibilities, and supporting stakeholder-driven, cyclical processes to optimize performance and quality.

Sustainability: IntraHealth will advocate for and support utilization of sustainable financing strategies for health workforce investments. We will advocate for innovative domestic resource mobilization, as well as global and country-level private sector investments in the health workforce, and support policy environments that enable and facilitate private sector investment in health workers.

Public health and protracted emergencies, and humanitarian settings: IntraHealth will leverage its leadership role in the Safeguarding Health in Conflict coalition to advocate for protection of health workers and health facilities in conflict situations—and for holding perpetrators accountable. We also will continue to apply our expertise to help countries and WHO address emerging public health threats.

Question 2:

We believe that the five-year action plan is well-developed and written. We would suggest, if possible, that the next Global Forum for HRH, planned to take place in Dublin in November 2017 be incorporated into the five-year action plan as feasible. In addition, we recommend that emphasis be placed, as recommended by the Commission, on prioritizing the 15 to 20 countries most in need of support to achieve universal health coverage.
Question 1:

We are concentrating our submission on feedback to the ILO OECD WHO Five-Year Action Plan.

Question 2:

Save the Children is the world’s leading independent organisation for children, working in 120 countries through our members, programmes and partners. Our mission is to inspire breakthroughs in the way the world treats children and to achieve immediate and lasting change in their lives. Save the Children has a dual mandate as a development and humanitarian agency, covering issues such as health and nutrition, education, child protection, child rights governance and child poverty. Our work is grounded in human rights and the United Nations (UN) Convention on the Rights of the Child in particular. Save the Children welcomes the opportunity to provide comments to the “Health Employment and Economic Growth: A Five-Year Action Plan (2017-21)” dated 14-15 December 2017. First of all, we would like to commend ILO, OECD and WHO for this joint effort. We think that the solid focus on health workers rights and “social dialogue” is necessary and important and are thus very supportive of the approach taken by the Action Plan. Our main concern is on what seems to be use of incorrect numbers on child and maternal deaths in the context of humanitarian crisis. On page 7 the action plan mentions that “two thirds of maternal deaths and over half of under-5 deaths take place in settings of humanitarian crises”. These figures have been deconstructed and challenged in the following Lancet article: www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31793-7/fulltext. We also welcome deliverable 1.3 in page 9 (“Labour market and fiscal space analysis supported and institutional capacity strengthened”), given the importance for all countries to focus on domestic resources. In our advocacy, Save the Children has consistently recommended development partners to provide technical and financial support to help countries a) promote sustainable domestic revenue sources for health through progressive tax reforms and increased transparency; b) monitor domestic budgets to track resource flows; c) implement domestic and international reforms to curb illicit
financial flows. We believe these points could be emphasised in the Action Plan. Finally, the Action Plan should be more explicit on the role that civil society can play to take the Commission recommendations and immediate actions forward. Still in the context of deliverable 1.3 mentioned above, civil society can, for instance, engage in tax processes, advocate for progressive tax reforms and increased transparency, advocate for strong agreements on public and donor country financing for health as part of the sustainable development goals; and advocate for increased and more equitable revenue and expenditure.
Question 1:

IPSF represents over 350,000 pharmacy students worldwide and is continuously investing effort into providing pharmacy students and young graduates with the necessary tools and skills for professional fluency both by building upon existing knowledge of the pharmacy curriculum and through other, informal education pathways. Our commitment to effort in aspiring for global changes in the field of pharmacy can also be noted through providing input in formulating the Workforce Development Goals during the FIP Global Conference on Pharmacy and Pharmaceutical Sciences Education in Nanjing in November 2016. Through our established infrastructure, we shall be implementing all mentioned actions globally and through our regional offices. It is in our vision and interest to unite pharmacy students across the world in the efforts we are undertaking.

Question 2:

IPSF views the Five-Year Action Plan on Health Employment and Economic Growth as comprehensive and elaborate. The proposed recommendations and immediate actions clearly outline the necessary course of events and allows even for International Student Organisations to identify their strong areas and possibilities for involvement.

It is understandable that member states and other stakeholders will need to reflect on the plan and identify key areas of improvement through the implementation of these recommendations.
The objectives that follow from this could perhaps be additionally concretized to allow for easy recognition of the purpose at a glance.

Within the key strategic phases, we can identify several important pointers regarding the improvement of the health workforce, especially in the labour market. The needs of the population and countries for healthcare professionals need to be met and equally important, the workforce needs to be in a position where it is able to focus primarily on the quality of healthcare without barriers in execution. As a student organisation, we appreciate the inclusion of youth empowerment. Traditionally, students in health across sectors have held a strong international presence and have continued to advocate on behalf of their profession. We believe that cannot be overlooked.

Following the transition of students from the education sector into the labour market, the migratory component of health workers must be stressed. At least in the early stages of the reformation, such inflow of good practices into parts of the world which have a bigger burden to bear in terms of establishing quality health care can be a good kickstart. Afterwards, bilateral flow should prove to be possible.

Considering we represent students, we are pleased to see related points among deliverables. Through our members, we have the insight into the numbers of pharmacy students enrolled around the world and will strive for expansion in this area according to the needs.

Preventive care which was already stressed during the sessions in Geneva and is included in the plan can be a very concrete way for involvement for future pharmacists, through public health campaigns and general healthy lifestyle promotion in pharmacies. It is therefore our hope that this recommendation will be successfully implemented in national healthcare policies, as the plan puts it forward adequately.

We would also like to touch the point of funding and financials in general, which is imperative for a successful health system. It is our desire elements such as fair wages would be universally applicable and outlined in the plan also in relation to those in training, particularly students towards the end of their education, which are too often used as a source of cheap labour, despite committing equal amounts of time and work to the effort, to the best of their abilities.

Point 8 of the deliverables does a great job on following the previous thread on investments. As mentioned previously, we view it as important for institutional mechanisms to be put into place which will allow for greater engagement of civil societies and professional associations, such as that of pharmacy students.

Finally, closing on international recognition of the global action plan, we are excited to see this being emphasized. In studies, this is already being achieved in Europe due to Bologna agreement, which principally aims to unify study programmes across the continent, including those of health professions. However, further efforts in this must be undertaken globally. That, together with the mentioned WHO Global Code of Practice on the International Recruitment of Health Personnel and the group of deliverables put forward, has unrivalled ability in achieving the desired targets.
Question 1:

Women in Global Health commits to support the establishment of a Gender and Health Workforce Hub (as per 8.1), which will seek to bring greater gender equity to global health through thought leadership events and the development and promotion of tools to advance greater gender equity.

Question 2:

Women in Global Health welcomes the commitments to increasing gender equality in the global health workforce, and looks forward to the elucidation of the specific measures that will be undertaken to achieve this action plan. We also welcome the commitment to increasing data disaggregated by data. There are currently significant data gaps in understanding women’s role in the health workforces of many countries, and further research and investigation needs to be taken to examine women’s experiences on a qualitative level.
New and Emerging Professions can contribute to Health Employment and Economic Growth.

**Question 1:**

The Association of Italian Chiropractors (AIC) is a stakeholder for the chiropractic profession and is a member of the European Chiropractors Union (ECU.) The AIC will be participating in health workforce supply and patient demand side areas. The actions will be at intra and inter-professional level, nationally and regional. Actions will also be directed at health policy makers and legislators.

Recc 1, 2, 3: The AIC is promoting the opening of chiropractic colleges in Italy in partnership with a Life University of the US. The AIC is also lobbying for legislation to regulate the profession in Italy in line with other countries in Europe. The profession already has a good track record in recruiting women to the profession. The profession in Europe has harmonised standards and requisites for Life Long Learning, even in countries where the profession is self-regulated and not subject to statutory regulation.

REcc 4: Chiropractic is a primary health care profession and growth in this field, particularly in the area of health promotion and MSD will reduce the pressure on hospital and secondary care. The EU Expert Panel on Investing in Health has published an opinion on the need for Disruptive Innovation and Competition in Health care and an opinion on Primary Care: health systems need more gates of access to the health system and a variety of gate-keepers. The IMF (Gupta) has published detailing competition and patient choice as the number one area to invest in to obtain efficiencies; and the OECD, in Enhancing Beneficial Competition in Health Professions has highlighted to obstacles in competition in health care.

REcc 5: The profession has adopted social media in a capillary fashion to facilitate health promotion.

REcc 6. Investment and lobbying is needed to overcome resistance to change and competition from incumbent health professions to novel and innovative forms of health care delivery, and the emergence of new professions, and the spread of best practice in health workforce innovation. The new school will double the number of chiropractors in Italy in 10 years. Other schools in Europe will take the number from 6000 to 10000 in a similar time period with the opening
of new schools. and expansion of existing schools. However more radical plans to expand the profession are being studied.

Working with the ECU and national associations the profession will be regulated in an increasing number of countries, benefiting patients with improved access, safety and quality of care.

The stakeholders we plan to engage with are inter and intra professional. We will work with WHO via the WFC and engage with the EU on specific projects working with other health profession and advocacy groups in Europe and with the ECU.

Specific core activities include participation in the European Public Health Alliance Working Groups on professions and eHealth; and participation in the EU Health Workforce Expert Health Network and workforce related projects and consultations.

**Question 2:**

The 5 year action is solid. It lacks emphasis on demand side factors, and so important demand pressures, specifically MSD, are not calculated into HWF planning.

Secondly there is no plan or immediate action for the spread of best practice. Many countries face similar health demand pressures. Some have found functioning solutions, the WHO action plan should include action to identify best practice and promote the spread of best practice. Monitoring mobility is one aspect, to this, and is included as an action. The EU is conducting a census of regulated professions and barries/requisites to entry and the plan is to compare the proportionality between countries of these requisites. However incumbent stakeholders may block this aspect of the project. The WHO action plan could include collaboration with the EU DG Int Mkt project on the regulation of professions.
Question 1:

Merck is a leading science and technology company in healthcare, life science and performance materials. As the oldest pharmaceutical and chemical company in the world, founded in 1668, we have developed countless innovations that improve people’s lives. We are committed to improving sustainable access to high-quality health solutions to under-served and un-served populations, regardless of their geographic location or ability to pay. We aim to “go beyond the pill” by leveraging our cross-business expertise across the health value chain through our approach known as the “4As of Access”: Availability, Affordability, Awareness and Accessibility. Our commitment and efforts were recognized in the 2016 Access to Medicines (ATM) Index, where Merck ranked 4th out of the 20 largest innovative bio-pharmaceutical companies. An independent benchmark, the ATM Index aims to measure how companies are improving access to medicines through their core business activities, which account for 90% of the Index methodology. Through our Awareness efforts, we aim to empower health workers, patients and stakeholders to make well-informed health decisions by providing them with the needed tools, information and education. In the 2016 and 2014 ATM Index, our Su-Swastha program in India was recognized as an innovative and sustainable business model that aims to raise awareness of prevention and treatment of primary care needs, incorporating education and training elements for health workers involved in the program. We believe that Merck and the broader private sector can be a contributing partner in tackling health workforce needs and gaps in order to achieve the UN Sustainable Development Goals (SDGs). Please find below specific examples of how we propose to contribute to the recommendations and actions proposed by the Commission:

1. Stimulate investments in creating decent health sector jobs:
   - We welcome constructive dialogue and collaborative proposals and we would welcome the opportunity to provide the Commission and its stakeholders our experience in building effective health infrastructure.
2. Maximize women’s economic participation and foster their empowerment through institutionalizing their leadership
• Merck is already active through various diversity initiatives and in disease awareness programs that affect women around the world. For instance, through anemia awareness campaigns, such as Salaminkera Anemia Prevention Project in the Philippines and True Red Check Camps in India, we aim raise awareness of this disease that predominately affects women and provide them with the information and resources they need to fight this disease.
• We will explore opportunities to promote health empowerment among women in developing countries and target female health worker communities specifically.
• Among our private sector and pharmaceutical industry partners, we will aim to raise awareness of the importance of women’s empowerment and identify potential opportunities for engagement in this area as new initiatives are launched.
• We will seek to join existing multi-stakeholder initiatives focused on tackling gender inequality, such as the UN Foundation’s Data2X initiative on gender-based data and welcome other opportunities to support data and evidence strengthening. Another potential opportunity is the Gender Champions initiative, where engagement by the private sector is limited.

3. Scale up transformative, high-quality education and lifelong learning
• Through our health empowerment approach, adopted via our Charter on Access to Health in Developing Countries, Merck aims to support the High Level Commission’s recommendations around our commitments Merck has adopted, via an end-to-end and tailored approach to health empowerment, focusing on 6 target groups and 5 types of intervention, ranging from medical education to capacity-building in logistics and process infrastructure.8. Promote inter-sectoral collaboration at national, regional and international levels
• Merck is pleased to serve as a private sector representative to the Commission and was honored to participate in the High Level Ministerial Meeting in December 2016.
• As the Action Plan is finalized and this initiative moves forward, Merck will seek opportunities to raise awareness and be an intra-industry advocate for relevant parts of the Commission agenda.

10. Undertake robust research and analysis of health labor markets:
• We propose to support the planned analysis of health labor force market data by providing more information on how the company contributes to talent development in various countries, particularly in building a diverse workforce with enhanced opportunities for women, at all levels of the organization. As highlighted above, we will also support the Commission in the implementation of the 5 immediate actions around inter-sectoral engagement; commitment and advocacy; labor market data analysis; dialogue on how to “accelerate investment” in education; and welcome the opportunity to participate in an international platform on health worker mobility.

**Question 2:**

The Five-Year Action Plan provides a well-rounded, comprehensive and practical approach towards addressing health workforce needs in order to meet the UN Sustainable Development Goals (UN SDGs). We fully support the proposed tripartite, cross-sectoral and multi-stakeholder approach. Indeed, the challenges ahead towards addressing the health workforce needs and challenges are great and cannot be tackled alone by one stakeholder. Please find below our feedback on selected
goals where we feel Merck and private sector partners can truly make a difference and contribute to sustained change:

1. Stimulate investments in creating decent health sector jobs:
   • We recommend elaborating on the definition of the health labor market. Although health workers in the public and private sector do comprise significant share of the market, other sectors and industries contribute as well. For instance, Merck employees around 50,000 employees worldwide. In 2014, the innovative and generics pharmaceutical industry combined employed over 5 million people and paid USD 972 billion in salaries.
   • We agree that it will be important to align domestic resources and official development assistance (ODA) with national strategies. However, we would like to emphasize the importance of developing sustainable models to reduce dependency on ODA. Although ODA contributed greatly to the achievement of the Millennium Development Goals (MDGs), it is now clear that different innovative financing approaches are needed in the SDG era.

2. Maximize women’s economic participation and foster their empowerment:
   • We agree that fostering women’s participation and empowerment as well as tackling gender inequality will be critical to meeting health workforce needs. To address these issues, we strongly encourage liaising with other organizations who have been leading on gender mainstreaming issues, such as UN Women.
   • We support the development of regional and national guidance and initiatives. We emphasize the importance of ensuring that gender guidance is adapted to local contexts to address specific gender needs and challenges.

3. Scale up transformative, high-quality education and lifelong learning
   • We support the scale-up of education and transformative learning. Within the curriculum developed, we encourage looking holistically across the healthcare value chain for opportunities to meet health workforce needs. The private sector can be a partner in this area. At Merck, we have a comprehensive approach to raising awareness and empowering health workers to make informed health decisions across the continuum of: health literacy, medical education, R&D training, technology transfer and capacity building.
   • We support the development of the Knowledge Platform and recommend that this be a cross-sectoral platform to which all stakeholders, including the private sector can contribute. The Platform could be a helpful resource and tool to reduce the learning curve in identifying and scaling best practices and sustainable models.

8. Promote inter-sectoral collaboration at national, regional and international levels:
   • We believe that multi-stakeholder and cross-sectoral collaboration are critical in order to meet the health workforce needs and the broader SDG agenda. We welcome the opportunity for the private sector, including the pharmaceutical industry, to be a contributing partner in this area. The private sector can bring a diverse and broad-range of experience that extend beyond financial resources, which should be leveraged.
   • We support the development of the Global Health Workforce Network as part of the inter-sectoral collaboration of the plan. We suggest that this network be developed as a public-private entity using a social business model to sustainably address challenges and needs. A step-wise approach should be taken with built-in monitoring and evaluation system,
including targets for the short, medium and long-term. To avoid “pilotitis,” best practices should be identified and scaled, using the Knowledge Platform as an information resource.

- In order for the Global Health Workforce to achieve its vision and objectives, it will be important to ensure linkages with local initiatives at regional, national and local level. Coordination amongst all stakeholders at all levels will be critical to ensure alignment and that current and future health workers receive the training and empowerment they need.

10. Undertake robust research and analysis of health labor markets:

- As part of the data framework and analysis of health labor markets, it will be important to acquire an understanding of the trends of health worker mobility. The aim should be to understand the drivers of “brain drain” out of developing countries and to include incentives for health workers to reach un-served populations.
Submission #11

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<tr>
<th>Name/Position</th>
<th>Dr. Mit Philips, Senior Health Policy Analyst</th>
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<th>Name/Position</th>
<th>Marielle Bemelmans, Public Health Consultant</th>
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| Country                       | Belgium, South Africa                        |

| Question(s) Addressed         | 1, 2                                        |

**Question 1:**

Within this contribution, we have concentrated on feedback to the five-year action plan under point 3.c. As MSF we remain committed to our mandate of provision of medical assistance to people in crisis with urgent health needs. Through our experience working in over 60 countries, we would like to share our observations on needs and gaps related to the health workforce.

**Question 2:**

With the intended creation of 40 million new jobs in the health and social sector, we at MSF are in particular concerned with those in low and middle income countries (LMIC) since the projected shortfall of 18 million jobs in 2030 concentrate primarily here. We welcome the initiative as it is an opportunity to bring real change to a persisting and acute problem affecting people depending on effective health care. In fact in many countries the HRH crisis has only deepened. E.g. in Malawi despite the emergency human resources programme (2004-2010) pooling international resources for salary top-ups and training, that led to a 53% increase in the number of health workers, staff shortages have remained critical. Training of new health workers is not keeping up with population growth, with e.g. 1.99 MD per 100,000 population in 2009 versus 1.79 in 2016.

Overall, caution must be made to perceive HRH issues as an economic investment case, as privatizing health services can lead to inequity of access to health workers as the most vulnerable
population are likely not able to afford it. HRH policy should keep objectives of service utilisation and coverage, quality of care and health impact at population level at the centre of its concerns. All lives matter, including those with possibly less obvious economic or social interest. Furthermore, it is critical to provide in the 5 year-plan a combination of short term measures with rapid benefits to lift current obstacles and long term structural measures. MSF is concerned about the general trend of moving away from service delivery focused HRH interventions, and main attention focusing on policy development, pre-service training and non-financial incentives.

Task shifting and recognition of medium and lower trained cadres

Recommendation 4 focuses on service delivery models and prevention and primary care. In the countries of its operation, MSF has observed that task shifting occurred at different levels. Most clinical care in countries such as Sierra Leone, Malawi or Mozambique is provided by mid-level health care providers. Tasks including malaria treatment or HIV testing are often delegated to lay persons or Community Health Workers (CHWs). We recognize how the support and deployment of large numbers of CHWs is a most needed complementary to professional staff. However, there must be caution for overreliance and burden on mid-level and community-based health workers without addressing some of the fundamental issues hampering adequate remuneration, working and living conditions. The renewed interest for CHWs at both national and international level, overlooks formalizing their roles and measures allowing their absorption in the health system. Voluntarism cannot be equitable nor an effective base to build health service provision and risks to create similar problems as for professional health workers, in terms of poor motivation, retention and asking fees to patients. The global HRH strategy also calls upon enabling public policies and regulation to formally recognize all cadres including mid-level workers and community based cadres (p.17). This recognition at national level needs to include all necessary benefits in terms of remuneration and system support in order to allow them to contribute more effectively to priority public health services.

Hospital workforce

In MSF’s experience quality and access to referral care is problematic; very few actors support hospitals and important gaps persist, hampering comprehensive health care provision. Often hospital care is dominated by privatised initiatives or involves heavy financial burden and restricted access due to patient fees. Adequate remuneration of hospital staff is essential to avoid misuse of patients or drugs.

Vulnerable populations

There is a need to provide a stronger recommendation concerning specific support to deploy, pay and retain health workers in underserved areas and to care for vulnerable populations, which should get specific priority attention by public health services.

Training and education

Recommendation 3, 3.1 and 3.2 refers to the scale up of education and lifelong learning. In addition to expanding the number of students enrolled in health professional education, there is similarly a need to invest in continued medical education, including mentoring, in-service and on-the-job training. We are concerned that exclusive or exaggerated focus on pre-service training under the current recommendation would imply reduced investment in in-service training support, as seen in the recent HRH briefing note of the GFATM. Similarly, pre-service training production increases the need to be matched by increased absorption and retention in public services, otherwise additional staff risks to benefit mainly private-for-profit services or international brain drain. The current quality of pre-service training is highly problematic in several countries we work in. The 5 year-plan does not
include specific interventions to assess and improve quality of and gaps in pre-service training. The indicator related to 3.2 refers to an expanded number of students enrolled in training institutions, however it is important to include enrolled and graduated as experience shows us there can be significant drop-out rates.

No pre-service training without recruitment and retention in public services

Recommendation 1 refers to expanding the number of health workers and recommendation 7 on adequate funding. After training more health workers, they must be employed which is often not done due to restrictions on the governments’ pay roll and lack of fiscal space. Therefore, without addressing their absorption in the public sector (and official pay roll), lifting the freeze on recruitment of health workers and their insufficient remuneration, the restricted ability to swiftly recruit trained health workers into the public system undermines the effectiveness of any training programme. Lessons learned from the recent Ebola crisis in West Africa for instance highlight how health workforce issues critically determined the ability to serve the population’s urgent needs before, during and after the outbreak. A major structural issue is the lack of staff absorption capacity into the public sector because of public budget shortfalls and macro-economic restrictions on public expenditure, in particular on the wage bill. Strategic importance of lack of fiscal space

Whilst shortage of staff in the public health services persist, in many countries such as in Uganda, Kenya, Guinea and DRC, a high number of qualified personnel are part of the labour market, whom are mostly not employed in the health sector. This is mainly due to wage bill expenditure or budget restrictions. In Mozambique, between 4000 and 5000 health professionals have been paid through temporarily bridge funding by international partners whilst awaiting absorption into the civil servant or MoH payroll. With the suspension of the SWAP funding mechanism (‘ProSaude’) this funding is currently at risk. IMF and Ministries of Finance still strongly recommend macro-economic wage bill ceilings and restrictions to be applied, including for the health workforce and therefore, adaptation of these macroeconomic policies is needed to allow greater investment in social services (art. 50 of HRH global strategy). Indicator 1.5 refers to “health workforce expenditure as a proportion of total expenditure on health”. However, we observe that health worker salaries are often paid from different budgets than from health, such as public service. It would be more interesting to look at indicators measuring actual health workforce expenditure compared to the needs. Alternatively, vacancy rates within the health worker establishment could also be tracked.

Need for international resources for recurrent HRH costs

As also outlined in the HRH global strategy (art. 38), “domestic resources for HRH are to be supported by appropriate macroeconomic policies at national and global levels and some countries will require overseas development assistance for a few more decades to ensure adequate fiscal space for HRH/UHC”. High-level policy dialogue is needed to explore how international mechanisms for development assistance can provide sustained investment in both capital and recurrent costs. Also, “GHI’s should align their support to strengthen HRH in a sustainable way, with the possibility for investment in capital and recurrent expenditure, including salaries (art 52)”. In this context, MSF observes that donors remain reluctant to fund recurrent costs that would support health workers’ pay. On the contrary, in recent years several donor agencies have been withdrawing from salary support, for example in Sierra Leone, apart from DFID and GFATM, who co-funded salaries during the first years of the free health care initiative, there is little interest in funding recurrent costs or salaries. Also in Lesotho, where international donors supported the deployment of approximately
500 lay counsellors, in 2012 over half of them stopped working due to reduction of funds, impacting outcomes of the HIV programme, e.g. reduced testing rates. Financial and fiscal space issues require a more prominent place in the commission’s recommendations. Political and technical solutions should be found to ensure sufficient fiscal space to absorb newly trained graduates and adapt remuneration. Meanwhile international funds can assure bridge funding of salaries and other measures to circumvent these restrictions on the short term. Without credible measures to overcome (or circumvent) these restrictions, reliance on domestic funding to assure adequate recruitment and retention in public services is idle hope in most countries. Withdrawing international funding without credible alternative puts at risk the health workforce’s contribution to more accessible quality service provision and therefore also UHC and other SDGs. Equitable access and user feesReference to “broad based health financing reform” (recommendation 7) is too non-specific. The current donor discourse mainly counts on an increase of domestic funding to expand health services. Without adequate remuneration from public funds (domestic or international), the burden on households of out-of-pocket expenses for health will increase and risks for further impoverishment rise. Systematic underfunding of health workers in the public health system creates a dependence on formal or informal user fees, creating additional barriers to care. E.g. the health system in Guinea largely relies on patients’ out-of-pocket payments, with patient fees complementing low state salaries or lack of payment to “volunteers”, waiting to be absorbed on the payroll. This also reinforces the urban-rural maldistribution of staff: most qualified health care workers are concentrated in the capital or large urban areas where patients can pay.

Priority countries

Within several recommendations (1.3, 1.5, 2.2, 3.2, 6.1, 7.2), reference is made to ‘priority countries’. It is unclear in the plan what criteria are used to define these countries. We are concerned that definitions should not be based on economic classification criteria only (based on GDP per capita eg), as was recently done in the HRH guidance note of the GFATM. These categories are not reflecting health needs and gaps, neither do they relate to needs for health workforce support. A broader package of characteristics, linked to a realistic context analysis for the health workforce should be taken into account.
Question 1:

The Training for Health Equity Network (THEnet), a partnership of health workforce education institutions operating under a social accountability mandate, proposes to support recommendations three and eight of the 10 Commission recommendations.

For Recommendation 3 “Scale up transformative, high-quality education and lifelong learning so that all health workers have skills that match the health needs of populations and can work to their full potential” In particular, THEnet will invest staff and organizational resources to share and expand resources and experiences. THEnet will work with global partners across health cadres to build an evidence base on effective social accountability strategies. The goal is to identify what works, how and in what context as well as help institutions evaluate outcomes and measure the return on investment of institutional and educational strategies. THEnet provides education reformers with a platform to access and share resources as well as receive peer to peer support. THEnet will also continue to share its Framework for Socially Accountable Health Workforce Education and related toolkits to help schools design and implement transformative socially accountable education as well as evaluate the impact of their programs and strategies. THEnet’ will also ensure that the tools are aligned with the global recommendations and add value to other key global data gathering tools and efforts.

For Recommendation 8 “Promote intersectoral collaboration at national, regional and international levels; engage civil society, unions and other health workers’ organizations and the private sector; and align international cooperation to support investments in the health workforce, as part of national health and education strategies and plans,” THEnet and its partners can offer its platform, staff time and expertise. Such paradigm-shifting efforts that the Commission recommends, call for new types of leadership and action at government, institutional and individual levels.
Effective leadership to transform education and health service delivery systems is not about striving to control complex systems; rather, it is about creating the conditions for teams, organizations, and communities to effectively and creatively cope with challenges and co-create solutions. Today’s leaders need to inspire and create settings that enable others to be their best in the pursuit of shared goals. They make it easy for others to offer their perspectives and talents, speak up when they have problems, take initiative, make appropriate decisions, work with others, and share responsibility for success. To that end THEnet will support institutional and individual capacity development of governments, professional associations and health workforce training institutions and their graduates using its Framework for Socially Accountable Health Workforce education and by developing and scaling up its Facilitative Leadership for Social Accountability training.

Question 2:

ILO, OECD and WHO and other partners should encourage governments, and other relevant authorities, to support reform at education institutions with clear goals and objectives, enabling policies and inclusive multi-stakeholder planning efforts. This includes support for implementation research and monitoring and evaluation of initiatives, which in turn should inform policy and action. Accountability and enforcement mechanisms are vital to sustaining reform and ensuring the quality and relevance of institutional and educational efforts. Hence quality standards and strong feedback mechanisms between education and service delivery are essential including engaging communities and civil society accountability efforts.
Submission #13

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<th>Name/Position</th>
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**Question 1:**

Australia welcomes the report and five year action plan of the High-Level Commission on Health Employment and Economic Growth. Australia is supportive of the ten recommendations. Australia is well-placed to implement, or is currently implementing, the Commission’s recommendations and actions through existing initiatives both domestically and regionally.

In line with the recommendations, Australia is committed to the principles of the WHO Global Code of Practice on the International Recruitment of Health Personnel (the Code) and is taking steps consistent with the Code’s objectives to reduce Australia’s reliance on international health professionals within the health system.

Australia has a highly skilled and motivated health care workforce and we continue to implement policies to train and retain increased numbers of health professionals, with the ultimate goal of achieving self-sufficiency. The health care and social assistance industry is Australia’s largest employing industry, with women making up 78.3 per cent of the workforce, compared with less than half (46.4 per cent) of the workforce as a whole.¹

However, the biggest challenge for health workforce in Australia is not that of supply, but the unequal distribution of health professionals between inner metropolitan areas and rural/remote locations. The Government has introduced a number of strategies to address this issue, including rural training pathways, incentives for health workers to relocate to rural areas, international recruitment and support for telehealth and outreach services. Australia will look to the Commission’s recommendations in seeking to address these challenges.

We welcome the Commission’s focus on primary healthcare. Health systems in Australia are shifting towards prevention and primary care and a more ‘people-centred’ model of care. Primary Health Networks (PHNs) have been established throughout Australia to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve the coordination of care.

¹ ABS, Labour Force, Australia, Detailed, Quarterly, cat. no. 6291.0.55.003, Nov 2016, four quarter average of original data.
In addition to our domestic work, Australia works with partner governments in the Asia-Pacific region to identify and address areas of health worker shortages, support appropriate training and develop strategies for retention and development of the workforce. For example, Australia’s aid program is working to strengthen the provision of regional health services and training in Pacific Island countries. This work aims to improve the quality and accessibility of clinical care in Pacific Island countries, by supporting the delivery of essential hospital care and workforce training.

Recommendation 1:
Australia currently invests in a range of multi-sector initiatives to promote employment opportunities. Current employment policies and programs promote youth employment, such as the Youth Jobs PaTH initiative, and protect discrimination against women, through the work of the Workplace Gender Equality Agency.

Recommendation 2:
Australia’s labour laws support women to access jobs without discrimination, and balance their work and family responsibilities. Existing initiatives designed to maximise women’s economic participation include:

- the Workplace Gender Equality Agency, which assists businesses to address pay equity concerns, by assisting with gender pay gap audits, providing pay equity toolkits and running awareness campaigns; and
- demonstrating best practice in the Australian Public Service, by implementing the APS Gender Equality Strategy (released 28 April 2016).

Recommendation 3:
Australia commits to continued investment in enhancing workforce distribution, training capacity and quality by providing educational opportunities in settings where medical specialists will work once they obtain Fellowship, such as private hospitals, specialists’ rooms and community health settings. Additionally, the Government has invested in initiatives to ensure access to professional training and support in rural and remote areas for medical specialists, allied health professionals and nurses.

Australia has also established a National Nursing and Midwifery Education Advisory Network (NNMEAN) to provide high level strategic advice to Health Ministers on an evidence based approach to the planning and coordination of education, employment and immigration for nurses and midwives in Australia.

Recommendation 4:
Australia is also reforming the way we provide care for people with chronic and complex conditions, with plans to pilot a new model of primary care called ‘Health Care Homes’. A Health Care Home will be a ‘home base’ that coordinates the comprehensive care that patients with chronic and complex conditions need on an ongoing basis.

Recommendation 5:
Australia has provided support to implementing technological improvements in the delivery of training and services through access to remote supervision for health trainees, telehealth initiatives and My Health Record - Australia’s national digital health record system. Benefits of the system include improved coordination of care for patients, better clinical decision-making through access to quality health information, reduced adverse drug events and less avoidable hospital admissions.

Recommendation 6:
The Australian health workforce is well-placed to respond to a global humanitarian crisis. Ensuring there are health workers in the right numbers and the right places, with adequate, reliable remuneration is the foundation for peacetime service delivery, which can be built on to prepare for times of crisis.

The International Health Regulations (IHR) are an essential vehicle for action during public health emergencies and Australia is committed to implementing activities, in collaboration with WHO, that support IHR compliance.

Recommendation 7:
Australia’s Health for Development Strategy 2015-2020 provides guidance on investments in countries’ core public health capacities, and combatting health threats that cross national borders. The focus is on strengthening country-level health systems tailored to people’s needs. Australia works with partner governments in our region of Asia-Pacific to identify and address areas of health worker shortages, support appropriate training and develop strategies for retention and development of the workforce.

In addition, Australia has invested $52 million over five years (2015-2019), partnering with the World Bank and national governments in our region to analyse health financing arrangements, improve public financial management and ensure adequate funding is identified and allocated to essential health programs, including health security.

Recommendation 8:
Domestically, the Council of Australian Governments’ Health Council provides a forum for continued cooperation between governments on health system issues. A number of stakeholder bodies have been established to provide advice to Health Ministers, including through the Health Council mechanism, on issues relating to workforce training, planning and coordination. For example, the National Nursing and Midwifery Education Advisory Network and the National Medical Training Advisory Network.

Recommendation 9:
Australia is committed to the principles of the WHO Global Code of Practice on the International Recruitment of Health Personnel (the Code). It is taking steps consistent with the Code’s objectives to reduce Australia’s reliance on international health professionals within the health system.

Recommendation 10:
Australia has adopted a leadership role in the use of data for the development of nationally coordinated health workforce policy and planning. This includes:

- Development and maintenance of the National Health Workforce Dataset – Working with state and territory governments, medical colleges and key stakeholders to collect, analyse and report on data that contributes to our understanding of Australia’s health workforce needs
- Undertaking supply and demand studies for a range of health professions and applying these findings to policy and program development.
Question 2:

Australia strongly commends the tripartite collaboration between the WHO, OECD and ILO in responding to the report of the High-Level Commission on Health Employment and Economic Growth. We welcome the draft five-year action plan, which provides a sound basis on which to drive multi-sectoral action at global, regional and national levels to address the Commission’s recommendations.

ILO, OECD and WHO partnership

The success of the partnership between the WHO, OECD and ILO will be critical to ensure effective implementation of the Commission’s recommendations. Australia is pleased to see the clear division of roles and responsibilities between the three organisations, with nomination of lead and partner agencies for each deliverable. We would encourage robust coordination mechanisms to ensure effective and efficient collaboration and avoid duplication of effort.

We recognise that the action plan will serve as a basis for further operational planning within each organisation. Given the collaborative nature of this work, alignment of planning will be crucial, particularly where multiple lead agencies are listed. The process by which work is taken forward will require due consideration, with appropriate management of any sensitivities arising due to the differences in countries represented across the three agencies, as well as internal planning within each agency (for example with regard to which OECD Committees will lead on specific deliverables). Each organisation’s activities will also need to be adequately resourced in their respective programme budgets.

We also acknowledge the importance of collaboration with other relevant UN agencies, for example the IOM, and encourage the tripartite partnership to continue to extend and strengthen collaborative efforts.

Implementation

We support the clear objectives and rationale of the plan. With regard to section 4, we support the framework for key strategic phases of country-driven implementation and the use of labour market data and analysis to identify strengths, weaknesses, failures and underlying causes to inform context-specific national health workforce strategies. Figure 1 provides a good visual representation of this concept. We welcome the clear identification of key cross-cutting considerations underpinning the plan, and strongly support the application of a labour market approach, and coherence, alignment and coordination across all sectors. Figure 2 clearly demonstrates these linkages, and provides a useful representation of public policy levers.

Maximising synergies

Australia welcomes plans for reporting through existing processes. We welcome the adoption of deliverables derived from the Global Strategy on Human Resources for Health, and encourage alignment with other relevant global initiatives and programmes, including those related to gender equality, youth employment, and decent work, to avoid duplication and ensure any new work is complementary. Deliverables and indicators should be consistent with existing related work, including the 2030 Agenda for Sustainable Development.

With regard to the presentation of the deliverables table (pages 8-16), further clarification on the rationale for prioritising deliverables as well as the relationship between the immediate
actions and the recommendations would be helpful, for example through a numbering system to link these back to the ‘immediate actions’ detailed in the Commission’s report. While the colour coding is useful, further clarity could be provided to ensure linkages are clear. Alignment with existing SDG targets and indicators (as demonstrated on page 58 of the Commission’s report) should also be clearly identified. We acknowledge that targets are still to be determined and encourage the statistical offices of the three organisations to work closely together and ensure these are specific and time measured.
**Submission #14**

<table>
<thead>
<tr>
<th>Name/Position</th>
<th>Johanna Kruger</th>
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<tr>
<td>Organization</td>
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**Question 2:**

Generally speaking, it is laudable that investing in the health workforce is seen as a way to increase women’s economic empowerment and access to decent jobs, as reflected in recommendation number 2 from the Commission. Our concern is that when looking at the framework, there is very little to do with gender equality and women’s empowerment embedded in the targets and indicators for each recommendation that is not number 2. If gender equality is to be treated like a cross-cutting issue (see item 4 at the top of page 7), then it needs to get integrated as such into the framework, so that you can see and measure results for women at the outcome level. As it stands, GE seems to be siloed in recommendation 2.

On top of being treated as a cross-cutting issue, there should also be a number of targeted interventions/actions that ensure that women can overcome social barriers to their economic participation, as they relate to the health and social services workforce (lack of access to education/skills training, discrimination and violence against women, unpaid work burden, women’s lack of agency, etc.)

Using gender-sensitive indicators where possible, and collecting data disaggregated by sex (NOT gender) and age is also useful. The national strategies that are referred to in numerous places in the framework should be explicitly gender-responsive, so that they are designed and implemented in a way that addresses the needs and interests of women and men. A gender analysis should be undertaken before developing the national strategy to ensure it is meeting those needs.

Figure 2 on page 7 of the document makes no mention of gender equality despite making reference to public policy levers. Having gender-responsive policies linked to gender-sensitive budgets is key in ensuring that women benefit from any increased investment in the health labour force.

When creating social dialogue and inter-sectoral collaboration mechanisms, ensure that women’s civil society organizations are explicitly included (in reference to 8.2 on page 14).

On Recommendation 6:

We wanted to flag something about the 9th cross-cutting considerations “Public health and protracted emergencies, and humanitarian settings: Take special consideration of the specificities of
the health labour market and challenges in the education and training of health workers, decent work, and the protection and security of health workers in public health, protracted emergencies and humanitarian settings; recognizing that these cannot be ignored whilst two thirds of maternal deaths and over half of under-5 deaths take place in settings of humanitarian crises. “ (p. 7)

It has been brought to our attention that a correction/comment was issued by the Lancet recently that casts doubt on these figures---apparently they are all sourced back to one grey study where the data was calculated in an aggregated/crude manner (e.g. counted ALL maternal deaths in a country that had experiences of conflict or natural disasters as being maternal deaths in fragile or humanitarian situations). As it is right now there doesn’t appear to be a validly collected statistic on actual maternal deaths in humanitarian and fragile settings, it is a gap in the data. But in discussions it should be noted that the 60% quoted widely may not be statistically supported once the data is disaggregated.

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)32066-9/fulltext

On Recommendation 6:

Deliverable 6.2: we would like to see that tools, methodologies and systems be developed in collaboration with other relevant actors (such as ICRC, MSF, OCHA).

Deliverable 6.3: we would suggest that “technical support” for protecting occupational health and safety” be better explained. It is not clear to how this would be done and examples of technical support would add more clarity to that indicator.
Submission #15

<table>
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<tr>
<th>Name/Position</th>
<th>Ann Danelski, Global Health Officer</th>
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**Question 2:**

The HEEG recommendations have implications across many different global initiatives and stakeholders—spanning gender, education, youth, finance, health, social, labor. Many of these extend beyond the stakeholders that WHO normally engage with, and it is lesser known how ILO and OECD engage with initiatives that focus on LMIC. For reference, on the USAID side, none of our youth, social service, and education experts were aware of the HEEG from their various area-specific networks, and it was only brought to their attention by colleagues working on HRH. Additionally, to our knowledge, ILO has had very little direct engagement with in-country HRH and social service workforce working groups and partners, including USAID and UNICEF (critical for the social service aspect), and the action plan is proposing that they will be helping to establish dialogue mechanisms. It would be helpful if the action plan included a description of how WHO, ILO, OECD plan to coordinate with/ across other relevant global initiatives. This is also of particular importance with the emphasis on targeting youth employment. A schematic that gives a visual of all the various relevant global initiatives that WHO, ILO and OECD hope to engage as part of the HEEG recommendations would be helpful reference to correspond to the deliverables table.

Including a description of how WHO, ILO, and OECD will be providing direct engagement to countries would be helpful. This would be particularly helpful for better understanding support to LMIC. For example, lesser is known on ILO regional/country presence and how it engages with countries. How will WHO be working through its regional /country presence to support this work? This is helpful background information for the deliverables table.

Acknowledging that this is an action plan for WHO, ILO, and OECD, there is quite a bit of ongoing HRH work and investment being made in countries. How will the action plan take this into consideration and work to leverage or build upon existing partner/donor investments who may be working to align with the HEEG recommendations? What role will GHWN have in this?

Greatly welcome the inclusion of the social sector into broader health workforce discussions. But the language throughout the document is inconsistent (at times health and social workforce, at times only health) and still needs to be better defined in the background text (*noting the HEEF recommendation language omits any reference to the social workforce) and included in the
deliverable table. For example, it is unclear if this document is meant to include the full diversity of the social service workforce who addresses the range of issues affecting one’s health and well-being (para professionals carrying out home visits to counsel and support children affected by violence, district social welfare officer within a Ministry of Social Welfare, school-based guidance counselors or child protection committee members, etc) or only that portion of the social service workforce that carries out its work with a specific focus on improving health (health facility-based social workers, community-based para social workers providing follow up to those experiencing health and other issues, etc). A footnote in section one would be a helpful addition to define the scope of the health and social sector workforce included in this document. Thereafter, one consistent term can be used throughout the document. In addition,

Text Specific:
- Include definition of social dialogue phrasing. Is this stakeholder engagement? Unfamiliar terminology.
- Pg. 7 Sustainability Cross-Cutting Consideration description can be made clearer. Perhaps specify ‘improved’ utilization of existing finances and ‘expand’ financing strategies? It is recommended that the terminology “health and social worker…” be replaced with “health and social sector workforce”
- Pg. 6 Key strategic phases of country-driven implementation, clarify timing of the phases and key stakeholders

Deliverable Table:
- Recommend that an activity column be added to the table to better understand role of WHO, ILO, OECD in each of the deliverables and contributions to the indicators:
  - For example, 1.3, is WHO confirmed to conduct labor market analysis in 20 countries? 1.3: How will utilization of data from labor market analyses to inform decision making be captured? For this particular deliverable, it would be helpful if WHO could help propose a consistent or standardize methodology/tools to use for labor market analysis.
  - For example, 1.5 and 7.1, what action does WHO envision/plan for support for this activity? How will WHO be facilitating intersectoral discussion on HRH financing? Specifically, Indicator for deliverable 1.5, “Health workforce expenditures as a proportion of total expenditure on health. Target: 20 priority countries” is unclear. Is it supposed to read “# of countries that have met their strategic goals around health workforce exp as a proportion of THE through combined donor and domestic resources”?  
  - For example, 2.2, will ILO and WHO be building country capacity to implement policies?
  - For example, 3.2, what is the role of the WHO in achieving this deliverable and attribute to the indicators? This indicator is very broad and inconsistent with the more nuanced dialogue around increasing the output of health workers that are appropriate to country health needs and labor markets. Suggest adding the italicized text so that the indicator looks like: “Number of countries that have expanded the number of students enrolled in professional, technical and vocational education and training, consistent with the goals outlined in country’s health workforce strategies. Target: 20 priority countries”).
For example, 3.5, 3.5- The Global Health Workforce Network (GHWN) will operate within WHO, so propose that WHO still be noted as lead agency, and GHWN be included in the indicator or activity language.

For example, 4.2, who from which sectors will be consulted in the development of guidance around interprofessional education? What will be the process to allow groups to provide input?

- There is no reference to the WHO GSHRH within the document. One suggestion is that a deliverable or indicator that directs WHO to connect monitoring /implementing the HEEG recommendations to achieving objectives of the GSHRH.

- A- Would be helpful to specify engagement with various global initiatives and outline examples, including of international decision-making forums.

- For the high level goal of promoting gender equality, it seems that the goal is focused only on gender equality at the lower level cadres and valuing unpaid work. Is there discussion to ensure there is also gender equality throughout the health care production chain including at the higher levels of management?

- More information needed on 7.2 and funding mechanism that is being proposed. “Funding mechanism established” hints at the promotion of establishing trust funds to deal solely with funding the health workforce. What would be the objective of the funding mechanism? Would it be a dedicated central mechanism that countries would use to fund health professional training programs and pay salaries? Or is it a mechanism just to do research and develop polices?

- More information needed on 8.3 and global compact.

- 10.2- recommend specifying # of countries reporting on NHWA as indicator.

- For deliverable 3, the term “lifelong learning” tends to have a broad definition that implies learning for both personal and professional gain. We should change the term to focus on learning for professional gain. Are there models similar to our Continual Medical Education model that would be acceptable in the developing country context?

- RE deliverable 5.1 “ICT tools evidence review” to meet the goal of harnessing technology: Shouldn’t we move toward activities that promote better dissemination and adoption of effective tools? This field is rapidly evolving and if the aim is just to do a review, then the global health community will already be multiple steps behind.

- RE deliverable 9.1. Remittances are one of the benefits of health workforce migration that can be better captured, when "mutually beneficial" outcomes of health workforce migration are discussed. Are there ways to link data collection on health professional migration to other work on migration remittances? Is there good remittance data disaggregated by migrant labor type?
Question 2:

With respect to deliverable 9, Jamaica underlines the importance of advancing bilateral agreements which foster mutually beneficial international health worker mobility.
Question 1:

Pour prendre en compte les recommandations de la Commission, la France s’engage aux niveaux national, européen et via son aide au développement bilatérale et multilatérale à :

- **Au niveau national** : accélérer la mise en œuvre des conclusions de la « Grande Conférence de la santé » de février 2016, qui a esquissé un nouveau modèle de système de santé, mettant l’accent sur la prévention, sur une offre de soins intégrée et centrée sur la personne, dans le cadre de la loi de modernisation du système de santé. Cela conduira notamment les autorités françaises à engager une réflexion sur la démographie médicale et la meilleure répartition sur le territoire des professionnels de santé, pour qu’elle soit plus en adéquation avec la réalité des besoins.

- **Au niveau européen** : promouvoir la dynamique européenne en matière de développement des ressources humaines en santé et d’innovation dans les parcours de formation. La France se mobilise pour que la mobilité des professionnels de santé se fasse dans des conditions satisfaisantes, en tendant vers l’harmonisation de la qualité et des standards de formations dans chaque pays de l’Union européenne.

- **Au niveau international** : accompagner le renforcement des systèmes de santé dans les pays les plus fragiles. La France s’est engagée dans ce sens à consacrer une part plus importante de sa contribution au Fonds mondial de lutte contre le vih/sida, le paludisme et la tuberculose à des actions bilatérales d’assistance et de conseil, jusqu’à 7% des contributions françaises au Fonds Mondial d’ici 2019, soit 25 millions d’euros annuels. La France entend aussi poursuivre ses efforts pour mettre en place, avec nos partenaires africains, un modèle d’institut de santé publique adapté aux besoins locaux, en mettant l’accent sur les zones rurales défavorisées. La France réfléchit à l’élaboration de formations à destination des personnels de santé francophones avec l’Association des Universités Francophones (AUF) et en lien étroit avec les acteurs et partenaires locaux (réseau de facultés reconnues) et l’OIF. Ce projet consisterait à créer les conditions d’un
partage d'expérience et d'expertise utile pour les bénéficiaires ainsi que les formateurs et adapté aux besoins de chaque pays pour tous les niveaux de compétences à développer. Cela permettrait de créer un réseau francophone de formateurs en santé publique, qui intègrerait, dans le cadre des formations, les outils du numérique et de e-santé et les moyens de communication disponibles.

La France s’engage aussi à :

- Poursuivre le renforcement de la mise en œuvre du Règlement Sanitaire International, via son soutien aux activités de l’OMS et également via son appui direct aux pays. L’amélioration de la sécurité sanitaire internationale doit se traduire par le renforcement du rôle et du réseau des points focaux nationaux, par leur formation à la surveillance et la gestion des épidémies, en s’appuyant sur des outils de formation novateurs, mais aussi par la formation plus large des professionnels de santé aux mesures de contrôle des épidémies, à leur protection individuelle et au bon usage des médicaments pour lutter contre les résistances antimicrobiennes. Enfin, dans une approche multisectorielle, formations et actions de sensibilisation doivent aussi s’adresser aux professionnels hors du secteur santé (santé animale, agriculture, transport, etc.) qui ont également un rôle dans la mise en œuvre le RSI et la garantie de la sécurité sanitaire.

- Appuyer l’OMS dans son rôle de coordinateur du renforcement des systèmes de santé et de la sécurité sanitaire internationale, en contribuant financièrement et par la mobilisation de notre expertise à ceux de ses programmes qui y sont dédiés. La France veillera en particulier à ce que les ressources humaines en santé soient partie intégrante du renforcement des capacités de mise en œuvre du RSI et que le plan quinquennal d’action pour la mise en œuvre des recommandations de la Commission et le programme FIT de l’OMS d’appui au renforcement des systèmes de santé soient coordonnés.

- Instaurer un cadre de dialogue sur la mobilité des personnels de santé au sein de l’espace francophone. La France y travaille avec ses partenaires au sein de l’OIF. Le Sommet de Madagascar de novembre 2016 a ainsi mis en exergue le besoin de coopération dans le domaine de la santé. La rencontre ministérielle des pays francophones de l’UEMOA, qui s’est tenue en mars 2017 à Abidjan, a été l’occasion d’approfondir les discussions sur la construction d’un tel cadre au niveau de la région ouest-africaine.

- Apporter son soutien à l’OMS, l’OIT et l’OCDE dans les différents processus de finalisation, d’adoption ou décision par leurs organes directeurs respectifs, puis de mise en œuvre du plan d’action quinquennal.

**Question 2:**

- La France salue l’approche globale retenue pour le plan d’action, qui prend en compte l’ensemble des recommandations du rapport et offre une vision complète de la problématique des emplois en santé
La France soutient l’approche intersectorielle et transversale du plan d’action, qui reflète les interconnexions existantes entre les recommandations et donc la conception technique et la planification des opérations qui en découleront. La France suggère de mettre en lumière, dans le chapeau explicatif : le rôle non seulement des organisations (en termes d’appui technique, de développement des compétences et avis) mais aussi et surtout des membres de ces organisations (Etats et organisations de travailleurs et d’employeurs) qui demeurent les premiers responsables de la mise en œuvre des actions et des réformes prévues par le plan.

Afin de gagner en lisibilité, une définition du terme « personnels en santé » au sens de la Commission (personnel médical, paramédical, personnel administratif, travailleurs sociaux en charge des soins de longue durée...) mériterait d’être clarifiée.

Il serait opportun d’expliciter davantage comment ce plan se fonde sur et vient en appui aux analyses, études, stratégies et plan d’actions des différents organisations, existants, en cours et à venir (OMS Stratégie mondiale sur les ressources humaines en santé à l’horizon 2030 ; OMS 4ème Forum mondial sur les ressources humaines pour la santé en novembre 2017, études de l’OCDE sur les personnels de santé).

Il conviendrait d’expliciter davantage les conséquences des actions à chaque niveau (à la fois au niveau des pays mais aussi des organisations internationales : rapport Siège / bureaux régionaux / bureaux pays) : local, national, engagement des gouvernements mais aussi des syndicats et associations d’employeurs (dialogue tripartite), régional (pour nous, implication forte de l’Union européenne) et international (mobilisation des organisations internationales).

La France suggère d’expliciter davantage comment s’articulera le travail des trois agences et l’implication du niveau d’action de chaque agence, entre les organisations responsables et les institutions partenaires, dans la mise en œuvre effective du plan d’action et quels seront les mécanismes de redevabilité.

Il serait nécessaire d’identifier plus clairement les actions prioritaires dans le temps : par exemple, l’action 1.3 relative à l’analyse du marché de l’emploi et de l’espace fiscal et à l’élaboration d’options politiques doit être l’une des premières mises en œuvre et servir de base à toutes les autres. En outre, une telle analyse pourrait être proposée à des échelles régionales.

La France salue la proposition d’action qui consiste à établir une plateforme internationale sur la mobilité des personnels de santé. Afin de ne pas mettre en place une plateforme déconnectée du terrain, il pourrait être utile, au préalable, de mieux connaître les besoins en main d’œuvre par pays (offre existante par rapport à la demande).

Il pourrait également être opportun de s’intéresser à l’attractivité de l’emploi en santé (question de la rémunération, barrières socio-culturelles...) du point de vue des personnels en santé.

La France suggère d’introduire des indicateurs plus qualitatifs. Les indicateurs quantitatifs sont en effet susceptibles d’introduire un biais.